OPHTHALMOLOGY ASSOCIATES OF SOUTH FLORIDA, P.A.

Patient Information
Please Print

Name: _____ **D.O.B.**_____

Address: _____

City: _____ **State**: _____ **Zip code**: _____

Home Phone #: _____ **Cell. Phone #:** _____

E-Mail Address: _____

SEX: Female Male **Marital Status**: Single Married Divorced Widowed

Employer _____ **Phone #**: _____

Emergency Contact: _____ **Phone #**: _____

Ethnicity & Race:

American Indian or Alaska Native	Asian
Black or African American	Hispanic or Latino
Native Hawaiian	White
Other Race: _____	Decline to specify

Primary Care Doctor: _____ **Phone Number**: _____

Referring Doctor: _____ **Phone Number**: _____

Pharmacy: _____ **Phone Number**: _____

I allow Ophthalmology Associates to access my prescription history thru my pharmacy? YES or NO

Patient Signature: _____ **Date:** _____

3100 Coral Hills Drive # 206 | Coral Springs, FL 33065
Phone: (954) 575-4711 | Fax: (954) 575-4722
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Past Medical History (please check all that apply)

- ☐ **None**
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ H/O: hypertension
- ☐ Hearing loss
- ☐ Human immunodeficiency virus infection
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of prostate
- ☐ Radiation therapy treatment management
- ☐ Transplantation of bone marrow
- ☐ Other _____

_____

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Past Surgical History (please check all that apply)

- ☐ **None**
- ☐ Abdominoperineal resection
- ☐ Bilateral replacement of knee joints
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ H/O: colostomy
- ☐ H/O: tubal ligation
- ☐ History of appendectomy
- ☐ History of bilateral mastectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of liver excision
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ History of total cystectomy
- ☐ History of transurethral prostatectomy
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy of breast
- ☐ Lumpectomy of left breast
- ☐ Lumpectomy of right breast
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous extraction of kidney stone with fragmentation procedure
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ Surgical biopsy of skin
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other _____

_____

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_____

Ocular History (Please circle all that apply)

Allergic Conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Corneal Dystrophy (Left eye, Right eye)
Diabetic Retinopathy Background (Left eye, Right eye)
Dry Eyes
Glaucoma (Left eye, Right eye)
Macular Degeneration (Left eye, Right eye)
Macular ERM (Left eye, Right eye)
Narrow Angles (Left eye, Right eye)
Ocular Hypertension (Left eye, Right eye)
Ophthalmic Migraine
Pseudoexfoliation
Retinal Tear (Left eye, Right eye)
Strabismus
PVD (Left eye, Right eye)
Vitreous Floaters (Left eye, Right eye)
NONE
Other _____

Ocular Surgery (Please circle all that apply)

Blepharoplasty(Left eye, Right eye)
Cataract Surgery (Left eye, Right eye)
Corneal Transplant (Left eye, Right eye)
DSAEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal Injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis Repair (Left eye, Right eye)
Punctal Plugs (Left eye, Right eye)
Strabismus Surgery
Retinal Laser (Left eye, Right eye)
Trabeculectomy (Left eye, Right eye)
Tube Shunt (Left eye, Right eye)
NONE
Other _____

Family History (Please circle all that apply)

Blindness
Cancer
Cataracts
Diabetes
Glaucoma
Macular Degeneration
Migraine
Retinal Detachment
Strabismus
NONE
Other _____

Medications (Please list all current medications) **NONE**

_____
_____
_____

Allergies to medications (Please enter all allergies) **NONE**

_____
_____
_____

Cigarette Smoking

Never smoked
Quit : Former Smoker
Smokes less than daily
Smokes daily

Alcohol Use

Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1-2 drinks a day
Alcohol: 3 or more drinks a day

OPHTHALMOLOGY ASSOCIATES OF SOUTH FLORIDA, P.A.

Notice of Privacy Practices
Patient Acknowledgement

I have read this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

I hereby authorize (**family member/friend**) _____ to be able to inquire and or request information regarding my ocular care and treatment.

