WELCOME

WHO REFERRED YOU TO OUR PRACTICE?

___Physician -Name ______________________
___Patient -Name __________________________
___Insurance Company
___Newspaper ad- which paper _____________
___Internet
___Florida Eye Surgeons and Associates Website
___Saw building

FAMILY DR ___________________________

FAMILY DR PHONE # ___________________

PATIENT NAME _____________________

Address _________________________________

____
City State Zip Code

Home Phone # __________________________

Cell Phone # ____________________________

Email Address (optional) ________________

Employer ______________________________

Business Phone # _______________________

Spouse Name ___________________________

Spouse Employer ________________________

Spouse Work# __________________________

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

NAME____________________________

RELATIONSHIP_____________________

PHONE# __________________________

TODAY'S DATE__________________________

SOCIAL SEC # __________________________

BIRTHDATE ____________________________

INSURANCE INFORMATION

Primary Insurance Company

____

Secondary Insurance Company

____

PLEASE BRING YOUR INSURANCE CARDS TO THE OFFICE

Ethnic Background -circle one

Hispanic or Latino Not Hispanic or Latino
Unknown

Race - circle one

American Indian/Alaska Native
Asian Indian or Other
Black or African American
Native Hawaiian
Guamanian
Korean
Samoan
Unknown
White
Chinese
Filipino
Pacific Islander
Japanese
Vietnamese
Other

Preferred Language_____________________________

Pharmacy Information

Pharmacy Name ______________________________

Address _____________________________________

Phone# _____________________________________

(THIS FORM MUST BE FILLED OUT BY PATIENT PRIOR TO SEEING PHYSICIAN AS PER
FEDERAL GUIDELINES)

Name ______________________________ Date_________________ Chart________________

YOUR EYE HISTORY

Glaucoma	Yes	No	Cataracts	Yes	No
Retinal problems	Yes	No	Retinal Disease	Yes	No
Macular Degeneration	Yes	No	Diabetic Disease	Yes	No
Crossed Eyes	Yes	No	Corneal Disease	Yes	No
Injury	Yes	No			

Any treatments for eye problems? ____

YOUR SURGICAL HISTORY

DATE_________

____
____
____

LIST ALL MEDICATIONS YOU TAKE

MEDICATIONS	MEDICATIONS
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

ALLERGIES

Codeine	Yes	No	Environmental	Yes	No
Sulfa	Yes	No	IVP Dye/Iodine	Yes	No
Penicillin	Yes	No	Tape	Yes	No
			Latex	Yes	No

List any others____

FAMILY HISTORY

Does anyone in your immediate family **(mother, father, brother, or sister)** have?

Cancer	Yes	No	Diabetes	Yes	No
Blindness	Yes	No	Heart Disease	Yes	No
Glaucoma	Yes	No	High blood pressure	Yes	No
Retinal problems	Yes	No	Stroke	Yes	No
Macular Degeneration	Yes	No			

YOUR SOCIAL HISTORY

Do you smoke?	Yes	No	Do you drink?	Yes	No
How much? ____________________________			How much? ____________________________		
Do you drive?	Yes	No	Occupation ____________________________		
Married	Single	Other			

REVIEW OF SYSTEMS

PLEASE FILL IN FORM COMPLETELY (CIRCLE Yes or No) Page 2 of 2

CARDIOVASCULAR SYSTEM

NERVOUS SYSTEM

Chest pain Yes No______
Irreg. Heart Rate Yes No______
Stroke Yes No______
Heart Disease Yes No______
Carotid Disease Yes No______
High blood pressure Yes No______
Cholesterol Yes No______
Heart Attack Yes No______

SKIN

Acne Rosacea Yes No______
Psoriasis Yes No______

BLOOD

Blood disorders Yes No______
HIV Yes No______

GI (stomach & intestines)

Nausea/Vomiting Yes No______
Blood in stool Yes No______
Ulcers Yes No______

ENDOCRINE

No______
Thyroid disease Yes No______
Diabetes (juvenile) Yes No______
Diabetes (adult) Yes No______
How long? _________________

