Eye Specialists of Mid•Florida, P.A.

PATIENT INFORMATION FORM

PLEASE COMPLETE FULLY AND BRING IT WITH YOU TO YOUR APPOINTMENT

PATIENT INFORMATION

NAME *(Last, First Middle)*	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS *(if applicable)*	ETHNICITY

CITY, STATE ZIP	PHONE	CITY, STATE ZIP *(of secondary address)*	HOME PHONE *(of secondary address)*	RACE

CELL PHONE	EMAIL	EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

PRIMARY EMPLOYER	WORK PHONE	SECONDARY EMPLOYER *(if applicable)*	WORK PHONE

ADDRESS	ADDRESS

CITY, STATE ZIP	CITY, STATE ZIP

HOW DID YOU HEAR ABOUT US?

- ❑ Building/Signage
- ❑ Dr Loyalty
- ❑ Dr/Medical Facility/ER Referral
- ❑ Dr Lecture/Talk/Presentation
- ❑ Employee Referral
- ❑ Facebook
- ❑ Family/Friend
- ❑ Google Internet or Maps
- ❑ Health Fair or Community Event
- ❑ Health Insurance or Vision Plan
- ❑ Instagram
- ❑ Linkedin
- ❑ Mailer
- ❑ Phone Book/Medical Directory
- ❑ Newspaper/Magazine Ad or Article
- ❑ Radio Commercial/Interview or Story
- ❑ Road Billboard
- ❑ TV Commercial or News Story
- ❑ Twitter
- ❑ Other _____

RESPONSIBLE PARTY INFORMATION *(if different than above)*

NAME *(last, First Middle)*	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS *(if applicable)*

CITY, STATE ZIP	CITY, STATE ZIP

HOME PHONE	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY MEDICAL INSURANCE

NAME OF INSURANCE COMPANY	RELATIONSHIP TO PATIENT	POLICY #	

NAME OF INSURED	GROUP #	

ADDRESS OF INSURANCE COMPANY	COPAY AMT $	DEDUCTIBLE $

CITY, STATE ZIP	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY MEDICAL INSURANCE *(if applicable)*

NAME OF INSURANCE COMPANY	RELATIONSHIP TO PATIENT	POLICY #	

NAME OF INSURED	GROUP #	

ADDRESS OF INSURANCE COMPANY	COPAY AMT $	DEDUCTIBLE $

CITY, STATE ZIP	EFFECTIVE DATE	EXPIRATION DATE

VISION INSURANCE *(if applicable)*

NAME OF INSURANCE COMPANY	RELATIONSHIP TO PATIENT	POLICY #	

NAME OF INSURED	GROUP #	

ADDRESS OF INSURANCE COMPANY	COPAY AMT $	DEDUCTIBLE $

CITY, STATE ZIP	EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

NOTICE OF PRIVACY PRACTICES

Eye Specialists of Mid-Florida, P.A. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings:
We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions:
If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for Workers Compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any futures uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions; but, if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health care plan for purposes of payment or health care operations, we will abide by your request.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations.

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law:
We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our **Notice** at any time. For more information about our privacy practices, contact the facility listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the Center's Director at the facility listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The Center's Director will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Information
If you have any questions, requests, or complaints, please contact:

Eye Specialists of Mid-Florida, P.A.
407 Avenue K, S.E.
Winter Haven, Florida 33880
(800) 282-3937

Effective Date: February 17, 2010

Assignment of Insurance Benefits

The undersigned hereby authorizes the EYE SPECIALISTS OF MID-FLORIDA, P.A. and EYE SURGERY AND LASER CENTER, LLC, and their physicians to apply for benefits on my behalf for covered services rendered and to request payments from my insurance carriers be made directly to the physicians and/or the EYE SPECIALISTS OF MID-FLORIDA, P.A. and EYE SURGERY AND LASER CENTER, LLC. I certify that the information I have reported is correct and I authorize the EYE SPECIALISTS OF MID-FLORIDA, P.A. and EYE SURGERY AND LASER CENTER, LLC, to release any necessary information, including medical information, for this or any related claim to insurance carriers in order to determine benefits to which I am entitled. I, also, hereby assign to the EYE SPECIALISTS OF MID-FLORIDA, P.A. and EYE SURGERY AND LASER CENTER, LLC, and their physicians all payments for medical services rendered to myself and/or my dependents. I understand that I am financially responsible for all charges (including equipment and/or supplies) not covered by this assignment (whether or not paid by said insurance).

