FLORIDA EYE INSTITUTE

Life is Looking Better Already

Welcome to Florida Eye Institute!

We look forward to greeting you as a new patient. Having served the Vero Beach community for over 35 years, it is our steadfast goal to help you achieve the best vision possible while receiving the best personalized care.

As a multi-specialty ophthalmology practice we offer the latest advances in cataract surgery, glaucoma treatment, macular degeneration and diabetic eye conditions; as well as general ophthalmic care, low vision evaluation, laser vision correction, and expert fitting of glasses and contacts; all within one comprehensive medical and surgical facility.

Enclosed are several important forms for you to review – **Medical History, New Patient Information and Financial Policy**. Please complete and bring to your appointment along with current medications (including eye drops), eyeglasses, and insurance identification.

Expect your appointment to last approximately 90 minutes.

Following your exam and eye dilation you may experience difficulty driving or reading for several hours; please bring sunglasses to protect your eyes and consider having a driver if your eyes are particularly sensitive.

Should you have any questions about your appointment or our services; please call Christina Hubbard, Scheduling Supervisor **(772) 569-9500**.

See you soon!

Staff and Physicians of Florida Eye Institute

2750 Indian River Blvd., Vero Beach, FL 32960 • 772.569.9500 • Fax 772.569.9507 • www.fleye.com

FLORIDA EYE INSTITUTE
Patient Information Sheet

Patient Name: _____ DOB: _____

SS#: _____

DL#: _____ DL State: _____

Sex: _____ Ethnicity: _____ Race: _____

Responsible Party: _____ DOB: _____

SS#: _____ Phone Number: _____

Patient Address: _____

_____

Alternate Address: _____

_____

Dates at this address: _____

Phone Number: _____ Email: _____

Cell Phone: _____ Preferred Contact Method: _____

Alternate Phone: _____ OK to leave a detailed message? YES NO

Spouse's Name: _____ Emergency Contact: _____

Spouse's Phone: _____ Emergency Contact's Phone: _____

Pharmacy/Location: _____

Provide your insurance cards to the receptionist for scanning.

Please indicate the reason for your visit:

- ❑ Complete Eye Exam
- ❑ Diabetic Exam
- ❑ Laser Vision Correction Evaluation
- ❑ Cataract Evaluation
- ❑ Glaucoma Evaluation
- ❑ Contact Lenses
- ❑ Having a medical problem _____

Which doctor are you scheduled to see today?

Thomas A. Baudo, M.D. Karen D. Todd, M.D. Daniel M. Stingl, M.D.

Wilson K Wallace, M.D. Cynthia L. Kipp, O.D. Christopher S. Shumake, M.D.

How did you hear about us? Please give names so we know who to thank!

- ❑ Our Patient _____
- ❑ Family Member _____
- ❑ Referred by M.D. _____
- ❑ Optometrist _____
- ❑ Insurance Co. _____
- ❑ Newspaper/Magazine _____
- ❑ Radio Station _____
- ❑ Seminar/Screening _____
- ❑ Our Website/online _____
- ❑ Senior Services Guide _____

DO NOT WRITE IN THE BOX BELOW - FOR OFFICE USE ONLY

Account Number: _____

Date registered: _____ Registered by: _____

Please complete this form in its entirety. Use 'N/A' if the question does not apply.

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FINANCIAL POLICY

We are pleased to have you as our patient, and we are committed to providing you with our best professional care. Your understanding of our Financial Policy is important to our relationship. Please ask us if you have any questions.

INSURANCE

Due to all the various insurance plans now in effect, we require that you check with your insurance carrier(s) regarding our participation in your specific network. There are instances when even though we are contracted with a carrier, the carrier has networks in which we do not participate. If our offices does not participate in your network, you will be responsible for a large portion of or the entire bill. The carrier contract information is located on the back of your insurance card. It is your responsibility to update us with any new card that you receive from your carrier. Some insurance plans require an authorization for services in our office. It is your responsibility to acquire the appropriate paperwork. If the visit is not authorized, you will be responsible for the cost of services. We will send your insurance carriers(s) a claim for all services provided. You will be billed for any balance due after the carrier settles your claim.

PAYMENT EXPECTATIONS

If you are not covered by insurance, you will be required to pay for your services on the date the service is required. All patients are required to pay co-payments, deductibles and co-insurance at the time of your visit. You will receive a statement from our office after your insurance has settled your claim if there is any balance due. Payments are expected within thirty dates of receipt of the statement. Our office accepts cash, checks and VISA/MasterCard/Discover.

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PATIENT AUTHORIZATION

I hereby authorize that payment from my medical insurance program or my Medicare benefits be made directly to Florida Eye Institute, PA and Florida Eye Institute Surgicenter, LLC for any unpaid bills for services provided to me on or after today. I understand that I will be financially responsible for any balance not covered by my insurance carrier.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

There will be a $25.00 charge for any returned checks.
There will be a $35.00 charge for any account having to be placed with a collection agency.

I have read and understand this policy.

Signature Date

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Patient Privacy Policy
Use and Disclosure of Protected Health Information HIPAA

By signing this *Consent Form*, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. Protected health information is individually identifiable information we create or receive including demographic information relating to your physical or mental health in the provision of healthcare services to you and the collection of payment for providing healthcare services to you.

Our *Notice of Privacy Policies* provides information about how we may use and disclose protected health information about you. If we change our Notice, you may obtain a revised copy by contacting our information privacy officer in writing:

Florida Eye Institute
Attention: Information Privacy Officer
2750 Indian River Boulevard
Vero Beach, Florida 32960

If you choose not to sign this *Consent Form*, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you copies of this documentation should you decide not to sign the *Consent Form*.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use *our Authorization for Release of Information* for purposes of requesting action, or you may simply send us a letter in writing.

