Brookswood Optometry Intake Form

Please fill out all required fields (indicated with an *).

Full Legal Name *

Prefix

First Name

Middle Name

Last Name

Preferred Name (if different from Legal name)

BC Care Card Number *

10-digit Medical Services Number

Date of Birth *

Month

Day

Year

Address *

Street Address

Street Address Line 2

City

Province

Postal Code

Please select your Gender. *

If you select Other, please indicate your pronouns to the

Preferred Pronouns

Please specify, if applicable.

Please Select your Preferred Contact Method *

Home Number

Cell Number

Work Number

Email

Would you like to confirm appointments via text message or email? *

By providing this information I agree to allow Brookswood Optometry to contact me.

Home Number

Cell Number

Who referred you to our Office?

Current Family Physician *

Work Number

Email *

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MSP Authorization Acknowledgement & Payment to Opted Out Practitioners

Patient Authorization:
I, the patient(s) named within this form, authorize MSP to pay the practitioners named below directly for reimbursements for benefits payable to me under the Medical and Health Care Serives Regulation for care provided to me. I authorize the practitioners to collect MSP payment from the date when this form is signed to the end of the calendar year in which this form is signed. For each optometric service provided, the practitioners will notify me of the full fee and what portion of the fee they will claim directly from MSP if applicable in accordance with the relevant payment schedule.

I make this authorization in full knowledge that the practitioners will receive the full amount that is reimbursable to me from MSP for this service, and that I will not receive further reimbursement from MSP for any monies I have paid for this service (if applicable).

Dr. Eva Kalicinsky*	Dr. Amit Sahota*	Dr. Forouzandeh Alavi*	Dr. Jason Hundle	Dr. Jeneta Rubaranjan	Dr. Katy Tan
MSP Practitioner#: 88816	MSP Practitioner#: 87566	MSP Practitioner#: 87537	MSP Practitioner#: 87723	MSP Practitioner#: 30928	MSP Practitioner#: 34001
MSP Payment#: 88816	MSP Payment#: 88816	MSP Payment#: 88816	MSP Payment#: 88816	MSP Payment#: 88816	MSP Prayment#: 88816

*Denotes Optometric Corporation

Practitioner Declaration:
We (the practitioners named above), have advised the patient that this form allows me to receive MSP reimbursement directly for services that are MSP benefits, and that the patient will not receive further reimbursement from MSP. We acknowledge that all claims for services provided to this patient comply with the Medicare Protection Act and the relevant payment schedule. For each service provided, we will notify the patient of the full fee and what portion of the fee I will be claiming directly from MSP.

We understand that this authorization is only valid for the remainder of the calendar year in which it is signed, and that ***the patient must complete a new MSP Authorization Acknowledgement & Payment to Opted Out Practitioners Form prior to directly bill MSP in future calendar years.*** Further, we understand that eligible patients are only eligible for supplemantary benefits for 10 claims per year for all supplementary services. As such, if the service relates to a supplementary benefit, I know that we will only receive reimbursement from MSP if the patient has eligible claims remaining for the year on the date of the claim submission.

Patient Signature

____

Date *

Month Day Year

Dr. Eva Kalicinsky* #88816__________________

Dr. Forouzandeh Alavi* #87537__________________

Dr. Amit Sahota* #87566__________________

Dr. Jeneta Rubaranjan #30928__________________

Dr. Jason Hundle# 87723__________________

Dr. Katy Tan #34001__________________

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PRIVACY POLICY ACKNOWLEDGEMENT

I have reviewed the Privacy Policy (Appendix A) and understand my rights contained therein. By way of signature, I acknowledge that Brookswood Optometry has provided me with a policy regarding the use and disclosure of my protected health care information for the purpose of treatment, payment, and health care operations as described in the Policy, as well as any persons listed above. An electronic copy of this document shall be as valid as the original. I agree to this practice's collection, use, and disclosure of any of my personal information as set out within the Privacy Policy.

Date *

Month Day Year

Signature

Extended Medical Information & Consent

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Primary Insurance Provider

(Ex: Canada Life, Sunlife, Pacific Blue Cross, etc.)

Cardholder Name

Cardholder Date of Birth

Month Day Year

Plan/Policy Number

Certificate/Member/ID Number

Secondary Insurance Provider

(Ex: Canada Life, Sunlife, Pacific Blue Cross, etc.)

Cardholder Name

Cardholder Date of Birth

Month Day Year

Plan/Policy Number

Certificate/Member/ID Number

FINANCIAL POLICY ACKNOWLEDGEMENT
I understand that I am financially responsible for changes when services are rendered. If my insurance is billed I am responsible for services, materials, or deductibles not covered. I authorize Brookswood Optometry to release medical information necessary to my insurance company to process claims submitted on my behalf. I have read, understood, and agree to Brookswood Optometry's Financial Policy (Appendix B).