Patient Signature: _____ Date: _____

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PATIENT FINANCIAL RESPONSIBILITY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your insurance policy is a contract between you and your insurance company, the doctor is not involved. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words, you agree to have your insurance company pay the doctor directly. Please be advised that some insurances require you to meet a deductible. If at the time of your visit this has not been met, you will be required to pay for services rendered that day. The deductable is calculated by allowable charges from your insurance company. There may be a difference in the amount we collect at the time of your visit and the amount stated on your EOB (explanation of benefits). We will either send you a statement for the balance due or issue you a refund check.

We do have prior arrangements with many insurers and other health plans and do accept assignment of benefits. We will bill those plans for which we have an agreement and will require you to pay the authorized co-payment at the time of service. We will collect your co-payment upon arrival of your appointment.

If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you on an assignment basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the charges. Payment is due upon receipt of a statement from our office.

All payments that are returned by the bank will be subject to a $50.00 returned check fee.

If you need to change your appointment, please call us at least 24 hours prior to your appointment date to avoid a **$100.00** no-show fee. **If you no-show to your appointment, we will not be able to reschedule your appointment.**

I have read and understand this policy.

Patient Signature _____ Date _____

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REFRACTION

One of the most important parts of your exam is the refraction. That is the part of the exam in which we determine whether you can be helped in any way by a new glasses' prescription. It is also how we determine your best visual acuity which is essential medical information for us to have as we assess your eye.

The refraction is **NOT** a cover service in this office since the insurance plans consider it a "vision" service not a "medical" service. The fee for the refraction is **$60.00**. This fee is collected at checkout the day of your appointment.

- o I have read the above information and understand that the refraction is not covered by my insurance. I accept full financial responsibility for the cost of the service and understand that it is due at the time of service.

- o I decline the refraction service. I understand that without the refraction Dr. Glick may not be able to fully assess the health of my eyes.

Patient signature: _____ Date: _____

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Glaucoma Testing

To Glaucoma suspect patients:

RE: Coverage for the OCT (Ocular Coherence Tomography):

Dr. Glick feels it is necessary to perform the glaucoma testing at the time of your visit if you are a Glaucoma suspect patient. The glaucoma testing helps to diagnose and follow glaucoma.

The OCT is no longer covered by Medicare guidelines and your insurance will NOT pay for the test. The cost for the OCT is **$40.00**, and it will need to be collected at the time of your visit.

- o I want the OCT performed. I **WILL** be asked to pay at the time of my appointment, but I also want my insurance billed for an official decision on payment. If your insurance pays for the testing, you will be refunded the payment.

- o I **DO NOT** want the OCT performed. I understand this is my choice and Dr. Glick will not be responsible for any consequences this decision may cause.

Thank you,

Billing department

_____ _____ _____

Patient Name Patient Signature Date

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LATE CANCELLATION AND NO-SHOW POLICY

We are always happy to accommodate you and your health care needs by reserving an appointment specifically for you. However, in consideration of other patients who are also waiting for care, we do request 24-hour notice (at least) for cancellation of your appointment.

In these complicated times, we understand that there are always circumstances that may prevent you from keeping your appointment. However, we are sure you will agree that 24-hour notice is the bare minimum we can use to accommodate a waitlist patient who is in need.

A fee of $100 ($200 for a procedure) will apply if you "no show" for your appointment or if our office does not receive notification of cancellation at least 24 hours prior. Payment of this fee will be necessary before a new appointment is scheduled. We reserve the right to request a credit card in order to hold the new appointment.

Patients who are running late are asked to call the office as soon as possible to check with the staff.

We greatly appreciate your understanding and cooperation. Please sign below that you have read, and acknowledge the above information provided to you.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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FOR PATIENTS 60 AND OLDER

Have you received a pneumonia vaccination on or after your 60th birthday?

- *YES*
- *NO*

Do you have a health care proxy in the event you are unable to make your own medical decisions:

- *YES, if so, Proxy Name:* _____
  Phone number: _____
- *NO*

Do you have a living will?

- *YES*
- *NO*

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