FLORIDA EYE
Microsurgical Institute, Inc.

1717 Woolbright Road * Boynton Beach, FL 33426
(561) 737-5500 * FAX (561) 737-7055 * fleyedocs.com

WELCOME TO OUR OFFICE

Date:

Last Name:	First Name:	Middle Initial:	Nickname:
Address:			
City:	State:	Zip Code:	Email:
Home Phone:	Cell Phone:	Sex: (circle) M F	Date of Birth:
Emergency Contact:	Name:	Relation:	Phone:
HIPPA Approved Contacts - Person(s) you would like to Authorize to Receive/Discuss Medical/Financial Information:	Name:	Relation:	Phone:
	Name:	Relation:	Phone:
What brings you in to see us today?			
Referred by: ❒ Physician ❒ Family Member ❒ Insurance ❒ Internet ❒ Friend/Co-worker ❒ Newspaper/Magazine			

OTHER PROVIDERS: *(First & Last Name)*

Referring Doctor:	Phone:
Primary Care Doctor:	Phone:
Other Eye Doctor:	Phone:
Pharmacy:	Phone:

CONSENT FOR TREATMENT

I hereby give my permission and consent for Florida Eye Microsurgical Institute and staff to treat me using generally accepted standards of medical care, which may include dilation. I am aware that the dilation can and will affect my vision. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above named individual and am legally authorized to initiate and consent for treatment on their behalf. I am aware that medicine and surgery are not exact sciences and no guarantee for successful outcome has been made or implied to me. I understand that treatment for my condition(s) will be based upon the information that I provide. I accept full responsibility should I provide inaccurate, incomplete or misleading information. I certify that the identifying information, address, and telephone numbers I have provided is correct and agree to inform Florida Eye Microsurgical Institute and staff if such information changes or becomes outdated.

X_____ _____ _____

Signature of Patient or Legal Guardian | Print Name | Date

PAST / CURRENT MEDICAL HISTORY: *Please check if you have or had any of the following conditions*

	None			Depression			Low Thyroid
	Anxiety			Diabetes	LBS: A1C:		Leukemia
	Arthritis	❒ Rheumatoid ❒ Osteo		Kidney Disease			Liver Disease
	Asthma			Acid Reflux - GERD			Lung Cancer
	Atrial Fibrillation (Irregular Heartbeat)			Hearing Loss			Lymphoma
	Enlarged Prostate / BPH			Hepatitis			Prostate Cancer
	Breast Cancer			High Blood Pressure			Radiation Treatment
	Colon Cancer			HIV / AIDS			Seizures
	COPD / Emphysema			High Cholesterol			Stroke
	Coronary Artery Disease / Heart Disease / Heart Attack			High Thyroid			Other:

SURGICAL HISTORY: *(unrelated to the eye)* ❒ ***NONE***

Have you had any surgery? **Y** **N** (If yes, please list below)	Complication with anesthesia? **Y** **N**
Type of Surgery & Date:	

MEDICATIONS: *(Name, Dosage and Frequency)* ❒ ***NONE***

ALLERGIES: ❒ ***NONE*** ❒ ***LATEX ALLERGY***

OCULAR HISTORY:

❒ ***NONE***

	Eye Injury or Trauma	*(Circle)* **R** **L**			Macular Degeneration	*(Circle)* **R** **L**	
	Cataract	*(Circle)* **R** **L**			Narrow Angles	*(Circle)* **R** **L**	
	Contact Lenses	*(Circle)* **R** **L**			Ocular Hypertension	*(Circle)* **R** **L**	
	Corneal Dystrophy	*(Circle)* **R** **L**			Retinal Disease / Tears / Detachment	*(Circle)* **R** **L**	
	Diabetic Retinopathy	*(Circle)* **R** **L**			Amblyopia (Lazy Eye)	*(Circle)* **R** **L**	
	Dry Eyes	*(Circle)* **R** **L**			Strabismus (Eye Muscle Misalignment)	*(Circle)* **R** **L**	
	Glasses				Floaters	*(Circle)* **R** **L**	
	Glaucoma	*(Circle)* **R** **L**			Other:		

OCULAR SURGERY:

❒ ***NONE***

	Blepharoplasty - Eyelid Surgery	*(Circle)* **R** **L**			LPI (Laser for Narrow Angles)	*(Circle)* **R** **L**	
	Cataract Surgery	*(Circle)* **R** **L**			LTP (SLT or ALT - Laser for Glaucoma)	*(Circle)* **R** **L**	
	Corneal Transplant	*(Circle)* **R** **L**			Ptosis Repair	*(Circle)* **R** **L**	
	Eye Muscle Surgery	*(Circle)* **R** **L**			Retinal Laser - Diabetes	*(Circle)* **R** **L**	
	Intravitreal Injection Name of Drug: Date of injection:	*(Circle)* **R** **L**			Retinal Laser - Tear or Detachment	*(Circle)* **R** **L**	
					YAG Capsulotomy (Laser after Cataract Surgery)	*(Circle)* **R** **L**	
	LASIK (Refractive Surgery)	*(Circle)* **R** **L**			Other:		