Patient Signature

Date *

Month Day Year

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Digital Signature

Please read the paragraph below and click the radio button to digitally sign this document.

By providing a signature below, I understand that I am digitally providing a signature for the collection and use of the information provided above according to Brookswood Optometry's Privacy and Financial Policies.
By selecting the box I agree that any above Signature requirement has been met through my providing this digital signature through the digital submission of this document.

Note - Appendicies A and B are located on the next two pages.

Digital Signature Requirement *

I herby submit the above information, and digitally sign this document.

Patient Signature

Date *

Month Day Year

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APPENDIX A - PRIVACY POLICY

Information collected: We take pride in helping you meet your needs through a full range of vision products and services. By obtaining our services, you share information with us about who you are, where you live and work, and aspects of your lifestyle. The information that we require about you may vary, depending on the type of product or service you need or request.

We obtain this information from you directly. With your consent, we may also obtain information from other medical professionals, financial institutions or other sources provided by you. All of this information is used
within the parameters set out in Canada's privacy legislation.

Sharing Information with Others: We obtain your written or verbal consent before sharing your personal information, and do not sell or otherwise distribute your personal information to anyone without your consent (except where required to do so by law or to meet credit reporting requirements). Privacy legislation provides specific instances in which
we are able or required to collect or report information without your consent – such as during fraud investigations or in response to orders from legal authorities.

There are also instances where we may need to share your information with our business partners (such as our lens labs), insurance firms, government agencies, or other medical professionals in order to provide the best level of overall care. Our office may also, from time to time, contact you regarding appointments, or
other products and services that we think may be of interest to you. If you would like to opt out of receiving this type of communication, simply let us know.

Financial Information: Depending on the method of payment that you use, we may collect your name, address, credit, or debit account numbers, and information necessary to complete your transaction. As with any of the information collected, we will not share this information with any parties other than those involved in processing your payment.

Viewing your Information: On request, you may see the personal health and financial information that we have in your file(s). If your file contains information from other parties, we cannot disclose that information to you as that information is legally the property of those other parties. Please contact us if you with to view the information in your file.
Please be aware that it may take up to ten working days for us to gather this information for your review.

How we Protect Your Privacy: Our doctors and staff are committed to protecting your privacy, and the information that you provide us. Our commitment to you, is that we will only use the information you provide us with as it is required pertaining to the product(s) and service(s) that you've requested.We also do the following to ensure the protection of your confidentiality and the security of your personal information;

- Keeping our offices, file storage, and desks secure
- Limiting access of your information to staff and consultants who require it.
- Using reasonable security measures such as passwords and encryption of electronic information.
- Investigating suspected security problems

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APPENDIX B - FINANCIAL POLICY

Message to the Plan member, Spouse and/or Dependent regarding Personal Information.

Any personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and Brookswood Optometry for the purposes of assessing your claims, underwriting, investigating, auditing, and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent

I authorize Brookswood Optometry to collect, use, and disclose personal information concerning any claims submitted on my behalf, with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law. I confirm that I am either the Plan Member, or am authorized by the Plan member to make this authorization. I also confirm that I am authorized by any other person(s) eligible under this plan, to disclose personal information about them to the insurer and/or plan administrator and Brookswood Optometry for the purposes described above and I confirm that these persons also authorize the insurer and/or plan administrator and Brookswood Optometry to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize any other person(s) eligible to assign benefit payments under the plan to the healthcare provider.

If there is overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Benefit Assignment

I hereby assign benefits payable for the eligible claims to Brookswood Optometry, who is responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to Brookswood Optometry. In the event that my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to Brookswood Optometry for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by Brookswood Optometry and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

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Brookswood Optometry - MSP Authorization Acknowledgement & Payment to Opted Out Practitioners

Patient's Name *

First Name Middle Name Last Name

Date

Month Day Year

Patient Personal Health Number *

Patient Signature

Patient Authorization:
I, the patient(s) named within this form, authorize MSP to pay the practitioners named below directly for reimbursements for benefits payable to me under the Medical and Health Care Serives Regulation for care provided to me. I authorize the practitioners to collect MSP payment from the date when this form is signed to the end of the calendar year in which this form is signed. For each optometric service provided, the practitioners will notify me of the full fee and what portion of the fee they will claim directly from MSP if applicable in accordance with the relevant payment schedule.

I make this authorization in full knowledge that the practitioners will receive the full amount that is reimbursable to me from MSP for this service, and that I will not receive further reimbursement from MSP for any monies I have paid for this service (if applicable).

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