EAST FLORIDA EYE INSTITUTE

509 Riverside Drive, Suite 302 | Stuart, FL 34994
P: (772)287-9000 F: (772)287-0507

451 SW Bethany Drive, Suite 200 | PSL, FL 34952
P: (772)337-5332 F: (772)398-1376

Welcome to East Florida Eye Institute!

Please fill out the below forms in black ink and bring them with you on the day of your visit. These forms will provide information relevant to the Doctors and staff of East Florida Eye Institute. Please review and complete the attached Financial Policy, Medical History form and medication list. *Incomplete forms may prolong your visit time.* We will need a copy of your insurance cards and your photo ID. If your insurance requires a referral or an authorization, it is your responsibility to obtain it *PRIOR* to your appointment date.

Your initial patient examination will be very comprehensive. Please plan on your visit taking approximately two hours. Our goal is to be as thorough and detailed as possible during your visit in order to provide the best plan of care possible. *Your eyes are a precious part of your life, quality care and treatment is essential to their health.*

We suggest you bring sunglasses to wear following your examination - the dilation drops used during your visit with us may make your eyes temporarily sensitive to light. It will be up to you and your comfort level if you feel comfortable driving while your eyes are dilated. Also, if you currently wear prescription glasses, please bring them with you at the time of your visit.

East Florida Eye Institute prides itself on being a nationally recognized leader in Ophthalmic Diagnosis and Management. State-of-the-art diagnostic equipment allows us to provide university level services right here in our Treasure Coast community. We welcome you to the practice. The doctors and staff look forward to serving your eye care needs.

Where Your Vision is Our Passion,

The East Florida Eye Institute Team

FINANCIAL POLICY

The purpose of this document is to inform our patients about East Florida Eye Institute's Financial Policy. If you have any questions about the below policy, please give us a call. We are dedicated to providing the best possible care and services to you and regard your understanding of our financial policy as an element of your care and treatment.

1. For Regular Medicare Patients: We will file to Medicare for all covered services rendered. Medicare patients are responsible for their co-payments and any items deemed Non-Covered or Medically Unnecessary by Medicare. We will file to your secondary insurance once. After 30 days from the date Medicare has processed the claim, we will look to the patient to resolve any non-payment issues directly with their carrier. If still unresolved at 60 days, all secondary charges will become the responsibility of the patient. We do not file to tertiary carriers. If you require additional documentation to file for your own reimbursement, other than what your primary and secondary insurance carriers have provided to you, we will be happy to provide documentation for a $5.00 per date of service copying fee.
2. For patients who are a member of a health care organization that we have a participating agreement with such as Cigna, Aetna, United Health Care and others; we will bill insurance plans with which we have an agreement and will only require payment of the authorized co-payment, co-insurance amount, deductible or non-covered services at the time of service. After 30 days from the date of service, we will look to the patient to resolve any non-payment issues directly with their carrier. If still unresolved at 60 days, all charges will become the responsibility of the patient.
3. If you are a member of a health insurance plan that East Florida Eye Institute does not participate with or are a cash patient, payment will be due in full at the time of service. We will provide you with an itemized receipt that you can submit to your insurance company for your own reimbursement.
4. Whenever you are having a procedure/surgery, it is the patient's responsibility to check with their carrier to determine if the procedure requires authorization and if the facility participates with your insurance company. The patient will be responsible for all charges that are denied for no authorization and/or non-par facility.
5. **There will be a $45.00 Missed appointment fee for any patient that does not show or call to cancel their appointment. Patients that chronically no-show for their appointments may be released from the practice.** Please call the staff to cancel your appointment with a minimum of 2 business days prior to your appointment. This courtesy allows other patients who are waiting for an appointment to use this time slot.
6. Please call the office, as soon as possible, if you are going to be late. Most of our appointments are based on tests that need to be completed prior to seeing the Doctor. If arriving late, we may need to reschedule to a different day due to testing time not being available at the later time.
7. **Payment is due at the time service are rendered, (Copay and Deductible)**
8. East Florida Eye Institute accepts cash, personal checks, money orders, traveler's checks, MasterCard, Visa, Amex, and Discover.
9. Pursuant to Rule 64B8-10.003, Florida Administrative Code – Medical Records requested by the patient to be released to the patient will be subject to a fee: for the first 25 pages, the cost shall be $1.00 per page. For each page in excess of 25 pages, the cost shall be $0.25. There is no fee to send your medical records to another doctor's office.
10. A $55.00 fee will be assessed to the account for every check returned to East Florida Eye Institute for insufficient funds.
11. There will be a $30.00 administrative services charge for the completion of any form we are asked to complete by patient, insurance companies, etc. As an example, some of these forms would be: driver's license forms, housing forms, disability forms, life insurance forms, etc.
12. Credit Balances will remain on accounts toward payment for future services unless the patient requests a refund. Refunds will be issued to patients on a bi-monthly basis. Refunds will be issued in the form of a check to those accounts paid with cash, credit card or check (check must have cleared bank first).
13. East Florida Eye Institute reserves the right to turn any patient over to collections if it is deemed that the account has been in default of their payment obligations or compliance of this policy. It is understood and agreed that East Florida Eye Institute shall recover all costs and expenses incurred in the collection of any such delinquent amounts directly from the patient or guarantor.