RESPIRATORY

Emphysema Yes No______
Sarcoidosis Yes No______
Asthma Yes No______
Shortness of breath Yes No______
Chronic bronchitis or cough Yes No______

CENTRAL

Migraines Yes No______
Stroke Yes No______
Numbness Yes No______
Seizures Yes No______

ONCOLOGY

Cancer Yes No______

EARS/NOSE/THROAT

Hearing loss Yes No______
Sinus problems Yes No______

CONSTITUTIONAL

Fever Yes No______
Weight loss Yes No______
Chronic fatigue Yes No______

GU (Genitourinary)

Kidney stones Yes No______
Bladder problems Yes No______
Prostate problems Yes No______
Female problems Yes No______
Renal failure Yes

MUSCULOSKELETAL

Arthritis Yes No______
Gout Yes No______
Lupus Yes No______
Fibromyalgia Yes No______

PSYCHIATRIC

Anxiety Yes No______
Depression Yes No______

LIST ANY OTHER DISEASE OR ILLNESS NOT MENTIONED ABOVE

____

____

Have you ever used Flomax or any other prostate medication? Yes No

____

Florida Eye Surgeons and Associates

Dr. Eric A. Cohn **Dr. Craig Cole**
Dr. Mathew George **Dr. Huberto Perez**

Retinal Services

If you need a prescription for new glasses, are noticing a decrease in vision, or being evaluated for Cataract surgery, there is a $50 refraction fee due at the time of service.

Refractions are not covered by your medical insurance.

If you elect not to have this test performed, please let the technician know.

By signing this form, you are acknowledging this policy, not agreeing to having this test performed.

Signature:______________________ Date:________

SANFORD OFFICE
313 N. Mangoustine Ave.
Sanford, FL 32771
(386) 574-0700

BILLING & CORRESPONDENCE ADDRESS
2850 Wellness Avenue
Orange City, FL 32763
(386) 574-0700

ORANGE CITY OFFICE
2850 Wellness Avenue
Orange City, FL 32763
(386) 574-0700

FLORIDA EYE SURGEONS AND ASSOCIATES
2850 WELLNESS AVE
ORANGE CITY, FL 32763
(386) 574-0700

HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

> Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
>
> Obtain payment from third-party payors
>
> Conduct normal healthcare operations, such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices and have received a copy of the Patient's Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice Of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name____

Signature____

Witness____

Date____

FLORIDA EYE SURGEONS AND ASSOCIATES
2850 WELLNESS AVE
ORANGE CITY, FL 32763
(386) 574-0700

HIPAA PATIENT NOTICE OF PRIVACY PRACTICES

THIS NOTICES/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 Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally to be kept properly confidential. This ACT gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and/or disclose your health information.

We may use and/or disclose your medical records only for each of the following purposes:

- Treatment- we will use and disclose your Protected Health Information (PHI) to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose information to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

- Payment-your PHI will be used, as needed, to obtain payment for your health care services. This may include activities your health plan may take before it approves or pays for health care services such as a determination of eligibility or coverage for insurance benefits. For example, obtaining approval for a hospital stay may require that your PHI be disclosed to the health plan to obtain approval

- Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging other business activities. For example, we may use a sign-in sheet at the registration desk, where you will be asked to sign your name. We may also call you by name in the waiting room. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment or to anyone who answers your phone.

You have the following rights with respect to your PHI, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions, on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it until you request, in writing, to remove it.
- The right to reasonable requests, to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and receive a copy of your PHI
- The right to have an amendment filed with your PHI
- The right to receive an accounting of disclosures of PHI
- The right to obtain a paper copy of this notice from us upon request

Florida Eye Surgeons and Associates

Lifetime Authorization Insurance Assignments

and Authorization to Release Information

1. RELEASE OF INFORMATION- I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or government agency, such as Blue Cross or Medicare), any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

2. PHYSICIAN INSURANCE ASSIGNMENT-I hereby authorize payment directly to any physician examining or treating me for surgical and/or medical benefits otherwise payable to me for their services but not to exceed the reasonable customary charge for these services.

