MID FLORIDA Eye CENTER | CATARACT & RETINA LASER INSTITUTE
EXCELLENCE IN EYE SURGERY

Name:
Account#:

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

Preferred Contact#: ❒ Home ❒ Work ❒ Cell Marital Status: ❒Sing ❒Mar ❒Div ❒Wid ❒Sep

SSN:_____ DOB:_____ Sex: ❒ M ❒ F

Preferred Language: ❒ English ❒ Spanish ❒ Other_____

Street Address/City/State/Zip:_____

Billing Address:_____

Email Address:_____ Employer/Occupation:_____

Full Time Resident? ❒ Y ❒ N If No, Other Address:_____

Primary Care Physician:_____ Address:_____

Who Can We Thank For Referring You To Our Practice:
❒ Eye Doctor:_____ ❒ Other Doctor:_____
❒ Family/Friend ❒ Insurance ❒ Employer ❒ Website ❒ TV ❒ Magazine ❒ Newspaper ❒ Internet ❒ Billboard
❒ Yellow Pages ❒ MFE Bus ❒ Seminar/Health Fair ❒ Other_____

GUARANTOR OR RESPONSIBLE PARTY: ❒ Self (Patient) ❒ Other (If Patient Is Minor)

If Other, Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

DOB:_____ Relationship To Patient:_____

EMERGENCY CONTACT (Other than telephone number listed above)

Name:_____ Relationship To Patient:_____

Home Phone: _(_____)_____ Work: _(_____)_____ Cell:_(_____)_____

PRIMARY MEDICAL INSURANCE

Company:_____ ID#:_____ Group#:_____

Policyholder Name:_____ DOB:_____ Relationship To Patient:_____

SECONDARY MEDICAL INSURANCE

Company:_____ ID#:_____ Group#:_____

Policyholder Name:_____ DOB:_____ Relationship To Patient:_____

VISION INSURANCE **(Please Note, not all Routine Vision Plans accepted. Please notify the front desk staff to confirm eligibility.)**

ID#:_____ Group#:_____ Policyholder Name:_____

DOB:_____ Relationship To Patient:_____

X_____ _____ **X**_____ _____
Patient Signature Date Guarantor Signature Date

ALTERNATIVE CONTACT/PREFERRED METHOD OF COMMUNICATION FORM

NAME:_____ **DATE:**_____

This authorization allows our staff to speak with only an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

Option 1

❒ (initials) _____ I do **NOT** authorize anyone to receive information regarding my medical care.

Option 2

❒ I authorize my physician and the employee of this clinic to speak with:

1. Person: _____ Relationship: _____
   Phone Number: _____
   ❒ Appointments and Account/Bill ❒ Medical Care and Treatment (including Test Results and Lab Results)

2. Person: _____ Relationship: _____
   Phone Number: _____
   ❒ Appointments and Account/Bill ❒ Medical Care and Treatment (including Test Results and Lab Results)

3. Person: _____ Relationship: _____
   Phone Number: _____
   ❒ Appointments and Account/Bill ❒ Medical Care and Treatment (including Test Results and Lab Results)

Please select your primary and secondary preferred methods of communication:

❒ Home Phone/Answering Machine ❒ Mail ❒ Work Phone
❒ Cell Phone (Voicemail) ❒ Cellphone (Text Message)
❒ E-mail and E-mail Address: _____

Electronic Communication is my preferred method: ❒ Yes ❒ No

(In order to electronically communicate with you or anyone you designate, we are required to have your written permission.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

X_____ _____ **X**_____ _____

Patient Signature Date Guarantor Signature Date

CONSENT FOR CARE AND TREATMENT

NAME:_____ **DATE:**_____

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Mid Florida Eye Center. Treatment provided by medical providers, nurses, and medical assistants at Mid Florida Eye Center may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Mid Florida Eye Center. I understand that all supplies, medical devices and other goods provided to Patient are provided by Mid Florida Eye Center AS IS and Mid Florida Eye Center disclaims any expressed or implied warranties.

Patient Rights: I understand that a copy of Patient Rights and Responsibilities is available upon request. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Mid Florida Eye Center.

Communicable Disease Testing: I agree that if a Mid Florida Eye Center employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Florida law, Mid Florida Eye Center may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Mid Florida Eye Center may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Mid Florida Eye Center can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply. Messages may include private health and billing information protected under federal and state law. Messaging utilizes a public telephone network and full encryption and security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN. I will have the ability to opt out of text messages at any time by using the STOP function.

