SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

CORONAVIRUS QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Patient Temperature Reading: _____
Temperatures of 100 or higher, patients will be asked to seek primary care medical attention

1). **Have you traveled to any of these locations in the last 14 days?**

☐ **Yes** ☐ **No**

Check all that apply:

☐ China ☐ South Korea ☐ Italy ☐ Japan

☐ New York/New Jersey ☐ Other _____

2). **Have you been on a Cruise since Feb 2020?** ☐ **Yes** ☐ **No**

If Yes, Which Cruise Line/Ship? _____
Where did it go? _____

3). **Have you come into close contact (within 6 ft) with anyone with a laboratory confirmed COVID-19 in the last 14 days?** ☐ **Yes** ☐ **No**

4). **Have you had any of these symptoms in the last 14 days?**

☐ Fever greater than 100 ☐ Difficulty breathing/Shortness of Breath

☐ Cough ☐ Chills ☐ Muscle Pain ☐ Headache

☐ Sore Throat ☐ Loss of Taste

If you answered No to question 1 and/or 2, but Yes to 3 & 4, please let our office know and call your primary care provider.

Please adhere to the social distancing and do not get close to anyone with a compromised immune system or other underlying condition.

SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

This Acknowledgement of risks regarding COVID-19 (this "***Acknowledgement***") applies to all physicians, nurses, medical assistants, employees, directly or indirectly, managed by, or otherwise affiliated with, South Florida Eye Institute Inc (each, a "***Provider***"). Both the patient and the patient's accompanying guests, as applicable, are parties to this Agreement and are referred to as "I". This Acknowledgement lays out the legal terms and conditions that apply to all treatment(s), procedure(s) or service(s) (referred to in this document as "***Services***") I will receive from any Provider.

Acknowledgement Regarding Precautions During Coronavirus (COVID-19)

Recommendations for treatments and services laid out by professional organizations and regional and local Departments of Health are aimed at safeguarding the health and safety of patients and providers. The Provider has determined it is appropriate to deliver care related to ophthalmologic care and will utilize available means to manage the risk of disease transmission between persons.

I understand that information regarding COVID-19 and the medical communities' understanding of this disease is rapidly evolving and that risk(s) may come to light of which we are presently not aware. I acknowledge that guidance from the Center for Disease Control ("***CDC***") and the American Academy of Ophthalmology ("**AAO**") may change at any time based on new information regarding COVD-19.

I understand, that I might have been or may become exposed to COVID-19 prior to or while receiving Services by Provider. I understand that despite the measures that Provider is taking I may become exposed to COVID-19 during my/our treatment with Provider or on account of such treatment. I understand that, at the present moment, the availability of testing is limited and the Provider has limited ability to refer patients for COVID-19 testing. I understand that I may have the option to be tested for COVID 19 by following local, state, and national testing guidelines. If I choose to be tested, I understand and agree that I must discuss these results with the Provider prior to any treatment. I understand that COVID-19 tests are not 100% accurate. I understand that PCR tests have varying levels of false negatives, and positive antibody tests may not result in immunity from COVID. If I demonstrate symptoms, my provider may cancel my appointment even if I have been tested.

I further understand that should I be directly exposed to COVID-19, be diagnosed with COVID-19, or become symptomatic with any illness which could possibly be COVID-19 (even in the absence of a positive COVID-19 test), Provider may elect to postpone, reschedule, or terminate or modify the manner in which Provider renders Services, depending on the clinical circumstances. I understand that it is my obligation to inform the clinic if I am not feeling well, have a fever or any other symptoms associated with COVID-19, or if I have reason to believe that I have been exposed to COVID-19. I understand that should any of the forgoing apply to me, the clinic may elect to reschedule my appointment, visit, or any Services a later date.

I agree that I will contact the Provider to reschedule my appointment if I experience any of the following symptoms: cough, fever, shortness of breath. I also agree that I will inform the

Provider immediately if I have been in close contact with an individual known to have COVID-19, or I have had exposure to an individual with the previously listed symptoms.

