Patient Information

Last name_____First_____M.I.____

Address_____Apt_____

City_____State_____Zip_____

Preferred Phone (_____)_____Home / Cell / Work Please circle one

Alternate Phone (_____) _____Home / Cell / Work Please circle one

Other Mailing Address_____Apt_____

City_____State_____Zip_____

Birthday _____/_____/_____ Age_____ Soc. Sec. # _____ Sex: Female / Male

I authorize Palm Beach Eye Center to contact me at the following email address:_____

Are you ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED?

Primary Language:
☐ English
☐ Spanish
☐ Creole
☐ French
☐ Other _____

Ethnicity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Unknown
☐ Decline to Specify

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other _____
☐ Decline to Specify

Employer _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to our office? _____

Primary Care Physician _____ Phone (_____)_____

Name of person to contact in case of an emergency _____

Relationship _____ Phone (_____)_____Phone (_____)_____

Do you have a living will? ☐ Yes ☐ No

INSURANCE Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If no, who is?

Name_____Relationship_____DOB_____

Address _____ City _____ State _____ Zip _____

☐ Medicare #_____ ☐ Medicaid #_____

☐ Blue Cross/Blue Shield_____Type_____Subscriber_____

☐ Other_____Policy #_____Phone (_____)_____

We must have a copy of all insurance cards and identification in order for the Palm Beach Eye Center to process/submit any claims for you. The above information is true and correct.

Signature_____**Date**_____

VICTOR FARRIS MEDICAL BLDG. ▪ 1411 North Flagler Drive, Suite 8100 ▪ West Palm Beach, FL 33401
Phone: (561) 366-8300 ▪ Fax: (561) 366-8320
www.palmbeacheye.com ▪ info@palmbeacheye.com

PALM BEACH EYE CENTER

PATIENT NAME_____ **DATE**_____

Yes / No
- ☐ ☐ Lung Disease-Type_____
- ☐ ☐ Kidney Disease_____
- ☐ ☐ Arthritis _____
- ☐ ☐ Diabetes Type_____# of yrs._____
- ☐ ☐ Neurological Disease_____
- ☐ ☐ Migraines_____
- ☐ ☐ Psychiatric Disorder_____
- ☐ ☐ Any Nervous Disorder_____
- ☐ ☐ Heart Disease_____
- ☐ ☐ Stroke_____
- ☐ ☐ High Blood Pressure_____# of yrs._____
- ☐ ☐ Scarring Keloids_____

Yes / No
- ☐ ☐ Head or Spinal Injuries_____
- ☐ ☐ Seizures, Convulsions, or Fainting_____
- ☐ ☐ Thyroid Disease ☐ Low Thyroid ☐ High Thyroid
- ☐ ☐ Carotid Artery Disease_____
- ☐ ☐ (Women) Are you pregnant or nursing?____
- ☐ ☐ Stomach/Intestinal Disorder-Type_____
- ☐ ☐ HIV / AIDS # of yrs_____
- ☐ ☐ High Cholesterol_____
- ☐ ☐ Permanent defect from illness/injury_____
- ☐ ☐ Any other disease_____
- ☐ ☐ Smoke? Packs___ Per Day / Week / Month
- ☐ ☐ Drink? Drinks____ Per Day / Week / Month

Please list all Medications that you are currently taking:

_____

_____

_____

Please list all Drug Medications you are Allergic to:

_____

<u>Your Ocular History</u> (Have you been diagnosed with any of the following in the past?)

Yes / No
- ☐ ☐ Cataracts_____
- ☐ ☐ Retinal Disease_____
- ☐ ☐ Crossed Eyes_____
- ☐ ☐ Iritis_____

Yes / No
- ☐ ☐ Corneal Disease_____
- ☐ ☐ Glaucoma_____
- ☐ ☐ Other Eye Disorder_____
- ☐ ☐ Injury-Explain_____

_____

In the past have you had:

1. Cataract Surgery ☐ Right_____ (Date of Surgery) ☐ Left_____ (Date of Surgery)
2. Other Eye Surgery ☐ Right_____ (Date of Surgery) ☐ Left_____ (Date of Surgery)

<u>Family History</u> (Has anyone in your family (blood relative) had any of the following?)

Please note <u>relationship</u> to patient: F-Father **M**-Mother **P**-Paternal **M**-Maternal **S**-Sister **B**-Brother **GF**-Grandfather **GM**-Grandmother **U**-Uncle **A**-Aunt

Yes / No
- ☐ ☐ Glaucoma_____
- ☐ ☐ Cataracts_____
- ☐ ☐ Corneal Disease_____
- ☐ ☐ Macular Degeneration____
- ☐ ☐ Retinitis Pigmentosa_____
- ☐ ☐ Diabetic Retinopathy_____

Yes / No
- ☐ ☐ Retinal Detachment_____
- ☐ ☐ Other Eye Problem_____
- ☐ ☐ Diabetes_____
- ☐ ☐ Heart Conditions_____
- ☐ ☐ Stroke_____
- ☐ ☐ Other Health Problems___

<u>Surgical History</u> (Please include Date and Type, use additional sheet if necessary)

_____

_____

Financial Policy

We appreciate the confidence that you have expressed in selecting Dr. Khouri as your physician. If you have any questions about our services, fees, or other aspects of your care please feel free to discuss your concerns with us.

