



WELCOME TO EYE SPECIALISTS!

We appreciate that you have chosen Eye Specialists for your complete eye care. We enclose our Patient Registration forms for you to complete at your convenience.

Please **bring** the completed forms with you to your appointment. Also, bring a list of medications and eye drops you are currently using, along with your eyeglasses or contact lenses. Please be sure that you have all your insurance cards with you when you come to the office.

First visits usually take at least one hour and dilation of your eyes will be required for the examination.

We are happy to bill Medicare and other insurance plans for you. Payment is expected at the time of your visit for any deductible, co-payments or non-covered services and may be made in cash or by check or credit card.

When you arrive, we hope you will take the time to meet Gail Pettit, our licensed Optician. She is superb at selecting the best frames and lenses for you – at the best price.

As you visit our website, please be sure to download a brochure for Patricia Miller, our licensed Aesthetician. Patricia focuses on medical grade eye and skin rejuvenation. We hope you'll take advantage of the complimentary coupon she offers – you'll look and feel terrific.

We look forward to meeting you! Please call us if you have any questions or concerns at (941) 957-4987.

Sincerely,

Julie
Director of Reception

NOTE:

PLEASE PROVIDE US WITH 24 HOURS NOTICE IF YOU MUST CANCEL YOUR APPOINTMENT. A \$25 CANCELLATION FEE IS ASSESSED IF YOU DO NOT PROVIDE US WITH THIS NOTICE.



PATIENT REGISTRATION FORM

Name: Dr. Mr. Mrs. Miss Ms. _____
First Middle Last

Birthdate _____ Social Security # _____ Male / Female

Local Address _____
Street City State Zip

Local Phone Home _____ Work _____ Cell _____

Email Address _____

Other Address _____
Street City State Zip

Other Phone Home _____ Work _____

Occupation _____

Are you: Single Married Widowed Divorced Spouse's Name _____

Primary Medical Doctor _____

Referred by Friend/Relative (Name) _____ Newspaper _____
TV _____ M.D./O.D. _____ Insurance _____ Other _____

In Case of Emergency Contact _____ Relationship _____
Name

Phone _____

When was your last eye exam? _____ How old are your current glasses? _____

Where were they purchased? _____ Do you want new lenses and/or frames? _____

Patient Signature Date

Parent or Guardian Signature Date

PATIENT MEDICAL HISTORY FORM

Patient Name _____ Date _____

▪ **GENERAL HISTORY**

Please mark if you have or have had the following:

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Sugar diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Immune deficiency disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: _____ |

List any medicines you are allergic to: _____

Do you have any food or environmental allergies: _____

Please list any medications you take: _____

Please circle if there is use of cigarettes, alcohol or substance abuse; how much? _____

▪ **EYE CARE HISTORY**

Please mark if you know that you have any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Double Vision /prism in your glasses | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Contact Lens wearer: (circle) soft / hard | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Dry Eye | |

Please list if you have had any eye surgeries and when: _____

Please list any eye drops that you use: _____

Do you have any other eye problems we should know about: _____

FOR EYE SPECIALISTS USE ONLY: _____ _____ _____ M.D. _____ O.D.
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LIFETIME MEDICARE B / INSURANCE SIGNATURE AUTHORIZATION

I understand that my doctor may provide services and / or devices that he/she deems necessary for my care / treatment which my insurance may not cover. My doctor’s decision is a professional one made in my best interest and is not dictated by any governmental agency. To this end, I hereby authorize and accept full responsibility for the charges associated with such services and / or devices.

I authorize Eye Specialists to use this signature as a release to the Social Security Administration, its intermediaries, carriers, or the billing agent of this physician or supplier, any information needed for this or a related Medicare / Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefit either to myself or the party who accepted assignment. I may revoke this authorization by notifying Eye Specialists in writing.

I UNDERSTAND THE ABOVE PAYMENT PLAN AND AGREE TO MEET MY OBLIGATION FOR EXPENSES INCURRED.

MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized Medigap benefits be made on my behalf to Eye Specialists for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to Eye Specialists any information needed to determine these benefits for related services.

Patient Signature

Date

Parent or Guardian Signature

Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

When signing this Privacy Notice, you are authorizing the following:

▪ **TREATMENT**

Eye Specialists and any physician examining and/or treating you to release to any subsequent treating physician any medical information and/or records concerning diagnosis and treatment.

▪ **PAYMENT**

Medical records and/or information will be shared with third party payers, such as insurance companies or the Social Security Administration or its intermediaries or carriers when requested for use in connection with determining a claim for payment.

▪ **APPOINTMENT REMINDERS**

We may use or disclose your health information to provide you with appointment reminders, including but not limited to voicemail messages, postcards or letters.

▪ **HEALTHCARE OPERATIONS**

Medical record information may be used in performing the following activities:

- Quality improvement
- Reviewing competence or qualifications of healthcare professionals
- Underwriting, premium rating and other insurance activities
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs
- Business planning and development

General administrative duties including, but not limited to:

- Compliance management
- Customer service
- Resolution of internal grievances

▪ **YOUR RIGHTS**

- You have the right to request restrictions regarding usage/disclosure of information
- You have the right to receive confidential communications
- You have the right to inspect and copy protected health information
- You have the right to amend incorrect or incomplete protected health information
- You have the right to receive an accounting of disclosures
- You have the right to receive a paper copy of this Notice

Additional HIPAA compliance notification information is available. Please ask to speak to the Privacy Officer if you have any questions.

Patient Signature _____
Date

Parent or Guardian Signature _____
Date