I further understand that there may come a point where the Provider may not be able to support continued Services (e.g, illness of doctors or laboratory staff which would prevent Provider from rendering services or clinic being required to pause operations) and if this occurs the Services may be postponed or cancelled.

I understand that prior to and during my treatment that I should continue to practice preventive measures, i.e. physical distancing, handwashing, use of personal protective equipment (PPE- i.e. masks and gloves, hand sanitizer) and all current CDC recommendations to reduce the risks of infection.

I understand that the Provider may be under a Stay at Home or Shelter in Place Ordinance that may restrict my ability to travel in my local community. I agree that I will familiarize myself with all such applicable orders. I acknowledge that I am leaving my home for medical treatment and that I should and will take precautions to remain isolated during my travel to not increase the chance of infection to myself or others. I agree to wear a mask, either fabric or medical, for the duration of my commute to the Provider's office, and to sanitize my hands upon arriving at the Provider.

I understand that the Provider is taking extra precautions to limit the chance of spreading COVID-19, including prescreening for fever and social distancing practices during my treatment. I agree to comply with these efforts, and I understand that my failure to do so may result in the cancellation of my appointment. I understand that if during my prescreening at the clinic I am found to have a fever, I will be asked to reschedule my appointment at such a time when the Provider believe it is appropriate. I acknowledge that despite these efforts it is still possible that I could become infected with COVID-19 during my travel to and from the clinic or while at the clinic. I agree to hold the clinic, physicians, and staff harmless in the event that I am infected.

The risks, potential benefits of and alternatives to this treatment or procedure have been explained to me by the Provider. I understand the explanation that has been given to me.

I have had the opportunity to ask any questions I may have about the Services and this Acknowledgement and those questions have been answered to my satisfaction.

Patient

Print Name: _____

Signature: _____ Date: _____

SOUTH FLORIDA EYE INSTITUTE

PATIENT INFORMATION – PLEASE PRINT

Today's Date: _____ Primary Language: _____

Date of Birth: _____ Sex (M/F): _____ Social Security: _____

Last Name: _____ First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Religion: _____ Race: _____ Ethnicity: _____ Occupation: _____

Employer: _____ Work Address: _____

Marital Status (circle one that applies) Single Married Divorced Widowed

Primary Care Physician (PCP): _____ PCP Phone: _____

Referring Physician: _____ Referring Phone: _____

How did you hear about South Florida Eye Institute? _____

Generally, describe the reason for your visit: _____

For Insurance purposes, please list the responsible party (subscriber) if different from patient:

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Relationship to Patient: _____ Responsible Party's DOB (month/day/year): _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary: _____ ID#: _____ Group#: _____

Secondary: _____ ID#: _____ Group#: _____

Insurance Authorization – Required

I authorize and request that my insurance company directly pays to the Physician's and providers of South Florida Eye Institute the amount due to me in my pending claims for medical and/or surgical services.

Patient/Legal Guardian Signature: _____ Date: _____

SOUTH FLORIDA EYE INSTITUTE

Authorization to Release Medical Information

I authorize South Florida Eye Institute to share my information with those listed below.

Name: _____ Phone: _____ Relationship: _____.

Name: _____ Phone: _____ Relationship: _____.

Patient/Legal Guardian Signature: _____ Date: __/__/__.

Notice of Privacy of Practices – Required

I acknowledge, I have received, read and understand the Notice of Privacy Practices.

I hereby authorize the physicians of South Florida Eye Institute to release to any and all parties noted on the Notice of Privacy Practices, any information, including diagnosis and the records of any treatment, examination or surgery rendered to me during the period of such medical care and/or surgical care.

Patient/Legal Guardian Signature: _____ Date: __/__/__.

Patient Affirmation – Required

By signing below, I am confirming that all the information on both patient information sheets is correct, unless noted. If any of my insurance is not correct or current and in the event that South Florida Eye Institute cannot be reimbursed due to uncovered charges, I acknowledge that I am responsible for payment in full.

Patient/Legal Guardian Signature: _____ Date: __/__/__.

SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

MEDICATION INFORMATION

Last Name:_____ First Name:_____M.I___ Date:_____.

Prescribed Medication Information: Please list all prescribed medication that you are currently taking.

Medication name	Strength	Medication Usage

Medication Allergies: List all medications that you are allergic to. **For example:** Penicillin, Sulfa, Iodine, Codeine, etc.

Over the Counter Vitamins, Herbal Supplements Information: Please list current supplements.

Name	Strength	Usage

Preferred Pharmacy Information:

Pharmacy Name:_____Phone:_____Fax#:_____.

Pharmacy Address:_____City:_____State:_____Zip:_____.

My signature below confirms that all the information contained herein is correct.

Patient / Legal Guardian Signature: _____ Date: _____

SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

MEDICAL HISTORY QUESTIONARE

Name: _____ Sex: ☐M ☐F Date of Birth: _____ Date: _____.

Ocular history: (check all that apply) ☐ Allergies ☐ Blepharitis ☐ Cataract ☐ Conjunctivitis ☐ Corneal Disease ☐ Corneal Ulcer ☐ Diabetic Retinal Disease ☐ Dry Eyes ☐ Glaucoma ☐ Herpes ☐ Macular Degeneration ☐ Retinal Detachment ☐ Retinal Disease ☐ Retinal Tear ☐ Toxoplasmosis ☐ Other _____.

List all major illnesses and injuries (i.e. Diabetes, high blood pressure, trauma, accidents) _____.

_____.

List all surgeries and dates undertaken _____.

_____.

Do you have any current or past issues in the following areas? If yes, please provide details:

GENERAL HEALTH

☐ Fever ☐ Heat Stroke ☐ Weight Loss ☐ Weight Gain ☐ Unusually tired ☐ Other: _____

EAR, NOSE, THROAT

☐ Ear Ache ☐ Hard of Hearing ☐ Ringing in the Ear ☐ Stuffy Nose ☐ Dry Mouth ☐ Other: _____

CARDIOVASCULAR

☐ High Blood Pressure ☐ Pace Maker ☐ Racing Pulse ☐ Other: _____

RESPIRATORY

☐ Congestion ☐ Wheezing ☐ Shortness of Breath ☐ Tuberculosis ☐ Other: _____

GASTROINTESTINAL

☐ Upset Stomach ☐ Diarrhea ☐ Hernia ☐ Constipation ☐ Other: _____

GENITAL, KIDNEY, BLADDER

☐ Painful Urination ☐ Frequent Urination ☐ Yellow Jaundice ☐ Dialysis Other: _____

FEMALE MATERNITY Pregnant? (Y/N) _____ Nursing baby? (Y/N) _____.

MUSCLE, BONES, JOINTS ☐ Arthritis ☐ Lupus ☐ Scleroderma ☐ Other: _____.

SKIN

☐ Growths ☐ Rash ☐ Moles ☐ Cancer ☐ Other: _____

NEUROLOGICAL

☐ Numbness ☐ Headache ☐ Seizures ☐ Other: _____

PSYCHIATRIC

☐ Anxiety ☐ Depression ☐ Insomnia ☐ Other: _____

SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

ENDOCRINE:

☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Hyperthyroid ☐ Hypothyroid ☐ Other:_____.

BLOOD DISORDR:

☐ Anemia ☐ Bleeding ☐ Blood Transfusion Complication ☐ Other: _____.

ALLERGIES

☐ Codeine ☐ Iodine ☐ NSAIDS ☐ Penicillin ☐ Sulfa ☐ Other: _____.

_____.

FAMILY HISTORY Has any of your family members (mother, father, grandparents, siblings, aun/uncle) had any of the following diseases? (Check all that applies)

☐ Blindness – Relationship _____ ☐ Cataract – Relationship _____

☐ Glaucoma – Relationship _____ ☐ Diabetes – Relationship _____

☐ Hypertension – Relationship _____ ☐ Heart Disease – Relationship _____

☐ Stroke – Relationship _____ ☐ Cancer – Relationship _____

☐ Other hereditary diseases _____.