Accessing Pharmacy Information: I agree that if a Mid Florida Eye Center employee or provider needs to access my pharmacy information that they have my permission to do so.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice of Privacy Practices

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in 1996 (HIPPA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

X_____ _____ **X**_____ _____

Patient Signature | Date | Guarantor Signature | Date

BILLING PRACTICES

NAME:_____ **DATE:**_____

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

At Mid Florida Eye Center, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive that the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. (Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a $50 fee per patient.) We reserve the right to not make additional routine appointments for you should you have any remaining balance for previous treatment you received with our offices.

2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay (a small fixed amount required by your health insurer), deductible (amount you are liable before your health insurer will make payment), or co-insurance (percentage of total cost of medical expenses after your deductible has been reached) due at the time of service. If you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of $10 to your account in order to defray the cost of securing the co-pay.

3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. We reserve the right to charge the state allowable amount for filling out and completing forms or attorney requests for your various needs (i.e., SSI, disability, etc.).

4. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination.

5. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $25 and will be added to your account for each bounced check.

6. OTHER INSURANCE: I understand that Mid Florida Eye Center participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Mid Florida Eye Center if I belong to a plan with which Mid Florida Eye Center does not participate.

7. NON-COVERED SERVICES: I understand that Mid Florida Eye Center contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient (i.e., refraction, contact lens fittings) and treatment or tests not authorized by the health care service plan.** The undersigned agrees to cooperate with Mid Florida Eye Center to obtain necessary health care service plan authorizations.

(CONTINUED ON NEXT PAGE)

(BILLING PRACTICES CONTINUED) **NAME:**_____ **DATE:**_____

8. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Mid Florida Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Mid Florida Eye Center for payment. I understand and agree that if my account is delinquent, I may be charged interest of 1.5% (one and one-half percent) per month, 18% (eighteen percent) per year. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees of 33.3% (thirty-three and one-third percent) of the balance due, whether or not suit is filed. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Mid Florida Eye Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mid Florida Eye Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

The physicians and staff at Mid Florida Eye Center appreciate your confidence in allowing us to participate in your eye care.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

X_____ _____ **X**_____ _____

Patient Signature Date Guarantor Signature Date

NOTIFICATION OF NON-COVERED SERVICES

NAME:_____ **DATE:**_____

REFRACTION POLICY

WHAT IS A REFRACTION? - A refraction is an important measurement that determines the best potential vision of your eyes.

WHY IS IT NECESSARY? - It is necessary to perform a refraction to determine whether eye diseases or refractive errors are responsible for your current visual acuity. A refraction is performed at a new patient visit, an annual visit, a cataract consultation, or anytime there has been a change or decrease in vision.

DOES MY INSURANCE COVER A REFRACTION? - Refraction (CPT code 92015) is a non-covered service by Medicare. As a result, your healthcare provider is required by CMS (the department to the federal government that controls Medicare) to charge for this service. Most other medical insurance plans and Medicare Supplements plans follow Medicare's rules and consider a refraction a non-covered service. These plans consider refractions a "vision" service not a "medical" service. Routine Vision plans may cover this service. If you have a routine vision plan, please notify us prior to your visit to determine our participation status and benefits if applicable.

HOW MUCH DOES A REFRACTION COST? - Our fee for a refraction starts at $59. This fee is collected at time of service in addition to any copay, coinsurance, or deductible your insurance plan requires. The fee is subject to change.

REFRACTION RECHECKS - If you find that your glasses prescription is unsatisfactory, we will perform a refraction recheck within 90 days of the original service at no charge. If a new refraction is needed after 90 days, the standard refraction fee will apply.

CONTACT LENS FITTING POLICY

WHAT IS A CONTACT LENS FITTING? - A contact lens fitting is an additional exam consisting of measurements to find the most appropriate contact lens to optimize your vision. There is a large variety of lens types, materials, and sizes. A contact lens fitting is performed in addition to a complete exam for the health of the eye.

DOES MY INSURANCE COVER A CONTACT LENS FITTING? - Medical plans consider contact lens fittings a "vision" service not a "medical" service and therefore do not cover contact lens fitting costs. Routine Vision plans may cover this service. If you have a routine vision plan, please notify us prior to your visit to determine our participation status and benefits if applicable.

HOW MUCH DOES A CONTACT LENS FITTING COST? - Contact Lens Fitting fees vary depending on the type of lens and the difficulty of the fit. The fee ranges from $45 to $175 for most fittings. Once your physician determines which type of lens you will be fit for we will be able to offer you an estimate. This fee is collected at time of service in addition to any copay, coinsurance, or deductible your insurance plan requires. The fees are subject to change.