FAMILY HISTORY: Please indicate whether this pertains to: mother (**M**), father (**F**), siblings (**S**) and/or grandparents (**G**)

	Blindness	M	F	S	G		Heart Disease	M	F	S	G
	Cancer	M	F	S	G		High Blood Pressure	M	F	S	G
	CVA (Stroke)	M	F	S	G		Macular Degeneration	M	F	S	G
	Diabetes	M	F	S	G		Retinal Disease / Detachment	M	F	S	G
	Glaucoma	M	F	S	G		Strabismus (Crossed Eyes)	M	F	S	G

SOCIAL HISTORY:

Smoking Status:		Never Smoked	Driving Status:		Drives daytime
		Current everyday smoker			Drives nighttime
		Current occasional smoker			Drives daytime and nighttime
		Former smoker / Total Years Smoking:			Do not drive
Alcohol Use:		None	Occupation:		
		1-2 drinks per day	Employer / School:		
		3 or more drinks per day	Marital Status: S M D W Separated		

RACE / ETHNICITY: *This information is a government requirement for practices using electronic health records.*

RACE:		ETHNICITY:			
	White		Hispanic or Latino		
	American Indian / Alaska Native		Non Hispanic or Latino		
	Asian		Decline to answer		
	Black or African American	**PREFERRED LANGUAGE:**			
	Native Hawaiian or other Pacific Islander		English		Creole
	Other:		Spanish		Portuguese
	Decline to answer		Other:		

CONSENT FOR EMAIL COMMUNICATION

Communications over the internet and /or using the email system are not encrypted and are inherently unsecured. There is no assurance of confidentiality of information when communicated this way. Florida Eye Microsurgical Institute will not communicate health information that is specially protected under state and federal law (for example HIV / AIDS information, substance abuse treatment, mental health information) via email even if we agree to communicate with you via email. Email communications may be forwarded to other providers, including providers not associated with Florida Eye Microsurgical Institute for purposes of providing treatment to me or my child. I agree to hold Florida Eye Microsurgical Institute and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

❒ I understand the risks of unencrypted email and do hereby give permission to Florida Eye Microsurgical Institute to send me personal health information via unencrypted email.

E-mail address: _____

❒ I do not wish to receive personal health information via email.

X_____ _____

Signature of Patient or Legal Guardian — Date

FINANCIAL POLICY

The following information is regarding your account at Florida Eye Microsurgical Institute. With the ever changing healthcare industry, we want to make sure every patient is aware of our insurance and billing policies. If you have questions or concerns about any of the information contained below, please discuss them with our staff. We look forward to providing you and your family with excellent service for all of your eye care needs.

Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, noncovered services, etc. For your convenience, we accept all major credit cards as well as debit cards, cash, and checks. Payment on all accounts billed is expected within 30 days. If payment is not received within 30 days, a monthly administrative fee may be added to your account to partially defray postage and other office costs generated by multiple billings. All outstanding balances must be paid in full before scheduling surgery. Any account credit balance less than $5.00 will not be issued a refund check.

Insurance Plans Where We Are a Participating Provider: Our office strives to diligently stay abreast of the ever changing rules and regulations which we are contractually obligated to follow. There are over a thousand different insurance plans in the South Florida area and it is difficult to always know what is or is not covered by any particular plan. Our office therefore highly recommends that each of our patients find out exactly what their individual insurance covers in advance so that there will be no confusion on the day of your visit. Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. It is your responsibility to know your insurance and to provide our office with the most current and accurate information. All co-pays and deductibles are due prior to treatment. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. We can not be held liable for misquoted benefits, eligibility or estimates. If your insurance company has not paid your account in full within 45 days, you will be responsible for payment within 30 days upon receipt of the bill. Please be aware that some of the services provided may be noncovered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You will be responsible for payment in full, prior to that treatment.

Co-pays: Most insurances now require a co-payment to see a specialist. Please check with your insurance company prior to your visit to verify the amount of your co-payment. Some insurances also require an additional co-payment for diagnostic procedures. This may be a different amount from your visit co-payment. Co-payments are collected when you check-in. There may be an additional service fee if you prefer to have us bill you for your co-payment.

Referrals: If your insurance requires a referral, you are responsible for contacting your primary care physician/ pediatrician to obtain said referral prior to treatment. It is also your responsibility to verify that valid referrals are on file for any follow up care. In the absence of a referral, you will be responsible for payment in full.

Patients Without Insurance Coverage: Self-pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. If you come for an office visit and we do not participate with your insurance company, we assume you decided to see us as an out-of-network provider. Our office does not accept insurance liens, workers compensation, or attorney liens. Payment is the patient's responsibility and due in full at the time of service. Please note that our office does NOT accept vision insurance.

Medigap: I request that authorized Medigap benefits (if applicable) be made on my behalf to Florida Eye Microsurgical Institute. I authorize Florida Eye Microsurgical Institute to contact the State Insurance Commissioner on my behalf in the state my insurance company domiciles to collect their payment.

