PATIENT REGISTRATION FORM

Today's Date: _____ PCP: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Age: _____

Gender: ____Female ____Male

Address: _____ Apt: _____ DOB: _____

City: _____ State: _____ Zip Code: _____

Social Security no.: _____ Home phone no.: _____ Cell phone no.: _____

Occupation: _____ Employer: _____ Employer phone no.: _____

Student? ____Yes ____No School: _____ Email Address: _____

Pharmacy Name: _____ Pharmacy Address: _____ Pharmacy phone no.: _____

Whom may we thank for referring you? _____

Patient Advocates (Authorized to receive medical information, make decisions and/or attend appointments) *Include relationship and telephone number*

1. _____
2. _____

Other family members seen here: _____

INSURANCE INFORMATION

(Please give your insurance card and ID to the receptionist.) If Child/Parents ID

Person responsible for bill: _____ Birth date: _____ Relationship: _____

Address (if different): _____ City: _____ State: _____ Zip Code: _____

Is this person a patient here? ____Yes ____No Social Security: _____

Occupation: _____ Employer: _____ Employer phone no.: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Please indicate primary insurance: _____

Subscriber's name: _____ Date of Birth: _____

Policy No.: _____ Group no.: _____ Other Info: _____

Patient's relationship to subscriber: ____ Self ____ Spouse ____ Child ____ Other (Explain: _____)

Name of secondary insurance (if applicable): Subscriber's name: _____

Policy No.: _____ Group no.: _____ Other Info: _____

Patient's relationship to subscriber: ____ Self ____ Spouse ____ Child ____ Other (Explain: _____)

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Eye Care Specialists of Florida, LLC, Saira A. Choudhri, MD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for all charges whether or not paid by insurance. I also understand that payment is due at the time services are rendered. I hereby authorize Eye Care Specialists of Florida, LLC to release all information necessary to secure the payment of benefits and authorize the use of this signature on all insurance submissions. Furthermore, a copy of this assignment is considered valid in place of the originals.

In Signing this form I consent to treatment by Eye Care Specialists of Florida, LLC, Saira A. Choudhri, MD for my illness and/or health evaluation including by not limited to Fundus Photos, Laboratory Procedures, Medications & Office Procedures. I acknowledge and agree that no guarantees have been made to me as to the results or outcome of my medical ccare and I understand that state law requires providers to report certain communicable disease to the Health Department. I also acknowledge that you may use and disclose protected health information (PHI) to carry out treatment, payment, and health care operations and authorize Eye Care Specialists of Florida, LLC, Saira A. Choudhri, MD or its appointed representatives to e-mail, call my home, cell phone or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders cards, and patient statements as long as they are marked Personal and Confidential. Eye Care Specialists of Florida, LLC may also mail to my home or other alternative location any items that assist the practice in carrying out TPO.

In case of default payment, I agree to pay any reasonable attorney and collection fees incurred in collection of any amount due. I also agree to pay a $30.00 service charge if my check is returned for any reason whatsoever. I also agree to pay a $25.00 for any missed appointment if I do not call the office to cancel at least 24 hours in advance. Accounts not paid withing 30 days will accrue interest at the highest rate allowed by law. I also certify that the information hereby provided is true and correct to the best of my knowledge.

Patient/Guardian signature: _____ Relationship: _____ Date: _____

PATIENT QUESTIONNAIRE

Date:_____ Referred By: _____ Birthdate: _____

Patient Name:_____ Sex:_____ Age: _____

Address: _____ Phone(H): _____

Employer:_____ Occupation:_____ Phone(W): _____

Soc.Sec.No.: _____ Primary Care Physician:_____

Please answer the following questions about your medical status and history.

1. Have you ever been treated for any medical conditions(e.g. diabetes, high blood pressure, arthritis, etc)?
   YES __ NO __ If YES, please explain _____
   _____

2. Have you ever had any eye disease(e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   YES __ NO __ If YES, please explain: _____
   _____

3. Have you ever had any surgery? YES __ NO __ If YES, please explain: _____
   _____

4. Do you take any medications? YES __ NO __ If YES, please list: _____
   _____

5. Do you have any drug allergies? YES __ NO __ If YES, please list: _____
   _____

6. Do you currently have any of the following problems?

	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain fatigue	___	___	_____
Ear/nose/throat problems(e.g. hearing loss, sinus problems, sore throat)	___	___	_____
Heart problems(e.g. chest pain, irregular heart beat)	___	___	_____
Respiratory problems(e.g. shortness of breath, wheezing, coughing)	___	___	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	___	___	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	___	___	_____
Skin problems (e.g. rashes, excessive dryness)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	___	___	_____
Neurologic problems (e.g. numbness, weakness, headache, paralysis)	___	___	_____
Psychiatric problems (e.g. depression, anxiety)	___	___	_____

7. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? YES __ NO __ If YES, please explain: _____
   _____

8. Do you smoke? YES ___ NO ___ If YES, how much? _____
   Do you drink alcohol? YES ___ NO ___ If YES, please explain: _____

___ Reviewed by M.D. COMMENTS _____
_____
_____ M.D. signature _____ Date _____

Medication List

Name: _____ Allergies/NKA: _____

Pharmacy Name _____ Pharmacy Number: _____

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Eye Care Specialist of Florida, LLC

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you do make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Saira A. Choudhri, MD and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

Eye Care Specialists
Of Florida, LLC.