I have read and understand the Notification of Non-Covered Services: Refraction Policy and Contact Lens Fitting Policy.

X_____ _____ **X**_____ _____

Patient Signature Date Guarantor Signature Date

CATARACT & RETINA LASER INSTITUTE
EXCELLENCE IN EYE SURGERY

REFRACTION ACKNOWLEDGEMENT

Patient Name:_____ Date:_____

A REFRACTION is the process of determining the need for corrective glasses and / or contact lenses. A refraction is necessary depending on the patient's diagnosis and / or complaints presented. If a patient is experiencing blurred or decreased vision on the eye chart, a refraction is needed to determine whether it is due to glasses or due to a medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be improved with a glasses change. Therefore, a refraction is an essential part of your Complete Eye exam; however, Medicare and most insurance companies DO NOT cover the refraction charge. It is important to understand that if you decline your refraction, your provider may not be able to determine the cause of your decrease vision.

The basic refraction charge is **$59.00**, which is in addition to the office visit copay and /or deductible. Payment is due at the time services are rendered. **NOTE: This fee is due and payable regardless of whether you receive a written prescription or not.** Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses.

SELECT & INITIAL *(ONE)* OPTION BELOW:

Option 1:

❒_____(*initials*) I have read the information and understand that the REFRACTION IS A NON-COVERED SERVICE. I accept full financial responsibility for the cost of the service. I understand the copay and deductible are separate from, and not included in the refraction fee.

Option 2:

❒_____(*initials*) I have read the information and defer the refraction. I understand my provider may not be able to fully evaluate my Ocular health.

X_____ _____ **X**_____ _____

Patient Signature Date Guarantor Signature Date

OFFICE USE ONLY

❒ Decision to defer refraction changed, patient elects to proceed with refraction. Patient to make change on selection above and initial.

Employee Name/Signature:_____ Date:_____

PATIENT MEDICAL HISTORY **NAME:**_____ **DATE:**_____

Please check YES or NO if you have or ever had any of the following:

❒ Y ❒ N Cancer - Type_____
❒ Y ❒ N Taken Flomax / Hytrin / Cardura
❒ Y ❒ N High Blood Pressure
❒ Y ❒ N Stroke / CVA
❒ Y ❒ N Heart Disease / Murmur
❒ Y ❒ N Heart Attack
❒ Y ❒ N Congestive Heart Failure
❒ Y ❒ N Irregular Heartbeat / Palpitations
❒ Y ❒ N Asthma
❒ Y ❒ N COPD
❒ Y ❒ N Migraines
❒ Y ❒ N Arthritis
❒ Y ❒ N Sleep Apnea - Use a CPAP? ❒Y ❒N

❒ Y ❒ N High Cholesterol
❒ Y ❒ N Thyroid Disease
❒ Y ❒ N Diabetes – ❒Oral ❒Diet ❒Insulin
❒ Y ❒ N GERD
❒ Y ❒ N Kidney Disease
❒ Y ❒ N Kidney Stones
❒ Y ❒ N Liver Disease
❒ Y ❒ N Hepatitis – ❒A ❒B ❒C
❒ Y ❒ N Auto-Immune Disease – Type_____
❒ Y ❒ N Infectious Diseases_____
❒ Y ❒ N Dementia / Memory Loss
❒ Y ❒ N MRSA

Have you received a pneumonia vaccine? ❒ Y ❒ N
Have you ever smoked? ❒ Y ❒ N - Do you still smoke? ❒ Y ❒ N
Do you drink alcohol? ❒ Y ❒ N - ❒Daily ❒Occasionally ❒Rarely

SURGERIES

Please check the box if you have had any of the surgeries listed below:

❒ No Surgical Procedures
❒ Bypass
❒ Pacemaker
❒ Heart Stents
❒ Knee Replacement
❒ Hip Replacement
❒ Prostate
❒ Colostomy
❒ Mastectomy
❒ Thyroidectomy
❒ Appendectomy
❒ Gallbladder
❒ Back Surgery
❒ Cataract Surgery
❒ LASIK / RK
❒ Retinal Detachment
❒ Cornea Transplant
❒ Glaucoma Procedure
❒ Eyelid Procedure

OTHER EYE DIAGNOSIS

Have you been diagnosed with any of the following eye diseases/disorders:

