Patient Registration

PATIENT INFORMATION

Date:________________ Primary Care Physician:________________ DOB:________________

Last name:________________ First name:________________ M.I.:______ Age:______ Sex:______

Address:________________ Apt/Suite:__________ City:______________ State:_____ Zip Code:__________

SSN:______-______-______ Home Phone:________________ Cell Phone:________________

Employer: ________________ Occupation:________________ Work Phone:________________

Student?: YES _____ NO _____ School:________________ E-mail:________________

Pharmacy Name:________________ Pharmacy Address/Number:________________

Whom may we thank for referring you? ________________

Patient Advocates (Authorized to receive medical information, make decisions and/or attend appointments)

1.________________ Relationship:______________ Phone #:________________

2.________________ Relationship:______________ Phone #:________________

INSURANCE INFORMATION

Person responsible for the bill/subscriber:________________ DOB:__________ Relationship:______________

Address (if different): ________________ Apt/Suite:__________ City:______________ State:______

Zip Code:__________ SSN:______-______-______ Home Phone:________________ Cell Phone:________________

Employer: ________________ Occupation:________________ Work Phone:________________

Employer Address:________________ City:________________State:__________ Zip Code:__________

Please indicate primary insurance:________________

Policy Number:________________ Group Number:________________

Patient's Relationship to Subscriber: SELF _____ SPOUSE _____ CHILD _____ OTHER (Explain):________________

Secondary Insurance (if applicable): ________________ Subscriber Name:________________

Policy Number:________________ Group Number:________________

Patient's Relationship to Subscriber: SELF _____ SPOUSE _____ CHILD _____ OTHER (Explain):________________

IN CASE OF EMERGENCY

Name of friend of relative:________________ Relationship:______________ Phone number:________________

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 but not limited to Fundus Photos, Laboratory Procedures, Medications, and Office Procedures. I acknowledge and agree that no guarantees have been made to me as to the results or outcome of my medical care 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 an 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 reminder 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 an 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 charge for any missed appointment if I do not call the office to cancel at least 24 hours in advance. Accounts not paid within 30 days will accrue interest at the highest rate allowed by law. I also certify that information hereby provided is true and correct to the best of my knowledge.

Patient/Guardian Signature:________________Relationship:________________ Date:________________

Patient Questionnaire

Date:________________________ Referred by:____

Patient Name: ______________________________________ Birthdate:_____/______/______ Sex:_____ Age:_____

SSN:________-_______-_______ Primary Care Physician:____

Please answer the following question about your medical status and history:

Medical Conditions (circle all that apply):

Diabetes — High/Low Blood Pressure — Arthritis — Heart Disease

High Cholesterol — Stroke — Lupus — Epilepsy

Thyroid Disease — Liver Disease — Kidney Disease

Cancer:____ Other:_______________________________________

Eye Disease (circle all that apply):

Glaucoma/Glaucoma Suspect — Cataract(s) — Strabismus — Macular Degeneration

Retinal Detachment — Lattice Degeneration — Other:__________________________________

Have you ever had any surgeries (please include the year, if none then skip):__________________________

____

Do you take any medications: **YES** _____ **NO** _____ If **YES**, fill out on Medication List Form attached.

Do you have any medication allergies: **YES** _____ **NO** _____ If **YES**, fill out on Medication List Form attached.

Do you currently have any of the following problems?	**YES**	**NO**	**If YES, please explain:**	
Ocular (e.g. burning, itching, redness, watery)				
Chronic fever, unexpected weight loss/gain, fatigue				
Ear, nose, throat(e.g. hearing loss, sinus)				
Heart (e.g. chest pain, irregular heartbeat)				
Respiratory (e.g. coughing, shortness of breath)				
Gastrointestinal (e.g. heartburn, diarrhea, vomiting)				
Urinary (e.g. pain, discomfort, blood in urine)				
Skin (e.g. rashes, excessive dryness)				
Musculoskeletal (e.g. muscle aches, joint pain)				
Neurological (e.g. numbness, weakness, headache)				
Psychiatric (e.g. depression, anxiety)				

