West Palm Beach
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Ph: 561-659-9700

Jupiter
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Ph: 561-839-2780

Stuart
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Tradition
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Name: _____ Date: ___ /___ /___
Last First M.I.

Mailing Address: _____

City/State: _____ Zip: _____

Home #: (_____)_____ Work #: (_____)_____ Cell #:(_____)_____

I authorize you to call or text me on my cell phone. _____ (Please initial.)

Email: _____

Social Security #: _____ D.O.B : ____ / ____ / ____ Sex: ☐ Male ☐ Female

Ethnicity: (Please circle one) Decline to Answer Hispanic/Latino Non-Hispanic/Latino

Race: _____ Preferred Language: _____

Place of Employment: _____

Insurance Information:
Primary Insurance Company Name:_____

Primary Insured Name: _____

Address:_____

Insurance ID #: _____ Relationship: _____

D.O.B.: ____ / ____ / ____ Social Security #: _____

Is this the Patient's Legal Representative? ☐Yes ☐No

Secondary Insurance Information: _____

Insurance ID#: _____ Primary Insured Name: _____

Primary Insured SS#: _____ Primary Insured D.O.B.: ____ / ____ / ____

Primary Physician: _____ Referred By: _____

Out of Town Address: _____ Zip: _____

City: _____ State: ___ Phone #: (_____)_____
(Use this address from ____ / ____ / ____ to ____ / ____ / ____)

Emergency Contact: _____

Phone #: (_____)_____ Relationship: _____

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Please list all medications, including over the counter and vitamins, you are currently taking, including strength, dosage and frequency:

Patient Name: _____ Date: ____ / _____ / _____

Name, location and phone number of preferred pharmacy:

_____

_____

Medication	Strength	Dosage	Frequency

Patient Signature: _____

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS
INSURANCE INFORMATION, FINANCIAL AGREEMENT

Patient Name (Printed):_____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Florida Vision Institute, for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated as a Secondary Insurance (in Item 9 of the HCFA 1500 claim form or electronically transmitted), my signature authorizes releasing the
information to the insurer shown. Florida Vision Institute, accepts the charge determination of Medicare and I am responsible for coinsurance, deductibles and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to Florida Vision Institute for services furnished to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

DILATED EXAMINATIONS: In the event the doctor has to dilate or parch my eye, I am aware that I may experience blurry vision, light sensitivity, and or decreased depth perception. For this reason, it is suggested that you have someone to drive you home.

FINANCIAL AGREEMENT: I agree that in return for the services provided by Florida Vision Institute, I will pay my account at the rime service is rendered or will make financial arrangements satisfactory to the practice. If my account is sent to collection, I will be responsible for the existing outstanding balance along with a 35% collection agency's fee. If further action is required, then I will also be responsible for any attorney fees as established by the court. In case of a check being returned, there will be a service charge of $25. Most insurances require you to pay co-payments and deductibles. These are due, if known, at the time of service as well as any non-covered services. It is understood that I am primarily responsible for the payment of any services not covered by my insurance.

Signature: _____Date: ___ / ___ / ____

Name: _____ Date: ___ /___ /___
Last First M.I.

OCULAR HISTORY:

Date of last eye exam: ___ /___ /___

Reason for today's visit: _____

Do you have: ☐ Glaucoma ☐ Cataracts ☐ Retina Problems ☐ Macular Degeneration
Family History: ☐ Glaucoma ☐ Cataracts ☐ Retina Problems ☐ Macular Degeneration

	No	Yes	
Do you wear glasses?	☐	☐	reading glasses ☐ distance ☐ both ☐
Do you wear contact lenses?	☐	☐	soft ☐ hard ☐ brand _____
Currently use eye drops?	☐	☐	Please list _____
Previous eye surgeries:	☐	☐	Type of surgery / Date _____

MEDICAL HISTORY:

	No	Yes	Medication(s)	Surgery / Dates
Diabetes	☐	☐	_____	_____
Ear/Nose/Throat Problems	☐	☐	_____	_____
High Blood Pressure	☐	☐	_____	_____
Heart Condition(s)	☐	☐	_____	_____
Kidney/Prostate/Liver	☐	☐	_____	_____
Artritis	☐	☐	_____	_____
Osteoporosis	☐	☐	_____	_____
Thyroid	☐	☐	_____	_____
Cancer	☐	☐	_____	_____

