PER HIPPA REGULATIONS, PLEASE PRINT COMPLETED FORMS (pages 1-6) AND BRING TO YOUR APPOINTMENT.
Our Privacy Policy (pages 7-9) is for your information.

Stuart R. Winthrop, M.D.

Today's Date_____/_____/________

PATIENT INFORMATION

Last Name________________________ First Name ________________________ M.I.______

SS#________________________ Birth Date _____/_____/________ ◯ Male ◯ Female

Billing Address ________________________ ____________ ______ ________
Street City State Zip

Home Phone (____) ____________Work Phone (____) ____________Ext ______ Cell# (____) ____________

Secondary Address ________________________ ____________ ______ ________
Street City State Zip

Status: ◯ Minor ◯ Single ◯ Married ◯ Significant Other ◯ Divorced ◯ Widow

E-Mail ________________________ Fax # (____) ____________

Patient's Employer ________________________ Occupation ________________________

Address ________________________ ____________ ______ ________
Street City State Zip

Spouse ________________________ Occupation ________________________

Address ________________________ ____________ ______ ________
Street City State Zip

Phone Number (____) ____________ ◯ Home ◯ Work ◯ Cell SS#________________________

Current eye care practitioner ________________________

Whom do we thank for this referral? ________________________

What/who influenced your decision to see Dr. Winthrop? (Please check all that apply)

☐ Doctor ☐ Friend/Family ☐ Reputation ☐ Website ☐ Online Ad ☐ TV Commercial ☐ Yelp ☐ Facebook

☐ Other ________________________

PLEASE COMPLETE THIS SECTION IF DIFFERENT FROM PATIENT INFORMATION

Insurance Policy Holder and/or Responsible Party. If you are a minor, Parent or Legal Guardian

Last Name________________________ First Name ________________________ M.I.______

Home Address ________________________ ____________ ______ ________
Street City State Zip

Home Phone (____) ____________Work Phone (____) ____________Ext ______ Cell# (____) ____________

SS#________________________ Birth Date _____/_____/________ Relationship to Patient ____________

PLEASE BRING YOUR CURRENT INSURANCE CARD(S) TO PRESENT TO THE FRONT DESK PERSONNEL

Stuart R. Winthrop, M.D.

Patient Name: ______________________ **Date of Birth:** ______________ **Date:** ___________

SOCIAL HISTORY:

Student Homemaker Employed Retired Single Married Separated Divorced Widowed

Do you use Tobacco? Yes No; if yes:
Cigarettes Smokeless _______ # Packs/Times Day _________ # of Years

Do you use Alcohol? Yes No; if yes:
Rarely Daily Weekly; 1-2 drinks 2-4 drinks Other______________________

Substance Abuse? Yes No; if yes:
Rarely Daily Weekly Other______________________

LIST ANY DRUG ALLERGIES: ______________________

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)
If you have a list, please give to receptionist to copy in lieu of filling out form:

Medication Name	Dosage	Taken how often? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			
		___ Times a day ___ or PRN	Oral Topical Injection			

REVIEWED:

Staff	*Date*

☐ Patient refused to fill out form

Physician Signature: ______________________ Date: ____________

Use back of sheet if needed>>>

All information you provide is confidential and will not be released to anyone without your consent
Use back of form for any additional information that you need to add.

08/2017

Stuart R. Winthrop, M.D.

Medication Name	Dosage	Taken how often? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
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		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			
		___ Times a day ____ or PRN	Oral Topical Injection			

Staff	*Date*

Physician Signature: ______________________________________ Date**:** ______________________

All information you provide is confidential and will not be released to anyone without your consent
Use back of form for any additional information that you need to add.

Stuart R. Winthrop, M.D.

PAYMENT & BILLING DISCLOSURE AND AGREEMENT

We will bill your insurance for you **if we have the complete information at the time of your visit,** including your social security number. If we do not have the necessary information, and/or Dr. Winthrop is not a contracted provider, we will ask that you make a full payment at the time services are rendered. If you provide the necessary information within 15 days, we will bill your insurance, and when payment is received, a reimbursement check will be issued. Please be assured that we protect your information in accordance with HIPPA Federal law.

- **Co-payments are due at the time of service.**
- **Dr. Winthrop welcomes Medicare patients. However, he does not accept Medicare assignment.** This means you'll be responsible for 20% of what Medicare allows, and any non-covered services, as well as your annual deductible. If you have a Medicare supplemental insurance, please inform us at the time of service, and we will bill the insurer for 20% of the Medicare allowable charge.
- **$60.00 Refraction charges are due at the time of service.** This is not a billable event to *most* insurance companies, therefore we ask for this payment at the time of service. If *you know* your insurance covers this expense, we will bill it, and when payment is received, a reimbursement will be sent to you.
- It is the responsibility of the patient to be **informed of the exclusions and inclusions of their insurance policy**, including, but not limited to co-pay and deductible amounts.
- If you do not have proof of insurance**, by signing this form you understand and agree that you are fully responsible for complete payment of medical fees for services provided.**
- **Dr. Winthrop is not contracted with any HMO plans or Vision Plans**. If you have either kind of insurance stated above, and you choose to see Dr. Winthrop, you are expected to pay for this visit, in full, at the time of service.
- **If Dr. Winthrop is not a contracted provider on the panel of your insurance plan,** he is not under any obligation to accept the contracted amounts as payment in full. It is your responsibility to pay for the services rendered at the time of your appointment.

PLEASE CONTINUE ON BACK ⇒⇒⇒

515 E. Micheltorena St., Santa Barbara, CA 93103
Office: (805) 963-4272   LASIK Line: (805) 730-9111

Stuart R. Winthrop, M.D.

PATIENT SIGNATURE

With my signature below, I acknowledge that I have read and accept all policies as described in this document.

Signature_______________________________________Date_______________

As parent or legal guardian of patient, I agree to pay for all office charges at the time of service and all outpatient charges within thirty (30) days from the time they are provided. I understand that this office bills insurance as a courtesy and that payment of all charges is my responsibility.

Signature____Date_____________
(Parent or Legal Guardian)

Please Print Name____

If you would like a copy of this sheet, please inform our office staff. Thank you.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPAA (Federal Health Insurance Portability and Accountability Act)

I, ____ have been offered a copy of this practice's
Print Patient Name

Notice of Privacy Practices

HIPAA Privacy Procedures and Policies

❒ I choose to take a copy

❒ I choose not to take a copy

You have the right to refuse to sign this document

____ ______________
Patient Signature Date

FOR OFFICE USE ONLY

This office attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices and we were unable to obtain signed acknowledgement because:

_____the patient refused to sign.

_____communication barriers prohibited obtaining signed acknowledgement.

_____an emergency situation prevented this office from obtaining the acknowledgement.

Other____

____ ________________
Clinician Signature Date

HIPAA Contact Person: Jeff Harbison, COT, (805) 963-4272

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Stuart R. Winthrop, M.D.

EXHIBIT I
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

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We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

Stuart R. Winthrop, M.D.

This notice if effective as of August 15, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing. Our Compliance Officer is Jeff Harbison, COT, 515 E. Micheltorena Street, Suite D, Santa Barbara, California 93103, Phone 805-963-4272 ext 24.

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