By signing this consent, you acknowledge that you have been given the opportunity to read the *"Notice of Privacy Policies."*

Patient's Signature Date

Print Name

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History and Intake Form

Name: _____ **Date:** _____ **D.O.B**_____

Primary reason(s) for today's visit: ☐ Cataract ☐ Glaucoma ☐ Dry Eye ☐ Diabetes
☐ Macular Degeneration ☐ Blurred Vision ☐ Other:_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Kidney Biopsy (Right, Left)
Kidney Removed (Right, Left)
Kidney Stone Removal (Right, Left)
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Heart Stent

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Past Surgical History continued:

Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
None
Other_____

Ocular History: (please circle all that apply)

Allergic conjunctivitis
Blepharitis
Cataract (Right eye, Left eye)
Corneal dystrophy (Right eye, Left eye)
Diabetic retinopathy, background (Right eye, Left eye)
Dry eyes
Drusen (Right eye, Left eye)
Glaucoma (Right eye, Left eye)
Macular degeneration (Right eye, Left eye)
Macular Pucker (wrinkle) (Right eye, Left eye)
Monovision
Narrow Angles (Right eye, Left eye)
Ocular Hypertension
Ophthalmic Migraine
Retinal tear (Right eye, Left eye)
Retinal Detachment (Right eye, Left eye)
Soft/Hard Contact Lens Wearer
Strabismus
Lazy Eye/Amblyopia
Floaters (Right eye, Left eye)
Other_____

Ocular Surgery: (please circle all that apply)

Blepharoplasty (Right eye, Left eye)
Cataract surgery (Right eye, Left eye)
Corneal transplant (Right eye, Left eye)
DSAEK (Right eye, Left eye)
Eye Muscle Surgery
Intravitreal injections (Right eye, Left eye)
LASIK (Right eye, Left eye)
Monovision (Right eye, Left eye)
PRK (Right eye, Left eye)
Ptosis repair
Punctal Plugs (Right eye, Left eye)
Strabismus Surgery
Retinal Laser
Trabeculectomy
Tube Shunt (Right eye, Left eye)
Yag Capsulotomy (Right eye, Left eye)
None
Other_____

Family History/Immediate family member only: (please circle all that apply)

Blindness
Cancer
Cataracts
CVA/Stroke
Diabetes
Glaucoma
Heart Disease
High blood pressure
High cholesterol
Macular degeneration
Migraine
Retinal Detachment
Strabismus
None
Other_____

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Medications: (Please list all current prescription and over the counter medications) Please list dosage and frequency.

None

Allergies: (Please enter all allergies) Please list reaction(s).

None

Eye Drops: (Please list all over the counter and prescription drops, including frequency and eye(s).

None

Social History: (Please circle all that apply)
Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1-2 drinks a day
Alcohol: 3 or more drinks a day

Safety:
I feel safe at home.
I do not feel safe at home.
Other_____

Review of Systems: Are you currently experiencing any of the following?
(Please check all that apply)

Symptom

_____Poor Vision
_____Eye Pain
_____Tearing
_____Redness
_____Loss of Vision
_____High blood pressure
_____Rapid Heart Rate
_____Diabetes
_____Thyroid Abnormalities
_____Chills
_____Ear Ache
_____Dry Mouth
_____Shortness of breath
_____Upset Stomach
_____Constipation
_____Incontinence
_____Joint Pain
_____Arthritis
_____Headache
_____Depression
_____Weakness
_____Head Injury
_____Decreased Hearing
_____ None

Other Symptoms:
_____

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Alerts: Have you ever or are you currently experiencing any of the following?
(Please check all that apply for the following)

_____Allergy to Lidocaine
_____Allergy to Adhesive
_____Artificial heart valve
_____Blood thinners
_____Defibrillator
_____Flomax
_____MRSA
_____Narrow Angles
_____Pacemaker
_____Rapid heartbeat with epinephrine
_____Steroid Responder

Other Symptoms:

_____

Refraction Fee:

Refraction is the measurement of glasses prescription for the purpose of prescribing new glasses or determining the best-corrected visual potential of the eye. Medicare and many private medical insurance programs do not cover this service and require a separate charge apart from the medical part of the exam. Some supplemental insurance will reimburse this fee. You will need to contact your insurance company to find out if and how they cover this service. You will be given a receipt if this service is performed.

The refraction fee is $60. I have read and understand the refraction policy.

Patient's Signature: _____ **Date:** _____

[ ] History reviewed **[ ] No changes** **[ ] Additions as noted**

Technician Initials: _____

Physician's Signature: _____ **Date:** _____

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Notice of Privacy Practices for Protected Health

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!**

The office/hospital is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and planning for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.
- For instance it may become necessary to disclose some PHI during an appointment reminder if you require special services such as a stand-by person from a transportation service etc.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office or ASC or Hospital we are not required to grant the request, but we will comply with a request that is granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record you may exercise this right by delivering the request to our office. Under certain circumstances, your request may be denied. If your request is denied, you will be informed of the reason for the denial and a copy will be provided to a representative designated by you. You will have

- an opportunity to appeal a denial of access to your protected health information, except in certain circumstances;
- Request an electronic copy of your medical record at the costs of labor incurred in producing the electronic copy;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the health information kept by or for the office;
    - Is not part of the information that you would be permitted to inspect and copy;
    - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations unless your records are maintained electronically. The accounting will also not include disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact **Victor Basile, Administrator**, in person or in writing, during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office/hospital is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Notify you of a breach in your unsecured protected health information.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complain

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Victor Basile, Administrator, 772-569-9500.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Lyn M. Lane. You may also file a complaint by mailing it or e-mailing it to the **Secretary of Health and Human Services**, whose street address and e-mail address is: **Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.