A copy of this authorization is as valid as the original. This assignment will remain in effect until revoked by me in writing.

All co-pays, non-covered services and deductibles will be due at the time of service. Failure to meet my financial obligations may result in my account being referred to a collection agency with a $20.00 processing fee added to the balance due.

Refraction Charge Information

In order to determine how well you see, or if you may need a change in your glasses prescription, your doctor may order a refraction test. Without a refraction test we cannot prescribe or change your glasses prescription. A refraction is a test where a series of lenses are presented to the patient to determine which provides the sharpest, clearest vision. Medicare and most other insurance companies do not pay for the refraction. Medicare and commercial insurance companies require us to tell you that this is a non-covered service. You will be responsible for this charge at the time of your visit. We will not suggest a refraction if we do not feel it is necessary.

Frequently, it is necessary to perform a refraction even when the purchase of new glasses is not anticipated. If there has been a decrease in vision as noted in your vision test, we must determine if a change in glasses will improve vision. A refraction is the only reliable way to do this. If a change in the lenses improves vision, then you can decide whether or not to purchase new glasses. If a change in glasses does not improve vision, then we must search for an alternative reason for the decreased vision.

Therefore, a medical exam may be required. If you have a medical eye problem, Medicare and most other insurance companies will pay the medical portion of your eye exam. The medical portion of your eye exam includes the retina exam, glaucoma check, cataract check and other eye health checks.

- I understand the above and agree to make payment if my insurance does not cover the services performed during my visit.

- I am aware this will be the only notification of the above document I will receive. This document will become a permanent part of my chart.

EYE SPECIALISTS OF MID-FLORIDA, P.A.

PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

Pertaining to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), our attempts to protect our patients' right to privacy are found below. Marking the appropriate box(es) with an (X) indicates the degree to which your information is to be released.

Patient makes their own medical decisions ☐ Yes ☐ No

Full Medical Power of Attorney (enter information below) ☐Yes ☐No **On File** ☐Yes ☐No

( ) PATIENT IS A MINOR CHILD - Under Age 18:

Proof of guardianship required unless child lives with both natural parents.

( ) Divorce Papers ( ) Guardianship Papers ( ) Adoption papers ( ) Power of Attorney

( ) <u>Do Not</u> give any information to anyone other than myself.

Phone messages may be left on patient's / guardian's answering machine pertaining to: ( ) Appointments

☐POA / Name: _____

Relation to Pt: _____Phone_____
has my permission to:

( ) Make Appointments ( ) Bring For Appointments
and receive information regarding:

( ) Appointments ( ) Diagnoses ( ) Test Results

( ) Treatment ( ) Financial - Patient Balance Only

( ) Status of Acct - Any/All Financial Information

( ) Any/All of the above

☐POA / Name: _____

Relation to Pt: _____Phone_____
has my permission to:

( ) Make Appointments ( ) Bring For Appointments
and receive information regarding:

( ) Appointments ( ) Diagnoses ( ) Test Results

( ) Treatment ( ) Financial - Patient Balance Only

( ) Status of Acct - Any/All Financial Information

( ) Any/All of the above

I consent to the admittance of qualified observers, including, without limitation, medical students in the clinical setting for the purpose of medical education. I understand that such observers will not in any manner participate in my diagnosis or treatment. ( ) Yes ( ) No

By signing this, I am acknowledging I have been informed and received a copy of these items:

( ) Notice Of Privacy Practices **( ) Patient's Authorization for Release of Information**
( ) Refraction Charge Information **( ) Assignment of Insurance Benefits**

This assignment of information will stay in effect until revoked or changed by me in writing.

_____
Patient / Responsible Party Signature* ***POWER OF ATTORNEY REQUIRED**

_____ _____
Witness Date

_____
Staff / Witness seeking acknowledgement:

Signed: _____
If not signed, reason why acknowledgement was not obtained:

Patient label 04/3/2019

Eye Specialists of Mid•Florida, P.A.

