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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

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

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

Race: _____ Preferred Language: _____

Place of Employment: _____

Primary Physician: _____ Referred By: _____

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: _____

Emergency Contact: _____

Phone #: (_____)_____ Relationship: _____

FLORIDA VISION

KATZEN Eye Care & Laser Center
A FLORIDA VISION PARTNER

Date: ____/____/____

Patient Name: _____ D.O.B: ____/____/____

Pharmacy Name: _____

Pharmacy Location/Address: _____

Pharmacy Telephone Number: _____ — _____ — _____

Medication Allergies: ☐ Penicillin ☐ Sulfa Drugs ☐ Other:_____

Please list all medications you are currently taking, including over the counter and vitamins. Please document the strength of the medication, the dosage and the frequency.

Medication Name	Strength	Dosage	Frequency

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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 time 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: ___ / ___ / ____

FLORIDA VISION

KATZEN Eye Care & Laser Center
A FLORIDA VISION PARTNER

Date:____/____/____

Name: _____ Date of Birth: ____/____/_____
Last First MI

Primary Care Physician: _____
Referring Doctor: _____
Reason for visit:_____ Last eye exam: ____/____/____

Ocular History

	No	Yes	
Do you wear glasses?	☐	☐	☐ Reading ☐ Distance ☐ Both
Do you wear contact lenses?	☐	☐	☐ Soft ☐ Hard Brand: _____
Do you currently use eye drops?	☐	☐	List: _____
Have you had any previous ocular surgeries?	☐	☐	List:_____
Are you pregnant?	☐	☐	
Are you interested in LASIK?	☐	☐	

Health History

Do you or anyone in your immediate family have the following;

	You	Family		You	Family		You	Family
Glaucoma	☐	☐	Cancer	☐	☐	Thyroid	☐	☐
Cataracts	☐	☐	Hypertension	☐	☐	Migraines	☐	☐
Macular Degeneration	☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐
Amblyopia	☐	☐	Elevated Cholesterol	☐	☐	Other	☐	☐

Social History

	No	Yes	
Do you smoke?	☐	☐	If yes, how frequently? _____
Do you consume alcohol?	☐	☐	If yes, how frequently? _____
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 time 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 health 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