Eye Associates of Boca Raton, P.A.

Welcome To Our Office

PATIENT REGISTRATION

APPOINTMENT DATE: _____

PLEASE BRING THIS FORM WITH YOU AT TIME OF APPOINTMENT.

How Did You Hear About Us? (Check All That Apply)

- ❑ Newspaper: _____
- ❑ Radio: _____
- ❑ Television: _____
- ❑ Phone Book: _____
- ❑ Internet: _____
- ❑ Newsletter: _____
- ❑ Seminar/Special Event: _____
- ❑ Employee: _____
- ❑ Eye Doctor/Name: _____
- ❑ Family Doctor/PCP: _____
- ❑ Insurance Plan: _____
- ❑ Friend/Family: _____

DR. MR. MRS. MISS MS: _____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RESPONSIBLE PARTY: _____ REFERRED BY: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

LOCAL ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

OUT OF STATE ADDRESS: _____ EMAIL: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: Last 4 Digits only! - XX - _____ DATE OF BIRTH: ____ / ____ / ____

FAMILY PHYSICIAN: _____ PHONE: _____

OCCUPATION: _____ RETIRED: Y N

EMPLOYER: _____ PHONE: _____

IN CASE OF EMERGENCY, CONTACT: _____ PHONE: _____ RELATION: _____

RACE: ❑Asian ❑Black or African American ❑Hispanic or Latino ❑White or Caucasian ❑Other

ETHNICITY: ❑Hispanic or Latino ❑ Not Hispanic or Latino **LANGUAGE:** _____

PLEASE READ: PAYMENT IS DUE AT THE TIME OF SERVICES. PLEASE READ THE REVERSE SIDE FOR OUR PAYMENT POLICY. ALSO, IF CURRENTLY TAKING ANY MEDICATION, PLEASE BRING AN UPDATED LIST OF THESE MEDICATIONS WITH YOU.

INSURANCE INFORMATION: PLEASE LIST THE SUBSCRIBER OF THE POLICY IF OTHER THAN THE PATIENT.

PRIMARY: 1. _____ POLICY #: _____

ADDRESS: _____ GROUP #: _____

SUBSCRIBER: _____ RELATION: _____

ADDITIONAL: 2. _____ POLICY #: _____

ADDRESS: _____ GROUP #: _____

SUBSCRIBER: _____ RELATION: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

PLEASE READ & SIGN BOTH SIDES

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

PATIENT'S SIGNATURE: _____ DATE: _____

I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BENEFITS TO MY PHYSICIAN.

PATIENT'S SIGNATURE: _____ DATE: _____

Eye Associates of Boca Raton, P.A.

PAYMENT POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, or Visa. We will be happy to help you process your insurance claim-form for your reimbursement. In special instances, such as Medicare, we may accept assignment of insurance benefits.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1-1/2% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to a maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. For example: Medicare does not approve the REFRACTION which is performed to determine the need for eyeglasses and thus you are responsible for payment at the time this service is rendered.

4. MEDICARE ASSIGNMENT does not mean Medicare pays in-full for all services rendered. Medicare will pay 80% of those services they approve and thus the patient is responsible for payment of the 20%. Example: Medicare approves $100.00, they pay $80.00, the patient pays $20.00. We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of some insurance claims is a courtesy that we extend to our patients, ALL CHARGES are your responsibility from the date the services are rendered. We realize that occasionally there are financial problems which may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help.

Kindly acknowledge acceptance of this policy by signing the form below:

SIGNATURE: _____ **DATE:** _____

H2.6C NOTICE OF PRIVACY PRACTICES

(EYE ASSOCIATES OF BOCA RATON, 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.

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.
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 illness.

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 future 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.
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.
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 person 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 person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

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

Center Director
Eye Associates of Boca Raton, P.A.
950 NW 13th Street, Boca Raton, FL 33486
(561) 391-8300

Effective Date: March 9, 2015

I, _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

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

I hereby give my permission to the Eye Associates of Boca Raton, P.A. to leave a message with confidential medical information on my answering devices on my cell phone or my home phone.

Signed: _____

Date: _____

Staff Witness seeking acknowledgement

Signed: _____

Date: _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Eye Associates of Boca Raton, P.A. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other
☐ Spouse (provide name & phone number) _____	☐ Financial ☐ Medical as follows: _____
☐ Parent (provide name & phone number) _____	☐ Financial ☐ Medical as follows: _____
☐ Other (provide name & phone number) _____	☐ Financial ☐ Medical as follows: _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised January 2010

Eye Associates of Boca Raton, P.A.
Surgical & Medical Eye Care

REFRACTION

This is a diagnostic procedure to determine the amount of corrective lens power required to obtain your best vision. Your doctor believes this is a necessary part of making his medical decisions and recommendations at the conclusion of your visit.

It is customary in our area for ophthalmology offices to perform a refraction and to charge for it.

The fee for a refraction is $75.00 and is not paid by Medicare or most other insurance companies.