Other Condition(s) _____

MEDICATION ALLERGIES:

☐Penicillin ☐Sulfa Drugs ☐Other: _____

SOCIAL HISTORY

	No	Yes	
Do you smoke?	☐	☐	how much _____
Do you drink alcohol?	☐	☐	frequency_____
Do you use drugs?	☐	☐	

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Authorization to Use or Disclose Health Information

Name: _____ Date: ___ /___ /___

I understand that as part of my healthcare. Florida Vision originates and maintains health records describing my health history, symptoms, examination and test results. diagnoses, treatment and any plan for future care or treatment. In addition to health records, they maintain insurance information and other correspondence received on a day-to-day basis.

The doctors. staff and business associates of Florida Vision are authorized to use and disclose this information in the normal course of their workday. Similarly, pharmacies, other physicians and their staff, health insurers, billing agencies, and family or friends involved in my healthcare may also receive my health information.

I understand that I may revoke this authorization in writing at any rime by sending a written request to the practice at 1050 Monterey Road, Suite 104, Stuart, FL. 34994, Attention: Office Administrator, except to the extent that action has been taken in reliance on this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient. and if redisclosed, the information would no longer be protected by the federal privacy rule.

This authorization shall expire seven years after my last day of service.

_____ ___ /___ /___

Signature of Patient or Authorized Representative Date

If signed by patient's representative, please print name and describe the representative's authority to act on your behalf.

Representative's Name: _____

Representative's Authority: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE

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Notice of Privacy Practices Acknowledgment Form

Name: _____ D.O.B: ___ /___ /___

I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: ___ /___ /___

If signed by a Personal Representative:
Print Name: _____ Role: _____

Witness: _____ Date:___ /___ /___

If the individual has a personal representative with legal authority to make heath care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the personal representative. *If the individual or Personal Representative did not sign, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.*

Notice of Privacy Practices given to the individual on ___ /___ /___ by:

- ☐ Face to Face Meeting
- ☐ Emailing
- ☐ Mailing
- ☐ Other _____

Reason Individual or Personal Representative did not sign this form:

- Individual or Personal Representative chose not to sign
- Individual or Personal Representative did not respond after more than one attempt
- Email receipt verification
- Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail the efforts that were made to obtain the signature. More than one attempt must have been made.

- ☐ Face to Face Meeting
- ☐ Emailing
- ☐ Mailing
- ☐ Other _____

Staff Signature: _____ Title: _____

Print Name: _____ Date: ___ /___ /___

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Authorization to Use or Disclose Protected Health Information

Name: _____ D.O.B: ___ /___ /___

I, _____ hereby voluntarily authorize
Name, Date

Florida Vision to disclose information from my health record to:
Name of Person/Organization/Facility: _____
Address: _____
City / State: _____

The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability
☐ Other (Please Specify) _____

The information to be disclosed from my health record: (Check appropriate box(es)

☐ Only information related to (specify) _____
☐ Only the period of events from ___ /___ /___ to ___ /___ /___
☐ Entire Record

I understand that I may revoke this authorization in writing submitted at any time to the Medical Records Department at Florida Vision. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

_____ ___ /___ /___
Signature of Patient or Authorized Representative Date
If Representative, state relationship to Patient)

Representative's Name: _____
Representative's Authority: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE.

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DIAGNOSTIC REFRACTION TEST

Non-Covered Service Policy

A *REFRACTION* is a diagnostic test used by your doctor to determine the cause of decreased visual acuity. It is done routinely to diagnose the need for a change in prescriptive eyewear, to determine the need for surgery (e.g. Cataract), and to rule out eye diseases as the cause of diminished vision.

Most insurance companies, including Medicare and HMO's, ***DO NOT PAY*** for this diagnostic test. It is considered a Non-Covered Service for which the patient is responsible for payment.

The fee for this test is $65.00, payable on the day of service. If your insurance company pays for this specific test, you may submit the bill for reimbursement. If we receive payment from your insurance company for the service, we will reimburse you the amount covered by your insurance.

I , _____ understand that
(Print Name)
a Diagnostic Refraction Test is not a covered service by most insurance companies. I agree to be responsible for the $65.00 testing fee on the day of service.

_____ ___ /___ /___
Patient Signature Date