FLORIDA VISION INSTITUTE

West Palm Beach
1515 N. Flagler Drive
Suite #500
WPB, FL. 33401
Ph: 561-659-9700

Jupiter
600 University Blvd.
Suite #100
Jupiter, FL. 33458
Ph: 561-839-2780

Stuart
1050 SE Monterey Rd. #104
Stuart, FL. 34994
Ph: 772-283-2020

Tradition
10050 SW Innovation Way
Suite 101
Port St. Lucie, FL. 34987
772-345-1500

Port St. Lucie
1751 SE Port St Lucie Blvd
Port St. Lucie, FL. 34952
Ph: 772-337-2020

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

Mailing Address: _____

City / State: _____ Zip: _____

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

I authorize you to call or text me on my cell phone: _____ please initial.

E-mail: _____

Social Security #: _____ DOB: ___/___/____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐Married ☐Divorced ☐ Widowed

Ethnicity: (please circle one) Declined Hispanic/Latino Non-Hispanic/Latino

Race: _____ Preferred Language: _____

Place of Employment: _____

Insurance information:

Primary Insurance Company Name: _____

Primary Insured Name: _____ Relationship: _____

Address: _____ DOB: ____/____/____

Insurance ID Number: _____

Social Security #: _____ Is this the Patient's Legal Representative ☐ Yes ☐ No

Secondary Insurance Information: _____

Insurance ID #: _____ Primary Insured Name: _____

Primary Insured SS#: _____ Primary Insured DOB: _____

Primary Physician: _____ Who Referred You: _____

Out of Town Address: _____ Zip: _____

City: _____ State: _____ Phone #: ( ) _____

(Use this address from ____/____/____ to ____/____/____

Emergency Contact: _____ Phone #: ( ) _____

Relationship: _____

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

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Patient Name: _____ Date: _____

Medication	Strength	Dosage	Frequency:

_____
Patient Signature

5/9/18

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

Patient's Name (please print):_____

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 payables 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 patch 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. 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.*

_____ _____

Patient's Name or Authorized Party Date

FLORIDA VISION INSTITUTE

Name: _____ Today's Date: _____

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 glasses ☐ 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	Medications(s)	Surgery/Dates
Diabetes	☐	☐		
Ear/nose/throat Problems	☐	☐		
High Blood Pressure	☐	☐		
Heart Condition(s)	☐	☐		
Kidney/Prostate/Liver	☐	☐		
Arthritis	☐	☐		
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 of Birth____/____/____

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_____

Representatives Authority_____

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

FLORIDA VISION INSTITUTE
FLORIDA VISION OPTIQUE
FLORIDA VISION LASIK

Notice of Privacy Practices Acknowledgment Form

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Name:_____ Date of Birth:_____

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

Signature:_____ **Date:**_____
Individual of Personal Representative with legal authority to make healthcare decision

If signed by a Personal Representative:

Print Name_____ Role_____
(Parent, guardian, etc.)

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 above, 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 _____ (Date) by
*Face to face meeting
*Mailing
*Emailing
*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 presentation(s)_____
- Telephone contact(s)_____
- Mailing(s)_____
- Other_____

Staff Signature:_____ Title:_____

Print Name:_____ Date:_____

Authorization to Use or Disclose Protected Health Information

I, _____ Date of Birth____/____/____
(Name of Patient)
hereby voluntarily authorize 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 ____/____/____

☐ Other (specify) (Billing Stmt, etc.): _____

☐ 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 (State relationship to patient) Date

Representative's Name_____

Representatives Authority_____

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

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).
5/8/18

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 **$59.00**, 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, (print name) _____ understand that a Diagnostic Refraction Test is not a covered service by most insurance companies. I agree to be responsible for the **$59.00** testing fee on the day of service.

_____ _____

Patient's Signature Date

2/21/2020