3. MEDICARE/MEDICAID- I certify that the information given by me is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries any information needed for a Medicare/Medicaid claim. I hereby certify all insurance payment shall be assigned to the physician treating me.

4. I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office. This assignment will remain in effect until revoked by me in writing.

Financial Agreement

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.

2. Not all services are covered benefits under all contracts. All non-covered services, such as refractions, are the financial responsibility of the patient.

3. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance company within a reasonable amount of time, not to exceed 60 days.

4. If this account is assigned to an attorney for collection and/or suit or to a collection agency, the prevailing party shall be entitled to reasonable attorney's fees and all costs of collection.

I have read and understand the above Financial Policy

Signature____Date___________

Florida Eye Surgeons and Associates

2850 Wellness Ave
Orange City, Fl 32738
(386) 574-0700

Patient Authorization to Disclose Information

I give permission to Florida Eye Surgeons and Associates to release any of my personal health information, including any medical information in my chart to:

1.Name ________________________________ Phone Number__________________
Relationship to Patient ____________________________

2.Name ________________________________ Phone Number__________________
Relationship to Patient ____________________________

3.Name ________________________________ Phone Number__________________
Relationship to Patient ____________________________

4.Name ________________________________ Phone Number__________________
Relationship to Patient ____________________________

5.Name ________________________________ Phone Number__________________
Relationship to Patient ____________________________

6.Name ________________________________ Phone Number__________________
Relationship to Patient ____________________________

7.Name ________________________________ Phone Number__________________
Relationship to Patient ____________________________

Signature____ Date__________

Florida Eye Surgeons and Associates
2850 Wellness Ave Orange City, FL 32763
Phone (386) 574-0700 Fax (386) 574-1139

Records Release-HIPAA Complaint

Patient Name:____

Date of Birth:___________________________ Social Security #________________

I authorize and request the disclosure of all protected information of the above named individual's health information. I expressly request that the designated record custodian of all covered entities are under HIPAA identified above disclose full and complete protected medical information. I hereby authorize you to release my information including the diagnosis and records of any treatment or examination rendered to me during my treatment period, including visual fields, photos and operative reports.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

This protected health information is disclosure for the purpose of continued ocular medical care:

I understand the following:

- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to the authorization may be re-disclosed to other parties
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

Any facsimile, copy or photography of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

____ ____________
Signature of Patient or Legally Authorized Representative Date

____
Name and Relationship of Legally Authorized Representative to Patient

____ ____________
Witness Signature Date

Florida Eye Surgeons and Associates

No-Show Fee Policy

At Florida Eye Surgeons and Associates, we are committed to providing high-quality care to all our patients. We understand that life can be unpredictable, and sometimes appointments need to be canceled or rescheduled. However, when patients do not show up for their scheduled appointments without prior notice, it can significantly impact our ability to serve others. This is why we kindly request that you **notify us at least 48hr in advance** if you are unable to attend your appointment.

To help us achieve this, we need to ensure that we have an up-to-date phone number and email to send out reminders for appointments. This will help us serve you and our other patients more efficiently.

To minimize disruptions and maintain the best possible care for our patients, we have implemented a no-show fee policy:

- **No-Show Definition**: A "no-show" is defined as a patient who fails to arrive for a scheduled appointment without notifying the practice at least **48 hours** in advance.

- **Fee Amount**: A fee of **$50** will be charged for missed appointments and **$100** for missed office surgery/laser procedures. This fee will be billed directly to the patient.

- **Notification Requirement**: If you need to cancel or reschedule your appointment, please notify us at least **48 hours** in advance to avoid incurring this fee.

We appreciate your understanding and cooperation in this matter. Our goal is to provide timely and effective care to all our patients, and your support helps us achieve this.

Thank you for choosing Florida Eye Surgeons and Associates for your eye care needs.

Patient Signature:______________________________ Date:_______________