Notice of Privacy Practice Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice are subject to change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our Notice. You have the right to revoke this consent, in writing, except if we have already made releases in reliance on your prior consent.

*Patient Signature:*_____

*Please Print:*_____

*Date:*_____

*Witness:*_____

Financial Policy

In compliance with Federal Consumer Protection Act, Eye Care Specialists of Florida, LLC. is furnishing you with information regarding your financial responsibilities.

Welcome! We are pleased you have chosen Eye Care Specialists of Florida, LLC. for your specialty healthcare needs. We'd like to familiarize you with how our services are billed, which insurance claims we file on your behalf, when we request payment from you and our credit policies. It is our belief that the best service is possible when there is a mutual understanding between you and the physician. We ask that you take the time to read our policy so we can avoid any misunderstandings. If you have any questions our billing department will be happy to discuss them with you.

Insurances

Eye Care Specialists of Florida, LLC. participates in many PPO and HMO plans, as well as all BCBS products and Medicare/ Medicaid. All copays are due at the time services are rendered.

If you have an indemnity plan (80/ 20) and your deductible has been met we will file for you. You will be responsible for your 20% at the time services are rendered. If your deductible has not been met, payment in full is required at time of service.

After 30 days all unpaid balances will be transferred to your responsibility.

Note: Even though we may participate in your insurance program, some charges may always be your responsibility. It is always your responsibility to make sure appropriate authorization has been obtained for procedures and/ or hospitalizations when necessary. If your insurance company refuses to pay for services due to lack of an authorization you will be responsible for these non-covered charges.

It is always your responsibility to understand the coverage your insurance program provides and its referral authorization process.

Please understand that our office cannot accept responsibility for payment or nonpayment on your insurance claims. Questions about coverage and benefits are between you and your insurance company.

For patients not covered under any billable plans, we require payment at time of service.

Billing

We will furnish you with a monthly statement of your account showing the amounts billed to you and any payments received on your account. This monthly billing will also provide you with a detailed aging of how long balances have been outstanding.

Payment can be made in cash or by check from a local bank. For your convenience we also accept Master Card, Visa and American Express.

Credit Policy

If a check is returned to our office for lack of sufficient funds a fee of $25.00 will be added to the amount of the check and will be deemed payable immediately to be paid in full by cash or credit card.

Collection Policy

Payment for services which have been billed to you are due in full within 30 days of receipt of your billing statement. If you fail to pay within a reasonable amount of time or cooperate with the terms of an agreed upon payment schedule your account may be turned over to an outside agency for resolution.

Refund Policy

Overpayments to your account will be refunded to you within 30 days of overpayment, provided your account has a credit balance. If there is an outstanding balance due on your account all credits will be applied to that balance prior to issuing a refund.

In order to avoid problems due to delayed mail please notify us of any change in status such as name, address, phone number or insurance coverage.

_____ _____

Date Signature

Eye Care Specialists
of Florida, LLC

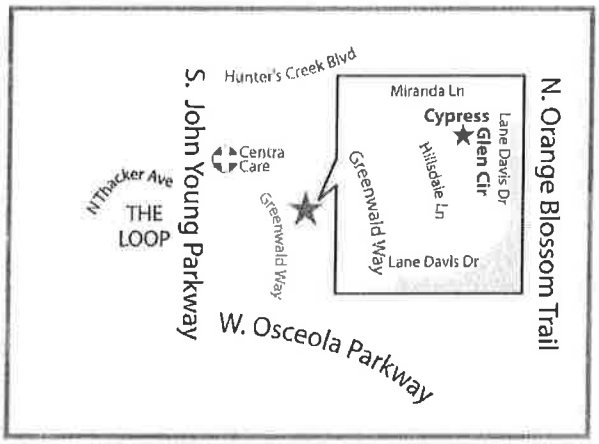
Items to bring to your Appointment

- Please complete all of the enclosed forms and bring them to your appointment. Make sure to include your Primary Care Physician's name, address, and phone number.
- You must bring your insurance card if you would like us to file your insurance. We must have the actual card in order to file. If a referral/authorization is required by insurance, please obtain this prior to your appointment. Without your insurance card and authorization (if required) we will not be able to see you and will need to reschedule your appointment.
- Driver's License or Picture ID is required.
- We require a current list of all medications/vitamins including dosage (see attached list). If you prefer you may bring your actual medication containers.
- If you wear eyeglasses, please bring them to your appointment.

General Information

- Both of your eyes will be dilated. Please bring a driver if you feel it is necessary.
- All children under 18 years of age must be accompanied by a parent or legal guardian, unless arrangements have been made prior to appointment.
- Please allow yourself plenty of travel time prior to your appointment. Arriving late may cause your appointment to be rescheduled.
- All co-pays/ past due balances are due upon Check-In.

Appointment Date: _____ **Time:** _____



Saira A. Choudhri, M.D.
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Medical and Surgical Diseases of the Eye

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