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
WWW.CSEYES.NET

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 _____

_____

_____

_____

_____

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 _____

_____

_____

_____

_____

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 today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses' prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems.

It is **NOT** a covered service by Medicare and many other insurance plans. These plans consider the refraction a "vision" service not a "medical" service. Our office fee for refraction is **$50.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any copayment or deductible you plan may require. Should you plan pay us for the refraction, we will reimburse you accordingly.

- ○ I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of the service and understand it is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

- ○ I decline the refraction service today. I understand that without the refraction Dr. Glick may not be able to fully assess the health and function 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.

- 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.
- 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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CREDIT CARD AUTHORIZATION

• NO SHOW/LATE CANCELLATION FEES

In order to provide you and other patients of Dr. Henry Glick the best possible care, a minimum of 24 hours notice is required to cancel or reschedule your appointments.

I, _____, understand the importance of notifying my Ophthalmology at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the no show fee of $100 for failing to call or show for scheduled appointment.

I, _____, give Dr. Henry Glick, the authorization to charge my credit card $100 for each missed appointment where 24 hours notice is not given and $100 for each appointment where I fail to call and show for the appointment. I will be provided a receipt for all payments upon request

I understand that I may revoke this agreement at any time. I am also aware that when Ophthalmology services rendered by Dr. Henry Glick have ended, this form shall be shredded once I am terminated from treatment.

Name on card:

_____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ **Code:** _____

Email address for receipt:

_____

Patient Name (printed):

_____

Patient (or Parent/Guardian)/Card Holder Signature:

_____

Date: _____