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 verify with front desk staff if we participate with your routine vision plan****

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

DOB:_____ Relationship To Patient:_____

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, text messaging utilizes a public telephone network and full 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.

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.

X_____ _____ **X**_____ _____

Patient Signature | Date | Guarantor Signature | Date

HIPAA AUTHORIZATION AND COMMUNICATION USE AND DISCLOSURE

I have had the opportunity to review MFEC's Privacy Practices. In order to protect our patients' privacy, MFEC Group will not discuss or release any information regarding our patients without their written authorization. Should you wish to authorize MFEC Group to discuss your account or medical information with someone other than yourself, please indicate the permission below.

Option 1

❒ (initials) _____ I do not authorize my personal medical information or account history to be shared with anyone at this time. If I wish to add anyone to my account, I understand I must do so in writing.

Option 2

❒ I authorize MFEC Group to discuss my personal medical and account history with the following individuals:

1._____ _____

Authorized Name | Relationship

2._____ _____

Authorized Name | Relationship

X_____ _____ **X**_____ _____

Patient Signature | Date | Guarantor Signature | Date

BILLING PRACTICES

NAME:_____ **DATE:**_____

Thank you for choosing Mid Florida Eye Center as your provider. Mid Florida Eye Center is committed to providing you with quality and affordable care. Mid Florida Eye Center is a private organization that relies on income from patients and their insurers. In order to provide the best possible medical care at the lowest possible cost, we need your assistance and agreement to our payment policies. As the patient or the person with legal authority to sign on the patient's behalf, you understand and agree to the following:

You agree to pay any required co-payments, co-insurance and deductibles, as well as charges for services not covered by insurance, outstanding balances and delinquent accounts at or before the time of service. For your convenience, we accept cash, checks and credit cards. CareCredit may also be available.

1. Insurance: participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the entire balance.

2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Furthermore, if you are treated without making applicable co-payment and deductible payments 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-payment or deductible payment.

3. Non-covered services: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. 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 service plan furnishes to the patient (e.g., refraction) and treatment or tests not authorized by the health care service plan.

4. Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Mid Florida Eye Center may use and disclose your information, and provide information to health insurers, programs, third party administrators, vendors, other providers, and health care facilities, as is allowed by federal and state laws and regulations. You authorize Mid Florida Eye Center to disclose all information as needed to ensure proper claims payment. You agree to assign to Mid Florida Eye Center any and all health care benefits to which you are entitled under any policy of insurance or benefit plan and authorize, to the extent permitted by law, payment of benefits directly to Mid Florida Eye Center.

5. Referrals/Pre-authorizations: If your insurance plan requires a referral or other pre-authorization, it must be presented before seeing the physician. If you do not have the required referral or pre-authorization, 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.

6. Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, to the extent permitted by law, the balance will automatically be billed to you. Please direct questions regarding non-payment by your insurer to the insurer, not to Mid Florida Eye Center.

7. Nonpayment: Our Billing Department will send a statement to the patient noting balances owed, 30, 60 and 90 days out from the date of service. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this situation occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day

(CONTINUED ON NEXT PAGE)

period, our staff will only be able to treat you on an emergency basis. Any balance that is under $100.00 and older than a year from the date of service will be recorded as Self Pay Bad Debt. If your account is delinquent, you may be charged interest at the lesser of: (1) 1.5% per month (18% per year); or (2) the greatest amount allowable by applicable law. If a delinquent account is sent to collections, the patient shall be responsible for collection expenses, including but not limited to reasonable attorney's fees and cost costs as applicable.

8. Insufficient Funds: Any payment made by check that does not clear your 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.

9. No-Shows & Cancellations: If you need to cancel or reschedule an appointment, you must provide no less than 24 hours' notice prior to the scheduled appointment time. You may contact Mid Florida Eye Center 24 hours a day, 7 days a week at: www.midfloridaeye.com/contact.htm.

Should your need to cancel arise after regular business hours, you may leave a message or navigate via the web to www.midfloridaeye.com/contact.htm. If you fail to provide such notice, our practice will bill you $35.00 per missed appointment. These charges will be your responsibility and billed directly to you. Any such charges must be paid in full before your next appointment. Please help us to serve you better by keeping your regularly scheduled appointment. If you fail to present for your appointments three or more times, you may face dismissal from the practice.

10. Medical Records: If you request that a copy of your medical records be sent directly to you or another third party, the practice will charge a per page fee, payable in advance. However, where your medical record is to be sent to a collaborating physician (primary care or specialist) to assist in your care, there is no charge. A schedule of Medical Records Request Fees is available upon request.

11. Conflicts: In the event of a conflict between this policy and any other information you receive, the information contained in this document shall apply.

Mid Florida Eye Center is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read, understand, and agree to the Patient Billing Practices described above and understand that Mid Florida Eye Center may refuse non-emergency treatment if my account is delinquent. If you are signing on behalf of a minor, incapacitated or otherwise legally dependent patient, please sign as "Guarantor" below and indicate your relationship to the patient.

A patient's Guarantor is the person with legal authority to act on behalf of a minor, incapacitated, or otherwise legally dependent patient, including the authority to consent to medical services. By signing this form as "Guarantor," you represent to Mid Florida Eye Center that you have such authority and that you accept financial responsibility for services rendered.

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 is $52. 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

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 Stints
❒ 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:_____

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**_____ _____

Patient Signature Date Guarantor Signature Date

Name:_____ Date:_____ Acct#:_____

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 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 performing detailed work (sewing, threading a needle, baiting a hook)	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