Do any medical or eye diseases run in your family? **YES** _____ **NO** _____

If **YES**, list what and who:____

____

Do you smoke? **YES** _____ **NO** _____ If **YES**, how much? __________________________

Do you drink? **YES** _____ **NO** _____ If **YES**, how much? __________________________

Comments:____

____

Doctor's Signature: ____________________________Date:____________

Medication List/Lista de Medicina

Name:______________________________ DOB:______________

Systemic Medications/Medicinas

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15

Ocular Medications(such as eye drops/ointments)/Medicina Ocular(como gotas para los ojos/unguento/pomada)

1
2
3
4
5

Medication Allergies/Alergias a Medicina:

1
2
3
4
5

Other Allergies/Otras Alergias:

1
2
3
4
5

DRY EYE QUESTIONNAIRE (DEQ-5)*

Name: ______________________ DOB: ____________

1. Questions about **EYE DISCOMFORT:**

a. During a typical day in the past month, **how often** did your eyes feel discomfort?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

b. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

2. Questions about **EYE DRYNESS:**

a. During a typical day in the past month, **how often** did your eyes feel dry?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

b. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

NEVER HAVE IT	NOT AT ALL INTENSE				VERY INTENSE
0	1	2	3	4	5

3. Questions about **WATERY EYES:**

During a typical day in the past month, **how often** did your eyes look or feel excessively watery?

NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
0	1	2	3	4

Score:

1a	+	1b	+	2a	+	2b	+	3	=	TOTAL

*R. L. Chalmers et al./Contact Lens & Anterior Eye 33 (2010) 55-60

Eye Care Specialists of Florida, LLC

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge 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 her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Name (print):____ Date:______________

Patient/guardian signature:____ Date:______________

Witness signature:____ Date:______________

Eye Care Specialists of Florida

FINANCIAL POLICY

In compliance with Federal Consumer Protection Act, Eye Care Specialists of Florida, LLC. is furnishing you with information regarding your financial responsibilities. We are pleased you have chosen Eye Care Specialists of Florida, LLC. for your specialty healthcare needs. We would 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 the 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 MasterCard, 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 agreement 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.

SIGNATURE:____ 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 health care 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 Name (print):____ Date:____________

Patient/guardian signature:____________________________________ Date:____________

Witness signature:____ Date:____________

Eye Care Specialists of Florida, LLC

MEDICAL VS VISION INSURANCE

Do you have vision/optical insurance?: **YES** _____ **NO** _____
If **YES**, with what company?:____

One of the most challenging billing issues in an ophthalmology office is whether we should be billing the medical or vision plan. **An Ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides very comprehensive medical eye exams.** However, ophthalmologists also provide routine vision exams for people with no eye disorders.

FOR PATIENTS WITH BOTH MEDICAL AND VISION COVERAGE
Your vision insurance is intended to provide you with a baseline eye evaluation. If you are being evaluated for **medical reasons** (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc), you are being provided with **medical care**. Your vision company **does not** provide coverage for medical care. Therefore, we will be billing your **medical insurance** for visits related to **medical complaints and problems**.

FOR PATIENTS WITH NO VISION/OPTICAL COVERAGE
If you are being seen for a routine eye evaluation and don't have vision/optical coverage, your medical insurance will not pay for an eye exam. However, if you have a medical problem (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc), your visit is considered a medical problem and can be billed to your medical plan(s). If so, please be aware that many plans are no longer paying for eye exams because of a diagnosis of blurred vision or a headache. They are considering this a routine vision exam and they will not pay for the visit.

REFRACTION SERVICE AND FEE

A refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary to write a prescription for glasses. **Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected).** If you have a separate vision plan that covers routine or annual examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for a refraction is $35.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly. If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

PATIENT ACKNOWLEGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

Print patient name:____
Patient/guardian signature:_______________________________ Date:_______________