Eye Specialists of Mid•Florida
Medical History Questionnaire

Name: _____ **Date Of Birth:** _____

Date: _____ **Referring Eye Doctor:** _____

Do you have allergies to any medications or food? YES NO

If yes, please list the medications: _____

Past History of Ocular Health Status:

OCULAR HISTORY	YES	NO	DETAILS
Eye Trauma			
Cataracts			
Macular Degeneration			
Retinal Detachment / Retinal Holes			
Diabetic Retinopathy			
Corneal Dystrophy			
Lattice Degeneration			
Dry Eye Syndrome			
Glaucoma			
Infection (Corneal Ulcer)			
Uveitis / Iritis			
Crossed-Eyes / Lazy Eye			
Color Blindness			

Please list any **eye surgery** you have had: _____

_____

Please list any **eye drops** you currently take *(prescription and over-the-counter)*: _____

_____

Social History *(please circle)*:

Do you drink alcohol?	No	Yes, occasional	Yes, socially	Yes, 1 per day	Yes, 2-3 per day
Do you smoke?	No	Former smoker	Yes, some days	Yes, every day	
Do you use illegal drugs?	No	Yes	Drugs Used: _____		

Please see back

Past History of Medical Health Status:

MEDICAL HISTORY	YES	NO	UNKNOWN	DETAILS
Lung Disease				
Seasonal Allergies				
Kidney Stones				
Kidney Disease				
Diabetes				*How long?* *Last blood sugar reading?* *Last A1c?*
High Blood Pressure				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Headaches				
Gout				
Skin Disease				
Gastrointestinal Disease				
Blood Disorders				
Multiple Sclerosis				

Other Major Illness/Hospitalizations/Surgeries: _____

_____

_____

_____

Medications *(not including eye drops)*: _____

_____

_____

_____

_____

_____

Current Ocular & Medical Health Status *(please circle)*

EYES			**RESPIRATORY**			**BLOOD/LYMPHNODES**		
Previous Surgery	Yes	No	Cough	Yes	No	Easy Bruising	Yes	No
Contact Lens	Yes	No	Congestion	Yes	No	Gums Bleed Easily	Yes	No
Pain	Yes	No	Wheezing	Yes	No	Prolonged Bleeding	Yes	No
Double Vision	Yes	No	Asthma	Yes	No	Heavy Aspirin Use	Yes	No
Glaucoma	Yes	No	**GASTROINTESTINAL**			Diabetes	Yes	No
Cataracts	Yes	No	Heartburn	Yes	No	**MUSCULOSKELETAL**		
Macular Degeneration	Yes	No	Nausea/Vomiting	Yes	No	Stiffness	Yes	No
Dry Eyes	Yes	No	Jaundice/Hepatitis	Yes	No	Arthritis	Yes	No
Flashes/Floaters	Yes	No	Acid Reflux	Yes	No	Joint Pain/Swelling	Yes	No
Blurred Vision	Yes	No	**GENITO-URINARY**			**SKIN**		
EAR, NOSE & THROAT			Pain/Difficulty	Yes	No	Rash/Sores	Yes	No
Hard of Hearing	Yes	No	Blood in Urine	Yes	No	Lesions	Yes	No
Ringing in Ears	Yes	No	History of Kidney Stones	Yes	No	Hives/Eczema	Yes	No
Vertigo	Yes	No	History of STDS	Yes	No	**NEUROLOGICAL**		
CARDIOVASCULAR			**PSYCHIATRIC**			Seizures	Yes	No
Chest Pain	Yes	No	Anxiety/Depression	Yes	No	Weakness/Paralysis	Yes	No
Dizziness	Yes	No	Mood Swings	Yes	No	Numbness	Yes	No
Fainting Spells	Yes	No	Difficulty Sleeping	Yes	No	Tremors	Yes	No
Shortness of Breath	Yes	No	**ENDOCRINE**			**IMMUNOLOGIC**		
Irregular Heart Beat	Yes	No	Increased Thirst	Yes	No	Hives	Yes	No
Difficulty Lying Flat	Yes	No	Increased Hunger	Yes	No	Itching	Yes	No
Hypertension	Yes	No	Increased Urination	Yes	No	Runny Nose	Yes	No
High Cholesterol	Yes	No	Increased Sweating	Yes	No	Sinus Pressure	Yes	No
CONSTITUTIONAL			Fingernail Changes	Yes	No			
Fatigue/Weakness	Yes	No						
Fever	Yes	No						
Weight Gain/Loss	Yes	No						

Has any member of your family had any of the following diseases? *(Mother, father, grandparent, sibling)*

☐ Diabetes	☐ Stroke	☐ Blindness	☐ Macular Degeneration	☐ Arthritis
☐ Cancer	☐ TB	☐ Cataract	☐ Retinal Disease	☐ Lazy Eye
☐ Heart Disease	☐ Kidney Disease	☐ Glaucoma	☐ High Blood Pressure	

☐ Other:_____

☐ Family History Unknown- Reason: _____

Thank you for providing us with the information above, it will allow us to better care for you. We hope you enjoy your time with us today.