PATIENT DEMOGRAPHICS

WHO IS COMPLETING THIS FORM (Please Check): **PATIENT____** **PARENT _____** **GUARDIAN_____** **RESPONSIBLE PARTY_______**

TODAY'S DATE: ____________________ D.O.B. ____/_____/_______ SOCIAL SECURITY NUMBER: ___________________________________

FIRST NAME ______________________________MIDDLE NAME ___________________LAST NAME ______________________________________

ADDRESS ____CITY STATE __________________________ ZIP CODE _______________________

SEX_____ MARITAL STATUS _________ RACE__________ LANGUAGE ___________ ETHNIC GROUP____________

EMAIL ADDRESS: ____MOBILE NUMBER: (______) _________ - ______________

OK TO EMAIL? ☐YES ☐NO ☐ PREFERRED OK TO TEXT? ☐YES ☐NO ☐ PREFERRED

HOME NUMBER: (______) _________ - ______________ WORK NUMBER: (______) _________ - ______________

OK TO LEAVE DETAILED VOICEMAIL? ☐YES ☐NO

PRIMARY PHYSICIAN:____REFERRING DOCTOR: ____

PHARMACY: ____ PHARMACY ADDRESS: ____

EMPLOYMENT: Y N EMPLOYER: _____________________________________EMPLOYER ADDRESS: _______________________________

EMERGENCY CONTACT: ____PHONE NUMBER (______) _________ - ___________

RELATIONSHIP TO PATIENT: ____

NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting it from the personnel at check-in.

Your pharmacy and healthcare information may be accessed and shared with your approved healthcare providers, via a secure health information exchange platform.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By initialing below, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations as described in our Notice. You consent to the use of your answering machine/voicemail by this office for brief messages regarding your medical care. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initials __________ Date ____/______/______
MM DD YYYY

RELEASE OF PERSONAL HEALTH INFORMATION ISSUES REGARDING MY MEDICAL CARE MAY BE DISCUSSED WITH THE FOLLOWING:

NAME:________________________________RELATIONSHIP: _____________ HOME PHONE: _______________CELLPHONE: ________________

NAME:________________________________RELATIONSHIP: _____________ HOME PHONE: _______________CELLPHONE: ________________

NAME:________________________________RELATIONSHIP: _____________ HOME PHONE: _______________CELL PHONE: ________________

Initials __________ Date ____/______/______
MM DD YYYY

MEDICARE/MEDIGAP

Lifetime Authorization MEDICARE Certification for Payment.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician or organization to submit a claim to Medicare for payment. I request that this authorization also apply to all other insurance.

I request that payment of authorized MEDIGAP benefits be made on my behalf to Florida Eye Associates for any services furnished to me by Florida Eye Associates. I authorize any holder of medical information about me to release any information needed to determine these benefits to Florida Eye Associates.

SIGNATURE: ____ DATE: _____/_______/______
MM DD YYYY

FINANCIAL AGREEMENT

The following is our Financial Policy, which will help you understand our billing and payment procedures.

- **ALL INSURANCE CARDS and a PHOTO ID WILL BE REQUIRED FOR COPYING OR SCANNING.**
  Patients are responsible for Self-Pay Balances, Deductible Balances, Co-Insurance, Co-Payments, and Non-Covered Amounts.
- All payments are due at the time services are rendered.
  We accept Cash, Checks, Money Orders, Debit Cards, and All Major Credit Cards. There will be a fee for all returned checks.
  Most insurance companies DO NOT cover the refraction for glasses prescriptions.
  Patient Out of Pocket Expense (if applicable) as follows below:
  Refraction Fee - $50.00
  No Show Policy: At least a 24-hour notice is required to cancel or reschedule your appointment.
  There is a $25.00 No Show Fee.
- Any changes or updates of insurance, address, phone number or emergency contact information should be reported immediately.
  We will submit an insurance claim on your behalf and whatever the insurance(s) does not pay; the balance is then your responsibility to pay within 30 days of the first billing statement.
  You are responsible for knowing your insurance benefits.
- I request that payment of authorized Medicare/or any third party benefits be made to FLORIDA EYE ASSOCIATES on my behalf for any services rendered to me. I authorize any holder of medical information about me to be released to the Center for Medicare/Medicaid Services and its agents or any third party any information to determine these benefits or the benefits payable for related service.
  If my account is over paid and a credit is smaller than $5.00, a refund check will not be issued, due to handling expense. The credit will remain in my account for future visits.
  In the course of your care, you may be referred for surgery to Ophthalmology Center of Brevard, LP which does business as ASC of Brevard. It meets the definition of physician owned ambulatory surgery center. It is owned in part by some of the FEA physicians. Ambulatory Surgery Center Support Services, Inc. provides anesthesia and medical clearance to surgery patients. It is also owned by some of the FEA physicians. You may ask your physician or staff about alternative facilities and providers. By signing below you acknowledge this relationship.

INFORMATION REGARDING DILATING EYE DROPS

Your exam may require dilation. Dilating drops are used to dilate the pupils to properly assess and diagnose certain conditions. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I authorize my physician or his/her designated assistants to administer dilating eye drops.

I certify that the information I provided is true and correct. I hereby authorize my insurance benefits to be paid directly to Florida Eye Associates and physician and I am financially responsible for non-covered services, deductible, coinsurances and copays. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge and agree that I have access and can receive a copy of the FEA Privacy Policies.

I agree to all the above related policies of Florida Eye Associates.

____ ___________/__________/______________

SIGNATURE Patient/ Guardian/Responsible Party **Date** : MM DD YYYY