Eye Care Specialists Of Florida

Caring for you, not just your eyes

First Name: ____________ Last Name: ____________ Date of Birth: ____________ Gender: ______

Address: ____________________ Apt/Suite: _____ City: ____________ State: _____ Zip Code: ______

SSN: _____-______-______ Home Phone: _____-______-______ Cell Phone: _____-______-______

Employer: ______________ Occupation: ______________ Work Phone: _____-______-______

E-Mail: ____________________ Pharmacy Name/Phone Number: ____________________

Referred By: ____________________ Primary Care Physician: ____________________

Insurance Carrier: ____________ Member ID: ______________ Group Number: ____________

Primary Member of Insurance Name/DOB: __________________________ Relationship: ________

Do you drink? YES/NO Do you smoke? YES/NO Pregnant? YES/NO Primary Language: ______________

Person authorized to receive medical information/Contact in case of an emergency:

Name: __________________________ Relationship: __________ Phone: ____________

Current Medications: __________________________ Medication Allergies: ______________

MEDICAL HISTORY

Do you currently have any of the following problems?	Y	N	If yes, please explain:
Ocular History (e.g. Glaucoma, Macular Degeneration)			
Ear, Nose, Throat (e.g. Sinus, hearing loss)			
Cardiovascular (e.g. Heart Disease, Hypertension)			
Respiratory (e.g. Asthma)			
Gastrointestinal/Digestive/Urinary			
Skin			
Muscles, Bones, Joints			
Endocrine (e.g. Diabetes, Thyroid Disease)			
Neurological/Psychiatric (e.g. Headaches, Depression)			
Cancer			
Major Surgeries			

Family History	Y	N	Relationship to patient:
Medical History			
Ocular HIstory			

Patient/Guardian Signature: ____________________ Relationship: ____________ Date: ________

Doctor Signature: ______________ Date: ________

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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 eyecare needs. We ask that you take the time to read our policy so we can avoid any misunderstandings. If you have any questions, our staff will be happy to discuss them with you. All copays, co-insurances, and deductibles are due at the time services are rendered. After 30 days, all unpaid balances will be transferred to your responsibility. 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 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 pay or non-payment 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 full payment at time of service. We will furnish you with a month statement of your account showing the amounts billed to you and any payments received on your account Payment can be made in cash, check, and/or any major credit card. 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. 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 resolutions. 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.

ASSIGNMENT AND RELEASE

I certify that I 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 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, payments, and health care operations. I authorize Eye Care Specialists of Florida, LLC, Saira A. Choudhri, MD or its appointed representatives to e-mail and/or call the numbers provided in reference to any items that assist the practice in carrying out TPO, such as appointment reminders. Eye Care Specialists of Florida, LLC may also mail to my home any items that assist the practice in carrying out TPO.

Print Patient Name: ____

Patient/Guardian Signature: ______________________________ Date: ____________

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NOTICE OF PRIVACY PRACTICES

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.

YOUR RIGHTS

- Get an electronic or paper copy of your medical record
- Ask us to correct your medical record
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

OUR USES AND DISCLOSURES

- To treat you by sharing your health information to share with other professionals who are treating you
- To run our practice, improve your care, and contact you when necessary
- To bill for your services and get payment from health plans or other entities
- To comply with the law by sharing information about you if state or federal laws require it
- To address workers' compensation, law enforcement, and other government requests
- To respond to lawsuits and legal actions

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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.

Print Patient Name: ______________________________

Patient/Guardian Signature: ______________________________ Date: ______________

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CANCELLATION/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company.

SCHEDULED APPOINTMENTS POLICY

We understand that delay can happen, however we must try to keep the other patients on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointments.

REFRACTION POLICY

It may be necessary for our office to perform a refraction test. While Medicare and some major insurance carriers do not cover this test, it is necessary to determine your visual acuity. This test can be used to determine your need for glasses, but it can also detect vision loss. Some of the time vision loss is slow and progressive and the patient may not even notice, that is why a physician will check the patient's vision by refracting them. This test can also uncover other problems a patient may be unaware of. **This test is charged separate from the exam because Medicare has deemed that a refraction is not a "medical service."** However, this is the ONLY way to detect some types of vision loss. The Office of Inspector General has deemed that not charging a patient for a service is an "inducement" to the patient, and therefore *illegal*, which is why we charge for this service to be done. A refraction may not be done at every visit. This varies based on the patient's diagnosis. **The fee for a refraction is $70, and due at the time of service in addition to any copays or deductibles.** Patient's initials: ___________

DILATION

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 after an examination, it's best if you 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. Signing below authorizes 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 your condition(s).

PATIENTS WITH BOTH MEDICAL AND VISION COVERAGE

Your vision insurance is intended to provide you with a baseline eye evaluation. If you're being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspects, etc), you are being provided with medical care. Your vision company does not provide coverage for medical care. Any refraction exam (prescription for glasses) will be billed to your vision insurance while the medical exam is billed to your medical insurance.

Print Patient Name: ____

Patient/Guardian Signature: ______________________________________ Date: ___________