SOUTH FLORIDA EYE INSTITUTE

PATIENT REGISTRATION – PLEASE PRINT

Date: _____

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

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell phone: _____

Date of Birth (month/day/year): _____/_____/_____ Social Security: _____-_____-_____

Email Address: _____ Sex: Male / Female

Religion: _____ Race: _____ Occupation: _____

Marital Status (circle one): Single Married Divorced Widowed

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

Referring Physician: _____ Language of Choice: _____

Pharmacy: _____ Pharmacy Address: _____

How did you hear about South Florida Eye Institute? _____

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 D.O.B. (month/day/year) _____/____/_____

Email: _____ Language of choice: _____

Insurance Information:

Primary: _____ ID#: _____ Group#: _____

Secondary: _____ ID#: _____ Group#: _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance Authorization - Required: I authorize and request that my insurance company/companies directly pay to the providers of South Florida Eye Institute Inc. the amount due to me in my pending claims for medical and/or surgical services.

By signing below, I am confirming that all of the information on all patient information sheets is correct. If any of my insurance information 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___/___/_____

Authorization to Release Medical Information - Optional

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

I hereby Authorize the Providers 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.

Patient/Legal Guardian Signature: _____ Date: ___/___/_____

NO SHOW AND NON-PAYMENT POLICIES

By agreeing to receive services at South Florida Eye Institute, the patient agrees to our NO SHOW AND NON-PAYMENT POLICIES. Recognizing that everyone's time is valuable, and the appointment time is limited. Our office requires a 24-hour cancellation notice to any appointment that is confirmed. Each time a patient misses an appointment without proper notice another patient is prevented from receiving care. Therefore, our office reserves the right to charge a fee of $75.00 for each missed appointment ("NO SHOW') which absent a compelling reason will be enforced.

"NO SHOW' fees are 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 of services to the patient.

After services are rendered, the patient is expected to pay our office for fees associated with the services rendered on the day of services. Our office will bill the patient for any uncollected fees by way of mail. Patients are expected to provide the office with updated mailing addresses. After the first statement is sent and not paid within the time frame given in the statement, our office will charge 18% per annum for all outstanding balances. In addition, any additional statements sent after the first sent statement will incur a $2.50 late fee notice. Any statement returned due to lack of mailing information will still be counted. In the event of non-payment, our office will reserve the right to send the uncollected balance to a collection's agency.

Medical Information

Last Name: _____ First name: _____

Main complaint/Reason for visit:

_____

_____

Prescribed Medication(s): Please list all prescribed medications you are currently taking.

Medication	Strength	Usage

Allergies: Please list all allergies. ☐ None _____

_____

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

_____

_____

Preferred Pharmacy Information:

Pharmacy: _____ Phone: _____ Fax: _____

Pharmacy address: _____ City: _____ State: ____ Zip: _____

Ocular History - Check all that apply

Blepharitis ___ Cataract ___ Conjunctivitis ___ Corneal Disease ___ Corneal Ulcer ___ Diabetic Retina Disease ____

Dry Eyes ___ Glaucoma ___ Herpes ___ Macular Degeneration ___ Retinal Detachment ___ Retinal Tear ___

Retinal Disease ___ Toxoplasmosis ___ Other _____

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

_____

List all surgeries and dates undertaken _____

_____

Do you wear contact lenses? Yes ___ No ___ How long have you had the same contact lens script? _____

Contact lenses comfortable? Yes ___ No ___ Have you tried discontinued use and retry? Yes ___ No ___

Do you wear glasses? Yes ___ No ___ How long have you had the same script for those glasses? _____

Have you ever had an eye injury? Yes ___ No ___ Describe: _____

Overall Medical History – Check all that apply

General Health:

Fever ___ Heat Stroke ___ Weight Loss ___ Weight Gain ___ Unusually tired ___ Other _____

Ear, Nose, & Throat:

Hard of Hearing ___ Stuffy Nose ___ Ear Ache ___ Ringing in the Ear ___ 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? ___ If yes, provide due date ___/___/_____ Nursing baby? _____

Muscle, Bones, Joints: _____

Skin:

Growths ___ Rash ___ Moles ___ Cancer & type _____

Neurological:

Numbness ___ Headache ___ Seizures ___ Other _____

Psychiatric:

Anxiety ___ Depression ___ Insomnia ___ Other _____

Endocrine:

Diabetes Type 1 ___ Diabetes Type 2 ___ Hyperthyroid ___ Hypothyroid ___ Other: _____

Blood Disorder:

Anemia ___ Bleeding ___ Blood Transfusion ___ Other _____

Family Medical History – Has any of your family members (mother, father, grandparents, siblings, aunt/uncle) had any of following diseases?

Blindness ___ Relationship _____ Cataract ___ Relationship _____ Glaucoma ___ Relationship _____

Diabetes ___ Relationship _____ Hypertension ___ Relationship _____

Heart Disease ___ Relationship _____ Stroke ___ Relationship _____ Cancer ___ Relationship _____

Other hereditary disease(s) _____

Social History:

Do you smoke? Yes ___ No ___ If yes, how many packs? _____ How long have you smoked? _____

Do you drink alcohol? Yes ___ No ___ If yes, how many drinks a day? _____ How long? _____

What is your occupation? _____ Do you drive? Yes ___ No ___ Daytime or night-time? _____

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

Patient Name/ Legal Guardian (Print): _____

Patient Signature/Legal Guardian: _____

Date: _____

SOUTH FLORIDA EYE INSTITUTE

Phone: 954-721-0000 | Fax: 954-721-6308 | Email: sfeiMRS@gmail.com

Patient Consent and Authorization for Release of Medical Records to South Florida Eye Institute Inc.

Patient Name: _____ **Patient Date of Birth:**_____

Patient Home Address: _____

Patient Telephone: _____ **Patient Email:** _____

Patient / Legal Representative Authorization

I, _____, hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me:

Most current medical visit notes and diagnostic results (including if any photos / visual fields / OCTs / MRIs / MRAs / XRays / Blood Lab Results / ophthalmic surgical notes/procedures) in your custody.

I hereby authorize _____ **to release the above-described information to South Florida Eye Institute Inc. by Fax: 954-721-6308 or Email: sfeiMRS@gmail.com**

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to: _____. The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not specify an expiration date or event, this authorization will expire 90-days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Legal Representative

Signature of Patient/Legal Representative: _____ **Date:** _____

Print Patient / Legal Representative Name: _____ **Date:** _____

Relationship to Patient: _____

CONFIDENTIALITY NOTICE *- The information contained in this transmission is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. If you are not the intended recipient of this information, do not review, re-transmit, disclose, disseminate, use, or take any action in reliance upon, this information. If you received this transmission in error, please contact the sender or contact the HIPAA privacy officer at 706-721-2661 for further instruction.*

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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