Collections: Should it become necessary to turn the account over to collections you will be charge a 30% administrative fee as well as all collection costs which include, but are not limited to, fees, court costs, attorney fees and any other fees or cost for the collection of the account balance. You and your immediate family members may be dismissed from the practice if you fail to meet your financial responsibilities and/or we must use a collection agency to bring your account up-to-date. If you wish to return to the practice, your account must be paid in full as well as all charges, including those incurred to collect the amount owed.

Returned Checks: If the bank returns your check unpaid for any reason, i.e. insufficient funds or closed account, you will be charged $35. Payment must be made prior to your return to the office and we may not accept any more personal checks.

Divorce, Dependent and Child Custody Cases: The presenting guardian accompanying the minor who receives care at Florida Eye Microsurgical Institute is responsible for payment of copays, co-insurance and/or deductibles at the time of service, regardless of the terms of any divorce decree or custody arrangement.

Missed Appointments: Appointment reminders are a courtesy. Failure to show up for, or cancellation of an appointment with less than 24 hour notice, may result in a "no-show" fee assessed to your account. This fee must be paid before a new appointment is scheduled. Excessive missed appointments will result in discharge from the practice.

Administrative Charges: Additional administrative charges may apply for items such as the completion of medical forms and physician letters. This service will not be billed to your account or your insurance company. Payment is due before the form(s) will be released.

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Eye Microsurgical Institute for any charges not covered by healthcare benefits. It is my responsibility to notify Florida Eye Microsurgical Institute of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Florida Eye Microsurgical Institute and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

My signature below indicates that I have read, understand and agree to the Financial Policy outlined above. I understand that even if Florida Eye Microsurgical Institute is contracted with my health care plan, I am financially responsible for payment of both covered and non-covered services performed during the course of my treatment. I understand that by signing this form that I am accepting financial responsibility for all payment for medical services and/or supplies received and I hereby guarantee timely payment in full of any such charges.

X _____

Patient/Legal Guardian Signature

_____ _____

Patient/Legal Guardian - Print Name Date

NON-COVERED SERVICES: Most medical insurance plans, including Medicare, do NOT cover routine eye exams or routine refractions. A "routine eye exam" takes place when you come for an eye examination without any medical eye problem, and there are no symptoms except for visual changes that can be corrected by eyeglasses. A refraction is the part of the exam by which we determine your best corrected vision and whether you can be helped in any way by a new glasses prescription. It is an **ESSENTIAL** part of an eye examination. At times, it is medically necessary to perform a refraction to help determine the cause of visual changes. This is particularly helpful when patients have multiple issues affecting their eyes such as cataract, glaucoma and macular degeneration. Despite being medically necessary, refractions are considered vision care and is NOT a service covered by Medicare or most medical insurances. Since it is not a covered service, we are REQUIRED to charge separately for a refraction. The Office of Inspector General has deemed that not charging a patient for a service is an "inducement" to the patient, and therefore illegal. The fee for refractions is $50 and is due on the day of your exam and is in addition to any co-payment or deductible for the medical portion of your exam. If there is a problem with your glasses prescription you have 45 days from the original exam to get rechecked, after the 45 days you will be charged an office visit.

By signing, I understand that the refraction may not be a covered service under my health insurance plan. If I want a glasses prescription update/renewal, I agree to pay any fees related to this non-covered service along with any other fees required by my insurance plans (co-payments/deductibles).

X _____

Patient/Legal Guardian Signature

_____ _____

Patient/Legal Guardian - Print Name Date

ASSIGNMENT OF BENEFITS & LIFETIME AUTHORIZATION

I request that payment of authorized and eligible insurance benefits be made on my behalf, for all subsequent and continuing treatment, services, and/or supplies provided to me during all courses of treatment and care. I assign my insurance benefits payable to Florida Eye Microsurgical Institute and authorize Florida Eye Microsurgical Institute to submit a claim to my insurance carrier, including Medicare, for payment. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with Florida Eye Microsurgical Institute. I authorize release to my insurance carrier and/or referring physician any information needed to determine these benefits or the benefits payable for related services, including diagnosis and records of any treatment or examination rendered to me to process this claim. I permit a copy of this authorization to be used in place of the original. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

X_____ _____

Patient/Legal Guardian Signature — Date

(Signature on file for payment authorization)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

By signing this I am acknowledging that I have read and understand this office's Notice of Privacy Practices. A copy of Florida Eye Microsurgical Institute's Notice of Privacy Practices has been provided to me. I consent to the use or disclosure of my protected health information by Florida Eye Microsurgical Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Eye Microsurgical Institute.

I give permission for Florida Eye Microsurgical Institute to discuss/release protected health information with my HIPPA approved contacts. Changes may be made to the list at any time in person or in a written request.

X_____ _____

Patient/Legal Guardian Signature — Date

_____

Patient/Legal Guardian Name (Print Name)

MEDICARE BENEFICIARIES

Florida Eye Microsurgical Institute accepts the charge determination of the Medicare carrier as the full charge, and you are responsible only for the deductible, coinsurance and non-covered services, which is based upon the charge determination of the Medicare Carrier. After you are seen by the doctor, Florida Eye Microsurgical Institute will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare forms submitted for you by our office.

X_____ _____

Patient/Legal Guardian Signature — Date

(Signature on file for payment authorization)