By signing below, I am confirming I understand and agree to the policies above.

_____ _____

Today's Date **Patient's Signature (or Legal Guardian, if minor)**

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HIPPA COMPLIANT AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION FOR RELEASE OF MEDICAL RECORDS.

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name (Please Print): _____

D.O.B: _____

Organization Requesting Information: ***East Florida Eye Institute***

Organization Providing Information: _____

Description of each purpose of authorized use or disclosure:
_____ Request of Individual _____ Insurance Purposes _____ Continuity of Care _____ Legal Action _____
Other (must describe) _____

This authorization will expire on 12/31/2030 or on the occurrence of the following event:
_____

This authorization may be revoked at any time by notifying East Florida Eye Institute, PA in writing to the above address. If I revoke this authorization, I understand that it will not have any effect on actions East Florida Eye Institute, PA took before it received the revocation. Pursuant to Rule 64B8-10.003, Florida Administrative Code – Medical Records requested by the patient to be released to the patient will be subject to a fee: for the first 25 pages, the cost shall be $1.00 per page. For each page in excess of 25 pages, the cost shall be $0.25. *There is no fee to send your medical records to another physician office.*

By signing below I acknowledge that I have read and understand this authorization form.

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement/authorization.
In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

Please ***print*** your name _____ Please ***sign*** your name _____

Legal Representative _____ Description of Authority _____

Date: _____

PLEASE BE AWARE, WHEN SUMMONED FROM THE RECEPTION AREA, YOU WILL BE ADDRESSED AS MR. OR MS. *YOUR LAST NAME*.
PLEASE NOTIFY OFFICE STAFF IF YOU WISH TO BE CALLED BY SOMETHING ELSE.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes caretakers and anyone who can have access to this patient's records)

Name _____ Relationship _____

Name _____ Relationship _____

I AUTHORIZE CONTACT TO **CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION** VIA:
( ) Cell Phone Confirmation ( ) Text Message to my Cell Phone
( ) Home Phone Confirmation ( ) Email Confirmation
( ) Work Phone Confirmation ( ) **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** TO BE CONVEYED VIA:
( ) Cell Phone Confirmation ( ) Text Message to my Cell Phone
( ) Home Phone Confirmation ( ) Email Confirmation
( ) Work Phone Confirmation ( ) **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **NEW TREATMENTS OR CLINICAL RESEARCH** VIA:
( ) Phone Message
( ) Text Message ( ) **Any of the Above**
( ) Email ( ) **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY:
As privacy officer, I attempted to obtain the patient's (or representatives') signature on this Acknowledgement, but did not because:
It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because _____ Other (please describe) _____
Signature of Privacy Officer

PATIENT DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____ **Age:**_____ **Social Security Number:** _____

Local Address: _____ SUITE/APT#:_____

City: _____ State: _____ Zip: _____

Summer Address: _____ SUITE/APT#:_____

City: _____ State: _____ Zip: _____

Please list the months you typically reside at your summer house: _____ - _____

Home Telephone: (_____)_____ **Work Telephone: (_____)_____**

Cell Phone: (_____)_____ **Summer Phone: (_____)_____**

E-Mail Address:_____

Height: _____ **Weight:**_____

Sex: Male / Female **Marital Status:** Single Married Divorced Widowed Other

Employer's Name: _____ **Location:** _____

Spouse's Name: _____ **Employer:** _____

Emergency Contact: _____ **Relation:** _____ **Phone #:**_____

Who referred you to us?: _____ **Phone #:**_____

Insurance Information

Note: HMO patients are responsible for obtaining their own valid referrals for each visit

Primary Insurance: _____ **Contract#:**_____

Insured's Name: _____ **Insured's D.O.B.:** _____
Is your insurance through your spouse? YES / NO **Spouse's Date of Birth**_____

Secondary Insurance: _____ **Contract#:**_____

Insured's Name: _____ **Insured's D.O.B:** _____

Medical Treatment:

I authorize examination by Ronald Frenkel, M.D., and/or their staff. I authorize performance of whatever procedures the judgment of the above-named Drs. may deem necessary during the treatment. I also authorize the administration of any anesthetics, including eye drops, which the above-named staff deem advisable. I may request that any procedure not be performed.