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No * If yes, how many packs per day / week?_____.

Do you drink alcohol? ☐ Yes ☐ No * If yes, how many drinks a day / week? _____.

What is your occupation? _____.

Do you drive? ☐ Yes ☐ No * If yes, daylight or night-time or both? _____.

COMMENTS:

_____.

_____.

_____.

I confirm that all of the information contained herein is correct.

Patient Name (Print): _____.

Patient Signature: _____.

Date: _____.

SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

24-hour Cancellation AND "No Show" FEE Notice

Recognizing that everyone's time is valuable, and the appointment time is limited, we ask that you provide a 24-hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Physicians of South Florida Eye Institute Inc. reserve the right to charge a fee of $75.00 for each missed ("No Show") appointment, which is, absent for a compelling reason, and is not cancelled within a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No Shows" in any 12-month period may result in the termination from our practice.

Thank you for your anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Patient Name (Please Print) **Date**

_____ _____

Patient Signature **Date**

6233 N. University Dr. • Tamarac, Fl. 33321 • 954-721-0000(P) • 954-721-6308(F)

SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

Patient Financial Policies

Payment Guarantee: For services rendered by South Florida Eye Institute, Inc. and its employees., you guarantee payment of your account at the time services are provided for the entire costs that will not be paid by an insurance carrier, or other third party payer (all called "PAYER"), or if at a later date after initial approval, your Payer denies the claim. You further understand that any out-of-network charges may be your responsibility as determined by your PAYER. You acknowledge that if your dependent is provided services you will be responsible for payment under these same terms and conditions. The "Responsible Party" listed on the Patient Data Sheet will be sent the bill and agrees to pay it. If the Responsible Party is not you and that person does not pay the bill, YOU agree to pay the bill.

Assignment of Benefits: To the extent there is third party coverage for payment of services, you agree that all medical and related benefits PAID by PAYER will be assigned to South Florida Eye Institute, Inc. on your behalf.

Billing Information: It is essential that you provide us with complete and accurate information to submit billing to your insurance company (i.e. home address, phone numbers). We will make every effort to submit claims to your insurance company and promptly provide you our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided; you may be dismissed and referred to a collection agency. To avoid this, please keep your information up to date.

Please be sure to bring your government-issued photo identification and your insurance cards to every visit so that we may properly bill your insurance company. If you do not have your insurance card with you, you may be required to make payment in full that day.

Insurance Billing: As your healthcare provider we will file your claims with your insurance company as a courtesy after services are provided, unless you notify us not to file it with your Payer. It is your responsibility to understand what services are covered under your medical insurance policy. If you have any questions whether a service will be covered, we urge you to contact your insurance company, before the service is provided. The codes that are listed for the services that are provided to you are based on the guidelines of the American Medical Association. There are several factors involved when making the decision for the type of services to be billed. Among those deciding factors is whether you are a new patient (not seen within the last three years) or established patient, the reason for the visit, the amount of time the service takes and the complexity of the medical problem.

Insurance companies make their payment decision about a specific medical service by looking at what your insurance policy provides. Example: If the reason for your visit is a sport physical and your insurance company does not cover that service we cannot go back and change the reason for your visit. It is your responsibility to find this out ahead of time.

Sometimes routine services such as office visits, laboratory services, diagnostic screenings, and annual check-ups are not covered under insurance policies. We suggest you contact your insurance company to find out what benefits you have under your policy, before services are rendered by us. The customer service number is usually found on your insurance card. Be advised that your insurance company may require a pre-certification, prior authorization, or referral for some services, such as: radiology, surgery, or specialist visits. Receiving prior authorization does not guarantee that your insurance company will pay for it. Patients have the responsibility to ensure that prior authorization has been obtained prior to services rendered.