Payment for your office visit is required at the time of service for:

1. Patients without insurance or with insurance for which we are out of network.
2. Patients who do not provide us with contracted insurance information (We must have a copy of your current insurance card on file).
3. Any service that is rendered by our office that is not a covered benefit by your insurance policy.

Please note that our office is not in-network with any vision plan insurance, we only take medical health insurance. If you want to use your vision plan, we suggest that you look for an office that is in-network with your vision plan.
ALL MONIES OWED BY THE PATIENT; CO-PAYS, DEDUCTIBLES, AND NON-COVERED SERVICES ARE PAYABLE AT THE TIME OF SERVICE.

Any patient who is seen or treated in our office, WITHOUT **PRIOR AUTHORIZATION IN WRITING FROM THEIR HMO GROUP,** is responsible for **FULL** payment at the time of their visit.

REFRACTION is a measurement of the lens power necessary to prescribe glasses. Most medical insurance plans, including **MEDICARE**, do not cover routine refractions. This procedure may be required for your treatment to determine if the cause of a decrease in your vision is due to an optical problem necessitating eyeglasses, eye disease or both. Your insurance requires that we charge separately for any non-covered service. This test also includes an OPD (optical path difference) scan which measures autorefraction, corneal mapping, corneal curvature, pupillometry, and corneal spherical aberrations. Refraction is only charged once a year so if a patient needs it repeated anytime during that year, it is free of charge.

I HAVE BEEN INFORMED THAT THERE MAY BE A $65.00 CHARGE FOR THE REFRACTION PROCEDURE AND THAT IT IS PAYABLE AT THE TIME OF SERVICE. THIS FEE DOES NOT INCLUDE A CONTACT LENS PRESCRIPTION OR CONTACT LENS FITTING.

CANCELLATION FEE

IF YOU NEED TO CANCEL AN OFFICE APPOINTMENT, WE MUST RECEIVE A CALL AT LEAST 24 HOURS IN ADVANCE. WE APPLY EVERY EFFORT TO GIVE PATIENTS WITH EMERGENCY SAME-DAY APPOINTMENTS. IF YOU DO NOT CANCEL WITHIN 24 HOURS OF YOUR APPOINTMENT, YOU WILL BE CHARGED A $25.00 SURCHARGE, WHICH IS NOT COVERED BY YOUR INSURANCE.

IF YOU ARE SCHEDULED FOR A PROCEDURE AND CANCEL, YOU MUST DO SO 24 HOURS IN ADVANCE. IF YOU DO NOT, YOU WILL BE CHARGED A $100.00 SURCHARGE, WHICH IS NOT COVERED BY YOUR INSURANCE.

Our staff will assist you in dealing with your insurance company, BUT it is your responsibility to know and understand your own insurance policy.
It is our sincere hope that this policy will be helpful in eliminating any confusion or misunderstanding.

I have read and understood the above information.

_____ _____

Signature **Date**

_____

PATIENT NAME (Please Print)

PALM BEACH EYE CENTER

ASSIGNMENT OF BENEFITS

I, the undersigned, state that I (or my dependent) have/has insurance coverage with the insurance carrier(s) whose identification cards I have presented to this office. I assign all insurance benefits directly to Palm Beach Eye Center, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance carrier and all attorney's fees should they be deemed necessary to collect on this financial obligation. I authorize the use of this signature on all insurance submissions.

Signature **Date**

RELEASE OF INFORMATION

I, the undersigned, hereby authorize this office to release all information, medical or otherwise, necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or correspondence.

Signature **Date**

MEDIGAP AUTHORIZATION (MEDICARE SUPPLEMENT)

I, the undersigned, state that I (or my dependent) have/has insurance coverage with the Medigap or Medicare supplemental insurance carrier(s) whose identification card(s) I have presented to this office. I assign all insurance benefits directly to Palm Beach Eye Center, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature **Date**

RELEASE OF LIABILITY

I understand that medication in the form of eye drops will be placed in my eyes during my eye examination. One of the eye drops is an anesthetic, and the others are to dilate my pupils. I understand that I can have an allergic reaction to the drops and that dilating the pupil in very rare instances could trigger a sudden rise in eye pressure (acute angle closure glaucoma) which, if not treated promptly could lead to irreversible loss of vision.

I understand that having my pupils dilated will blur my vision, especially at near, and make my eyes sensitive to light. These effects usually last for only a few hours but could in rare instances last until the next day depending on how fast my body metabolizes the drops and what drop concentration must be used in my case. During the time my pupils are dilated, if I drive or operate machinery, I am responsible for any bodily harm it may cause.

Signature **Date**

PATIENT NAME (Please Print)

Notice of Privacy Practices Acknowledgement

PALM BEACH EYE CENTER

I understand that, under the Health Insurance Portability & Accountability Act of 1969 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to changes its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

_____ _____

Signature **Date**

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices but was unable to do so as documented below.

Initials_____

Date_____

Reason_____

_____

_____