Assignment of Benefits:

I authorize the release of my medical information needed to process insurance claims. I assign medical/surgical benefits to include major medical benefits including Medicare, government insurance, private insurance, and any other health care plans to East Florida Eye Institute except for the amount paid by me. This authorization will be for lifetime unless revoked in writing. A photocopy of this is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance unless I am a Medicare patient and therefore responsible for 20% of what Medicare allows. My responsibilities include non-covered Medicare/insurance procedures and/or charges.

_____ _____

Today's Date **Patient's Signature (or Legal Guardian, if minor)**

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☐ I understand that the Refraction Exam I am about to receive may not be covered by my insurance and therefore has an out-of-pocket expense of $75.00

I understand that I am responsible for the payment of this exam fee. The payment is due TODAY at checkout.

☐ I do not wish to have a refraction exam at this time.

_____ _____
Patient Name (Printed) Date

_____
Patient Signature

MEDICATION LIST

Name: _____ D.O.B: _____

DATE BEGAN	MEDICATION NAME	DOSAGE	FREQUENCY	DATE STOPPED	REASON FOR MEDICATION

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Today's Date: _____ D.O.B: _____

Name of Medical Doctor: _____ Physician's Phone #: _____

Physician's Address: _____ Date of Last Exam: _____

REVIEW OF SYSTEMS

If applicable, are you pregnant? ***YES** / **NO**

Do you currently have any problems in the following areas? If "YES" please provide additional information.

***Mark** **YES / NO**	**YES**	**NO**	**Explanation of Problem**
Constitutional			
Fever			
Weight Loss			
Feeling run down/tired			
Integument (Skin)			
Head			
Headaches			
Migraines			
Scalp Tenderness			
Ear/Nose/Mouth/Throat			
Pain when Chewing			
Sinus Congestion			
Runny Nose			
Post-Nasal Drip			
Chronic Cough			
Dry Throat/ Mouth			
Respiratory Breathing			
COPD (Chronic Obstructive Pulmonary Disease)			
Asthma			
Chronic Bronchitis			
Tuberculosis			
Cardiovascular			
Congestive Heart Failure			
High Blood Pressure			
Gastrointestinal (Stomach/ Intestines)			
Genitourinary (Genitals, Kidneys, Bladder)			
Bones, Joints, Muscles			
Arthritis			
Joint or Muscle Pain			
Neurological System			
Stroke			
Lymphatics			

*Mark YES / NO	YES	NO	*Explanation*
Swollen Lymph Nodes			
Hematopoietic (blood)			
Bleeding Tendency			
Anemia			
Blood Loss or Shock			
High Cholesterol			
Allergic/ Immunologic			
Seasonal Allergies			
Hay Fever Systems			
Lupus			
Sarcoidosis			
Endocrine			
Diabetes			
Thyroid Disease			
Psychiatric			
Other Medical Problems Not Listed			
Steroid Use			
Exercise with Body Upside Down			

YOUR OCULAR HISTORY

*Mark YES / NO	YES	NO	Explanation	*Mark YES / NO	YES	NO	Explanation
Glaucoma				Itching			
Macular Degeneration				Burning			
Cataracts				Excess Watering/Tearing			
Loss of Central Vision				Mucous Discharge			
Distorted Vision				Tired Eyes			
Double Vision				Eye Pain/ Soreness			
Fluctuating Vision				Glare/Light Sensitivity			
Blurred Vision				Difficulty in Dim Light			
Drooping Eyelid				Chronic Infection or eye or lid			
Prominent Eyes				Styes/ Chalazion			
Lazy/Crossed Eyes				Dryness			
Redness				Sandy/ Gritty Feeling			

YOUR FAMILY'S HISTORY

*Mark YES / NO	YES	NO	Relationship	*Mark YES / NO	YES	NO	Relationship
Blindness				Diabetes			
Lazy Eye				Heart Attacks			
Cataract				Stroke			
Glaucoma				Cancer			
Macular Degeneration				High Blood Pressure			
Retinal Detachment				Arthritis			

Other than my eyes, my medical doctor is *aware and taking care of* the above issues ____ **YES** ____ **NO**

PAST AND SOCIAL HISTORY

List any **major illnesses** and **injuries**:

_____

_____

List any **surgeries** you have had in the past:

_____

_____

List all **hospitalizations with explanations** of what they were for:

_____

_____

List your current **immunization** status:

_____

List any **medications** you are CURRENTLY taking:

_____

_____

Do you have any **allergies** to any medications? **____ YES ____ NO** IF **"YES",** PLEASE LIST:

_____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Other

Current Occupation: _____

What kind of work have you done in the past?: _____

Education Level:

____ High School Graduate ____College Graduate ____Post-Graduate Degree ____Other

Do you smoke Cigarettes? ___YES ___ NO If **"YES"**, how many packs per day?: _____

Do you use street drugs? ___ YES ___ NO If **"YES"**, please indicate what kind?: _____

Do you drink alcohol? ___ YES ___ NO If **"YES"**, how many glasses per day?: _____

Have you ever had any of the following sexually transmitted diseases?

