Brookswood Optometry Intake Form

Section 1: Patient Information - Please fill in all required fields (Denoted by *)

Patient Name *

Prefix | First Name | Middle Name | Last Name

Date of Birth *

Month | Day | Year

Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Please select your Gender *

If "Other" please specify preferred pronouns below.

Preferred Pronouns

Please specify, if applicable.

BC Care Card Number *

10-digit BC Medical Services Number

How did you hear about our office?

If you selected "Friend", please let us know who.

Who told you about our office?

Please use First and Last Name

Current Family Doctor *

Home Number

Area Code | Phone Number

Cell Number

Area Code | Phone Number

Work Number

Area Code | Phone Number

Alternate Number

Area Code | Phone Number

Please Select your Preferred Method of Contact *

- [ ] Home Number
- [ ] Cell Number
- [ ] Work Number
- [ ] Alternate Number
- [ ] Email

Patient E-Mail *

example@example.com

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

By clicking below I release Brookswood Optometry to contact me using the methods above. *

- ○ YES
- ○ NO

Brookswood Optometry Intake Form

Section 2 - MSP & Insurance Information

MSP Authorization Acknowledgement*

I authorize Brookswood Optometry and its practitioners;

Dr. Eva Kalicinsky*	Dr. Forouzandeh Alavi*	Dr. Amit Sahota*
MSP Practitioner#: 88816	MSP Practitioner#: 87537	MSP Practitioner #: 87566
MSP Payment#: 88816	MSP Payment#: 88816	MSP Payment#: 88816

to collect payment on my behalf for benefits payable to me and those listed below through the Medical Services Plan of British Columbia for any services that are eligible under the Medical and Health Care Services Regulation.

*Denotes Optometric Corporation

Signature

Date *

Month Day Year

By selecting the button 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 submission of this document.

Digital Signature Requirement *

- ○ I hereby submit the above information, and digitally sign this document.

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Extended Medical Information and Consent

Primary Insurance

Cardholder Name

Cardholder DOB

Insurance Provider

Certificate/Member/ID Number

Plan/Policy Number

Secondary Insurance

Cardholder Name

Cardholder DOB

Insurance Provider

Certificate/Member/ID Number

Plan/Policy Number

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.

Signature

Date *

Month Day Year

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).

Signature

Date *

Month Day Year

ADDITIONAL FAMILY MEMBERS - Please add any other family members.

Patient's Name

First Name Middle Name Last Name

Date of Birth

Month Day Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other" selected, please specify to the right.

Preferred Pronouns

Please specifiy, if applicable.

Patient's Name

First Name Middle Name Last Name

Date of Birth

Month Day Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other" selected, please specify to the right.

Preferred Pronouns

Please specify, if applicable

Patient's Name

First Name Middle Name Last Name

Date of Birth

Month Day Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other" selected, please specify to the right.

Preferred Pronouns

Please specify, if applicable

Patient's Name

First Name Middle Name Last Name

Date of Birth

Month Day Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other" selected, please specify preferred pronouns to the right.

Preferred Pronouns

Please specify, if applicable.

Patient's Name

First Name | Middle Name | Last Name

Date of Birth

Month | Day | Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other" selected, please specify preferred pronouns to the right.

Preferred Pronouns

Please specify, if applicable.

Patient's Name

First Name | Middle Name | Last Name

Date of Birth

Month | Day | Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other" selected, please specify preferred pronouns to the right.

Preferred Pronouns

Please specify, if applicable.

Patient's Name

First Name | Middle Name | Last Name

Date of Birth

Month | Day | Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other" selected, please specify preferred pronouns to the right.

Preferred Pronouns

Please specify, if applicable.

Patient's Name

First Name | Middle Name | Last Name

Date of Birth

Month | Day | Year

BC Care Card

10-digit BC MSP Card

Gender

If "Other selected, please specify preferred pronouns to the right.

Preferred Pronouns

Please specify, if applicable.

Digital Signature

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

By selecting the box 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 submission of this document.

Digital Signature Requirement *

- ○ I hereby submit the above information, and digitally sign this document.

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

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

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.