You will be asked to pay this amount at the end of your visit today. As a courtesy to you, we will bill your insurance company for this. Should your insurance pay for the refraction, a prompt refund will be sent to you.

In the event that your new prescription changes within 60 days of your eye examination, we will recheck your vision at no additional charge.

Thank you for your cooperation and understanding and for choosing Eye Associates of Boca Raton, P.A.

Patient Signature: _____ Date:_____

Patient Name:_____ Date of Birth: _____

Eye Associates of Boca Raton, P.A.
Surgical & Medical Eye Care

Name:_____ **Date of Birth**:_____

Important Information about Dilation

Your vision may be temporarily impaired following your eye examination or during subsequent visits to our office. Dilating drops may be used during the course of your examination to aid in the diagnosis and treatment of various pathologic processes affecting the eyes. The use of these drops as well as other methods of examination and treatment may render your vision blurred for a varying amount of time, thus interfering with your ability to safely operate a motor vehicle. Whenever possible, you should come to the office with a driver. If your vision is blurred, please do not attempt to drive. You should wait in our office until your vision returns to normal (approximately 2 – 3 hours). If necessary, our office staff can assist you in arranging alternative transportation.

Adverse reactions, such as acute angle closure glaucoma, may be triggered by the use of the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize my eye doctor and/or such assistant he/she may designate to administer dilating eye drops.

Patient Signature: _____ Date: _____

Important Notice to Parents and Legal Guardians

I understand that my child's eyes may be dilated, this could impair his or her vision such that climbing, bike riding, and other activities could be potentially dangerous and should be avoided until vision returns to normal. Additionally, I hereby give consent to any additional examinations and/or treatment necessary for my child's condition.

Parent's signature: _____ Date: _____

Relationship: _____

Eye Associates of Boca Raton, P.A.

Surgical & Medical Eye Care

Name:_____ **Date of Birth**:_____

Allergies (Drugs, Food, Environmental) Please list all:

Allergy	Reaction

Medications (Please include all over the counter medications, herbal remedies, and supplements):

Name	Dosage	Frequency	Route (By mouth, inhaler, injection, etc.)

Review of Symptoms (Please indicate any symptoms you are having currently)

Constitutional
- ❒ Fatigue
- ❒ Fever
- ❒ Weight loss
- ❒ Weight gain
- ❒ Weakness

ENT
- ❒ Sinus problems
- ❒ Lump in neck

Respiratory
- ❒ Cough
- ❒ Difficulty breathing

Cardiovascular
- ❒ Chest pain
- ❒ Irregular heart beat

Gastrointestinal
- ❒ Stomach Pain
- ❒ Nausea/vomiting
- ❒ Heartburn

Genitourinary
- ❒ Painful urination
- ❒ Blood in urine

Metabolic/Endocrine
- ❒ Heat/cold intolerance
- ❒ Frequent drinking
- ❒ Frequent urination

Neurological
- ❒ Headache
- ❒ Memory problems
- ❒ Numbness
- ❒ Local weakness

Psychiatric
- ❒ Depressed
- ❒ Hallucinations

Integumentary
- ❒ Rash
- ❒ Skin changes

Musculoskeletal
- ❒ Back pain
- ❒ Joint paint/swelling
- ❒ Joint stiffness

Hematologic/Lymphatic
- ❒ Bleeding
- ❒ Bruising
- ❒ Swollen glands

Other:_____

Vital Signs

Height: ____ft _____ in Weight: _____ lbs

Past Ocular History (Eye-related problems):

Disease	Eye	Year occurred

Eye Associates of Boca Raton, P.A.
Surgical & Medical Eye Care

Name:_____ **Date of Birth**:_____

Eye Surgeries Please list all:

Procedure	Eye	Date	Surgeon	Location	Outcome

Medical/Surgery History:

Disease/Procedure	Side	Date/Onset	Management	Surgeon	Outcome

Family History:

Condition	Age / Onset	Relationship
❒ Blindness		
❒ Heart Disease		
❒ Corneal Disease		
❒ Diabetes		
❒ Glaucoma		
❒ Macular Degeneration		
❒ Retinal Disease		
❒ Other		

Diabetes:

Glucose (sugar level):_____ Date last checked: _____ Time: _____

Hemoglobin A|C: _____ Date last checked: _____ Time: _____

Social History:

Have you ever used tobacco? ❒ No/Never ❒ Yes Currently? ❒ Yes ❒ Quit

Have you tried to quit tobacco? ❒ No ❒ Yes List date, method, longest free period and/or relapse reason:

_____

Have you had passive smoke exposure? ❒ No ❒ Yes List type, location, length, level of exposure:

_____

Alcohol Use? ❒ No ❒ Yes List type, frequency, and amount:

_____

Consume Caffeine? ❒ No ❒ Yes Drug use? ❒ No ❒ Yes List:_____

Pharmacy Information

Patient Name:_____ Date of Birth: _____

Date: _____

Pharmacy Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____