❒ Cataracts
❒ Glaucoma
❒ Macular Degeneration
❒ Diabetic Retinopathy
❒ Corneal Disease
❒ Amblyopia / Lazy Eye
❒ Other_____
❒ Other_____
❒ Other_____

ALLERGIES

❒ Yes – Please list below ❒ No Known Allergies Latex Allergy? ❒ Yes ❒ No

MEDICATIONS

Please list any medications you take, prescription or over the counter; You may provide a list if available:

FAMILY HISTORY

Do you have any FAMILY history of: (Mother, Father, Siblings, Grandparents)

Diabetes ❒ Y ❒ N Who:_____
Glaucoma ❒ Y ❒ N Who: _____
Macular Degeneration ❒ Y ❒ N Who: _____
Blindness ❒ Y ❒ N Who: _____
Adopted/Unknown ❒

X_____ _____ **X**_____ _____

Patient Signature Date Guarantor Signature Date

REVIEW OF SYSTEMS

NAME:_____ **DATE:**_____

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EXCELLENCE IN EYE SURGERY

Please check all that apply to your **current** and **past** health.
Boxes that are not checked will be considered a negative response.

General / Constitutional

- ☐ Overall Healthy
- ☐ Weight Loss / Gain
- ☐ Fatigue
- ☐ Fever and Chills
- ☐ Weakness

Integumentary (Skin)

- ☐ Skin Cancer
- ☐ Rash
- ☐ Bruising
- ☐ Suspicious growths
- ☐ Itching

Ears/Nose/Mouth/Throat

- ☐ Dry Mouth
- ☐ Sinus Pain / Infections
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Wears hearing aids

Respiratory

- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Oxygen use
- ☐ Shortness of Breath

Cardiovascular

- ☐ Chest Pain
- ☐ Hypertension
- ☐ Heart attack
- ☐ Heart Surgery
- ☐ Palpitations

Gastrointestinal

- ☐ Heartburn / Acid reflux
- ☐ Diverticulitis
- ☐ Nausea
- ☐ Hernia
- ☐ Ulcers

Musculoskeletal

- ☐ Arthritis
- ☐ Back pain
- ☐ Swelling of joints
- ☐ Stiffness
- ☐ Muscle pain / joint pain

Neurological

- ☐ Memory Loss
- ☐ Headaches
- ☐ Parkinson's disease
- ☐ Seizures
- ☐ Tremors

Endocrine

- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Frequent Urination
- ☐ Excessive thirst

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Stress

Allergies / Immunological

- ☐ Allergic reaction to medications
- ☐ Allergic reaction to foods
- ☐ Seasonal / Environmental allergies
- ☐ Autoimmune disease

Other conditions or medical problems not listed?:

_____

_____

_____

X_____ _____ **X**_____ _____

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EXCELLENCE IN EYE SURGERY

NAME:_____ **DATE:**_____

VISUAL ASSESSMENT FORM AND LIFESTYLE QUESTIONNAIRE

Occupation:_____

Hobbies:_____

Circle the degree of difficulty you have doing the following activities because of your vision.

Functional Vision Assessment	**Circle One**			
Would you like to be less dependent on glasses??	Distance		Near	Both
Difficulty seeing street signs or driving (curbs, highway exits, traffic lights, halos/glare in lights)	No	Mild	Moderate	Severe
Difficulty seeing under glare (halos,, starburst, tracking golfball in sky, driving in bright Sunlight, oncoming headlights)	No	Mild	Moderate	Severe
Difficulty seeing TV or movies (faces, numbers, printing)	No	Mild	Moderate	Severe
Difficulty reading small print with glasses (books, newspaper, pill bottles, instructions, cell phone)	No	Mild	Moderate	Severe
Difficulty with personal correspondences (writing checks, reading bills, filling out forms)	No	Mild	Moderate	Severe
Difficulty with leisure activities (playing cards, bingo, bowling, golfing)	No	Mild	Moderate	Severe
Difficulty functioning around the house (cooking, general household upkeep, stairs, telephone)	No	Mild	Moderate	Severe
Difficulty recognizing faces of people (church, grocery store, clubs, other daily activities)	No	Mild	Moderate	Severe

Please circle the activities you would prefer to do with less dependence on glasses:

Reading Seeing pill bottles Looking at a menu Looking at your watch Using a cell phone

Card or table games Sewing Applying makeup Using a computer Seeing price tags

View dashboard of car Seeing price tags/shelves Shopping Bingo Driving

Playing sports, like golf Watching TV Watching live sports Going to movies Swimming

X_____ _____ **X**_____ _____

Patient Signature Date Guarantor Signature Date