You should normally receive a response from your insurance company within 30 days. This is in the form of an "Explanation of Benefits" (or "EOB"). If you do not receive it, we would appreciate you contacting your insurance company to check the status of your claim in order to expedite payment. Please call our Billing Department (the phone number is listed on your statement), if you encounter any difficulty with your insurance company. We will try to assist you. You are responsible for payment until the account is paid in full by your insurance company.

SOUTH FLORIDA EYE INSTITUTE

FULL EYE CARE FACILITY

Payment terms: Depending on your insurance policy benefits, you may be responsible for a co-payment, coinsurance, deductible, or for the entire services rendered. We may require payment for these items at the time of your office visit. If you fail to make payment at the time of service, we may charge a processing fee to cover our extra expense of preparing and sending out a bill. Once we have received an EOB from your insurance company, which indicates the amount you will be responsible for, a statement for the balance will be sent to you and payment is expected by the Due Date as stated on our bill.
If amounts due for services rendered become delinquent and the amounts are referred to an attorney and/or collection service, you agree that you will be responsible for all reasonable costs and expenses incurred in the collection efforts, including any interest charges due, court costs and attorney fees.

Note to divorced parents of dependents. Unless you provide us with a court order, the statement will be sent to the "Responsible Party" listed on the Patient Data Sheet and that person agrees to pay the bill. If the Responsible Party is not you and that person does not pay the bill, YOU agree to pay the bill. If there is a disagreement it is for the parents to determine who should pay without South Florida Eye Institute, Inc.'s involvement.

Self- Pay Patients: Self-Pay Patients are those not covered by any insurance policy or third-party payer. Payment is YOUR responsibility: Our relationship is with you, to provide quality healthcare to you and/or your dependent. Consequently, all charges incurred are your responsibility. The obligation to ensure payment in a timely manner lies with you. Unfortunately, we cannot always depend on your insurance company to make timely payment on your behalf. We are not responsible for delays, misplaced claims, or the need for additional information from you by your insurance company. If for any reason a check is returned for insufficient funds any charges incurred by South Florida Eye Institute Inc. will be passed on to you and you will be required to reimburse South Florida Eye Institute Inc.

Payment Options: If you are unable to meet your financial obligation, payment arrangements can be made. Financing options may be available. Contact our financial coordinator to discuss payment options, before your account becomes overdue. In cases of financial hardship, you might be considered under our hardship policy and you may ask us about it.

Making Payments: Patients may pay by cash, money order, check or personal credit card, which can include credit cards to pay from your "flexible spending account" and/or "health savings account," if you have these. One, or all, of these cards may be used to pay your bill and may be kept on file by us to facilitate billing. Patients agree if they have a credit balance after paying for a service, South Florida Eye Institute, Inc. can apply it to any outstanding balances on their account.

Fees Assessed by South Florida Eye Institute Inc.: You may be charged fees for the following: (1) Returned Checks (2) Completion of Forms (e.g. Disability or Family Medical Leave) (3) Copying of Medical Records (4) Failure to Cancel Appointment ("No Show") - if you do not advise us of your inability to keep your appointment prior to 24 hours before your appointment. These fees are set by each location and may change at any time.
You will be considered an active patient as long as we provide you services within a 3-year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual provider/location.

_____ _____

Patient/Legal Guardian Signature **Date**

_____

Print Patient/Legal Guardian Name

SOUTH FLORIDA EYE INSTITUTE

MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification – patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX 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 intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance. I authorize South Florida Eye Institute Inc. and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "South Florida Eye Institute Inc.") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against South Florida Eye Institute Inc, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.

Date: _____

Print Patient's/Beneficiary's Name: _____

Patient's/Beneficiary's Signature: _____

****

COMMERCIAL INSURANCE, MANAGED CARE MEMBERS AND SECONDARY PAYOR AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physician services to the SOUTH FLORIDA EYE INSTITUTE INC. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company. I authorize South Florida Eye Institute Inc. and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "South Florida Eye Institute Inc.") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against South Florida Eye Institute Inc, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.

Date: _____

Print Patient's/Insured's Name (Parent's Signature if child): _____

Signature of Insured: _____

Patient's/Insured's Signature: _____

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