East Florida Eye Institute

451 SW Bethany Drive, Suite 200, Port St. Lucie, FL 34986
P: **772-337-5332** F: **772-398-1376**

# ***Welcome!***

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 two to three 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.

The Center for Eye Care & Surgery 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,*

East Florida Eye Institute**.**
*451 SW Bethany Drive, Suite 200 • Port St. Lucie, FL 34986 • Phone: (772) 337-5332*

# FINANCIAL POLICY

**The purpose of this document is to inform our patients about East Florida Eye Institute's Financial Policy. 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$ 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. East Florida Eye Institute does NOT charge a fee to patients for no shows or late cancellations, however, in the future that policy may change. In order to avoid such charges, it is important that you call a member of our scheduling 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. Patients who chronically no-show for their appointments may be released from the practice.
6. Patients will receive a statement itemizing the services rendered. Any unpaid patient balances that remain after 2 billing cycles may result in additional billing fees being added to your account. If you are unable to pay for the visit at the time of service, please call our office prior to the appointment to discuss a payment plan with the Administrator.
7. For all services rendered to minor patients, the adult accompanying the patient will be responsible for payment for that day's services.
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 or receive a dictated summary.
10. A $55.00 fee will be assessed to the account for every check returned to East Florida Eye Institute for insufficient funds. 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.
11. 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).
12. 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)**

# 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:** _____

**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 in writing to the above address. If I revoke this authorization, I understand that it will not have any effect on East Florida Eye Institute 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 or receive a dictated summary letter.*

**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.

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**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:**_____

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

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

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

**Does your spouse have insurance through their employer?** YES / NO

**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.:** _____

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

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

**Medical Treatment:**

I authorize examination by Ronald Frenkel, M.D., Joseph Faust, 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 The Center for Eye Care & Surgery 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)**

# MEDICATION LIST

**Name: _____ D.O.B: _____**

| DATE BEGAN | MEDICATION NAME | DOSAGE | FREQUENCY | DATE STOPPED | REASON FOR MEDICATION |
|---|---|---|---|---|---|
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# 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.

| | 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** | | | |
| 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

| | YES | NO | Explanation | | 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

| | YES | NO | Relationship | | 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)**

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**History reviewed on: _____**

**By: _____**

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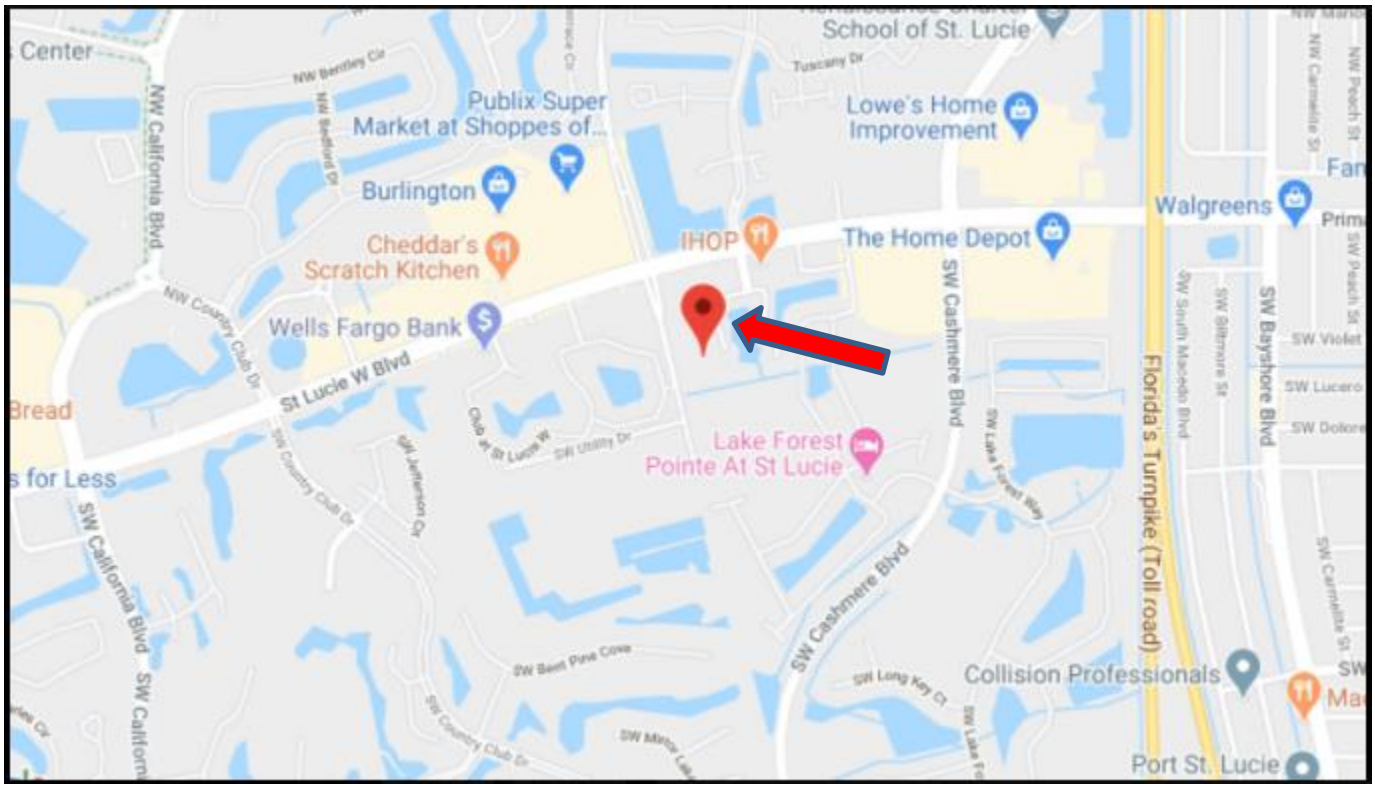
# East Florida Eye Institute

## Address:

## 451 SW Bethany Dr., Suite 202, Pt. St. Lucie, FL 34986

We are located in the Bethany Professional Building on the second floor in Suite 202. When you exit the elevator turn to your left and the office will be located on the left.




Directions:

From the North/South via 1-95 or FL Turnpike

- FL Turnpike to Exit 142 to Bayshore Blvd. Follow SE Bayshore Blvd to St. Lucie W. Blvd 3.3 miles. Turn left and go 0.9 miles to Bethany Dr.. Turn left on Bethany Dr. and go 0.2 miles to Bethany Professional Building the building will be on your left.
- 1-95 to Exit 121 St. Lucie West Blvd exit 1-95 and go west 1.5 miles to SW Bethany Dr.. Turn right onto Bethany Dr. and proceed 0.1 miles to Bethany Professional Building the building will be on your left.

From the North or South via US-1

- Take US – 1 to Prima Vista Blvd and go West on Prima Vista Boulevard 4.2 miles to Bethany Drive. Turn left on SW Bethany Dr and go 0.2 miles to Bethany Professional Building. The building will be on your left.