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

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights

You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record
- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
• Marketing purposes • M ost sharing of psychotherapy notes • Sale of your information
In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
We typically use or share your health information in the following ways.
We can use your health information and share it with other professionals who are treating you.
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

None

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
• Preventing disease • P reventing or reducing a serious threat to anyone's health or safety
• Helping with product recalls • Reporting suspected abuse, neglect, or domestic violence
• Reporting adverse reactions to medications • Do research • Comply with the law
• Respond to organ and tissue donation requests • Work with a medical examiner or funeral director.
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:
• For workers' compensation claims • For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions as military, national security, and presidential protective services
• Respond to lawsuits and legal actions

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

- **If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.**
- or You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- We will not retaliate against you for filing a complaint.

Eye Specialists of Mid-Florida, P.A.

Compliance Officer: Dorathy E. Nevitt

Phone: 863-294-3504

This Notice of Privacy Practices is effective January 1, 2023

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.