___Syphilis ___Gonorrhea ___AIDS

Have you ever had sexual contact with a person who may have been exposed to or infected with the AIDS virus?

___YES ___ NO

(Below to be filled out by Technician or Doctor)

History reviewed on: _____

By: _____

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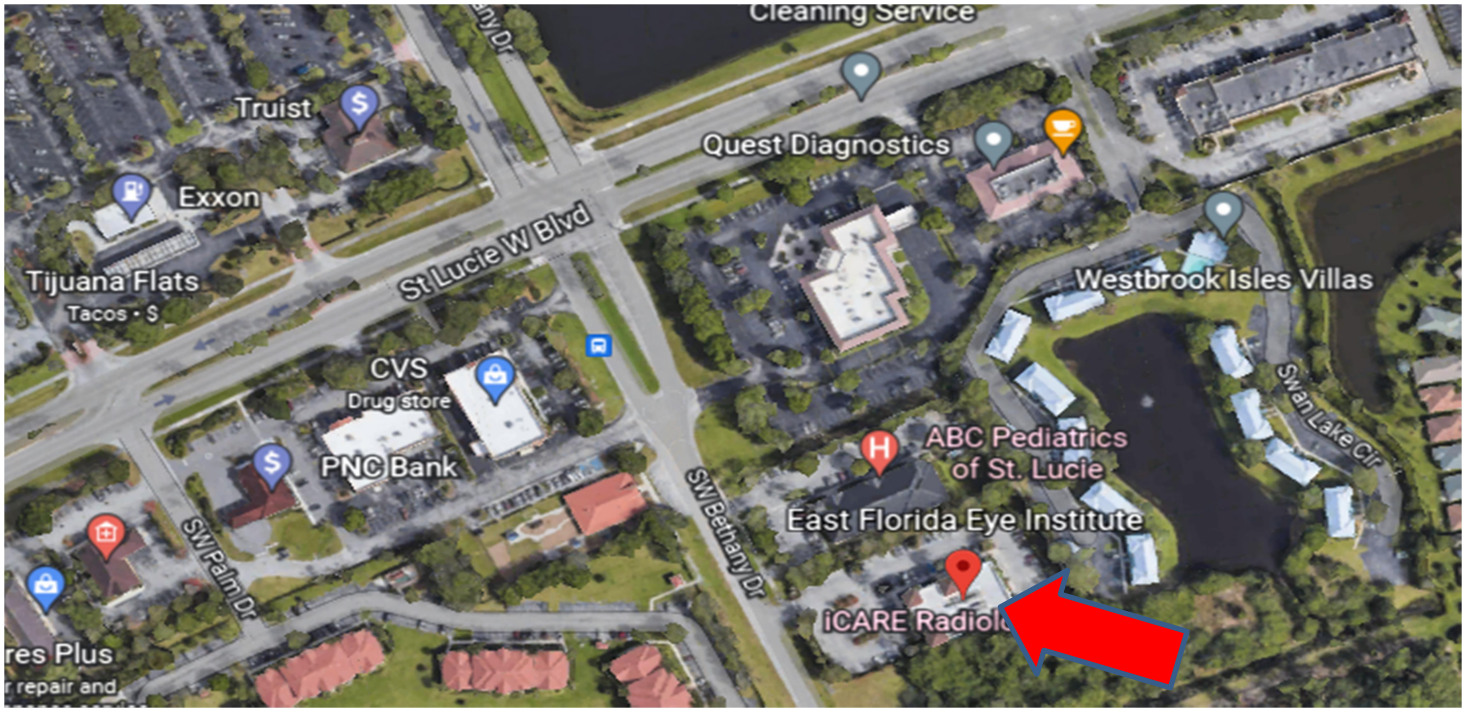

Directions:

From the North/South via I-95 or FL Turnpike:

- FL Turnpike to Exit 142 to Bayshore Blvd. Follow Bayshore Blvd to St Lucie W Blvd 3.3 miles. Turn left and go 0.9 miles to Bethany Dr. Turn Left on Bethany and go 0.2 miles to Bethany Professional Building on the left.
- I-95 to exit 121 St Lucie West Blvd, exit I-95 and go west 1.5 miles to SW Bethany Dr., Turn right onto Bethany Dr. and proceed 0.1 miles to Bethany Professional Building on the left.

From the North or South via US 1:

- Take US 1 – to Prima Vista Blvd and go west on Prima Vista Blvd 4.2 miles to Bethany Drive. Turn left on SW Bethany Dr. and go 0.2 miles to Bethany Professional Building on the left.

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