Hernando
Eye
Institute

Leonard R. Cacioppo, M.D., FICS
Diplomate of the American Board of Ophthalmology
James R. Jachimowicz, M.D.
Diplomate of the American Board of Ophthalmology

Due to COVID-19 we are taking precautions for your safety and the safety of our staff by adhering to CDC guidelines

When you come in, you will have your temperature checked.

You will need to wear a mask. If you do not have one, we will supply you with one.

If you have traveled (domestic or international), have symptoms of, or have been in contact with anyone who tested positive in the last two weeks, we will need to reschedule your appointment after you have quarantined for the required two weeks.

If you have a driver, they must stay in the vehicle. Please come at your appointment time to avoid unnecessary back up at the front desk to help with social distancing guidelines.

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WELCOME TO OUR PRACTICE

It will be a pleasure for all of us at Hernando Eye Institute to serve as *"Your Eyecare Specialists"* In order to mutually fulfill *our* goals and *your* healthcare needs, we ask that you take a few moments to complete the enclosed information in blue or black ink. Your visit will flow smoothly and timely if you follow these suggestions.

Please arrive at our office **15 minutes** prior to your scheduled appointment time.

Please bring the following items with you:

- Eyeglasses, Sunglasses and/or contact lens and prescription
- List of Current Medications (dosage and strength)
- Prior Medical Records from your previous Ophthalmologist, if applicable
- Current Insurance Cards and authorization forms
- All paperwork contained in this packet
- Please bring a driver as your eyes will be dilated

It is our mission of this practice to provide the highest level of service and concern possible to our patients. We want to help every individual achieve a higher level of well-being by enhancing the health, appearance, comfort, and function of their vision.
In providing this level of care, we will strive to treat every patient as we would want to be treated ourselves.

For your convenience visit our onsite optical dispensary for a wide range of styles to accommodate everyone's fashion and budget needs!

Thank You for choosing Hernando Eye Institute for all your Eye Care needs.

Sincerely,
Physicians, Staff and Optical Department

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PATIENT REGISTRATION

Please print clearly

Name:_____ Date:_____
Last First MI Month/Day/Year

Address:_____
Street City State Zip

Northern Address:_____
Street City State Zip

Home Phone:(____)_____Cell Phone:(____)_____ Male___ Female___

SSN:____-_____-_____ Birthdate:_____ Age:_____ Primary Language:_____
Month/Day/Year

Race:_____ Ethnicity: Hispanic/Latino/Non-Hispanic or Latino Tobacco Use: Y N

Retired: Y / N Occupation:_____ Email Address:_____
I agree to receive emails from Hernando Eye Institute only

Employed By:_____ Telephone:(___)_____

Address of Employer:_____

Marital Status: S M W D If married, Spouse:_____
Name Phone DOB

If patient is a minor-Parent/Guardian Name:_____ Relationship:_____

Emergency Contact:_____ Phone Number:_____

INSURANCE INFORMATION

Primary Insurance Company:_____
Name Policy Number Subscriber

Secondary Insurance Company:_____
Name Policy Number Subscriber

Preferred Pharmacy:_____ Phone Number: (___)_____
Primary Care Physician:_____ Phone Number:(___)_____
Whom May We Thank for Referring You:_____

MEDICAL HISTORY QUESTIONNAIRE

NAME:_____
DATE:_____

WHAT IS THE MAIN REASON FOR TODAYS VISIT?

_____
_____

DO YOU HAVE ANY OF THESE EYE SYMPTOMS?
- □ BLURRED DISTANCE VISION
- □ BLURRED READING VISION
- □ CONSTANT DOUBLE VISION
- □ FLASHING LIGHTS OR FLOATERS
- □ GLARE, HALOS AROUND LIGHTS
- □ ITCHING/BURNING EYES
- □ FOREIGN BODY SENSATION
- □ RED/DRY EYES □EYE PAIN
- □ OTHER_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS: □ NO KNOWN ALLERGIES

MEDICATION NAME/REACTION

_____
_____
_____

WHICH **EYE** MEDICATIONS DO YOU CURRENTLY USE: □ NONE

NAME	AMOUNT	TIMES PER DAY

WHICH **OTHER** MEDICATIONS DO YOU CURRENTLY TAKE: □ NONE □ ASPIRIN

NAME	DOSAGE	TIMES PER DAY

LAST EYE EXAM DATE:_____

DO YOU USE TOBACCO □ YES □ NO
DO YOU DRINK ALCOHOL □ YES □ NO

HAVE YOU EVER HAD ANY OF THESE CONDITIONS? □ NONE
- □ STROKE □ DIZZINESS □ ANEMIA
- □ ARTHRITIS □ DIABETES □ CANCER
- □ HEART DISEASE □ LUNG DISEASE
- □ THYROID DISEASE □ AIDS, HIV
- □ HIGH BLOOD PRESSURE
- □ HEADACHES □ OTHER_____

HAVE MEMBERS OF YOUR FAMILY HAD ANY OF THE FOLLOWING:
- □ GLAUCOMA □ CATARACT
- □ DIABETIC EYE DISEASE OR DIABETES
- □ CROSSSED EYES □ BLINDNESS
- □ MACULAR DEGENERATION
- □ IRITIS/UVEITIS □ POOR VISION
- □ RETINAL DETACHMENT
- □ OTHER_____

PLEASE LIST ANY **EYE** SURGERIES YOU HAVE HAD: □ NONE

TYPE OF SURGERY/	WHICH EYE/	YEAR
_____	RT LT	_____
_____	RT LT	_____
_____	RT LT	_____

PLEASE LIST ANY **OTHER** SURGERIES YOU HAVE HAD: □ NONE

TYPE OF SURGERY	YEAR
_____	_____
_____	_____
_____	_____

PLEASE LIST ANY NON-SURGERY ILLNESS THAT HAS CAUSED A HOSPITAL STAY: □ NEVER BEEN HOSPITALIZED

_____
_____

IF YOU HAVE GLAUCOMA:
IN WHAT YEAR WERE YOU FIRST DIAGNOSED:_____
WHAT MONTH/YEAR WAS YOUR LAST VISUAL FIELD:_____

HAVE YOU EVER WORN CONTACTS: Y N

WOULD YOU LIKE TO USE CONTACTS:
□ YES □ NOT AT THIS TIME

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CONSENT FOR TREATMENT

I hereby authorize Hernando Eye Institute, Leonard R. Cacioppo M.D., or James R. Jachimowicz M.D., to examine and treat me or the individual for whom I am responsible.
During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare. Driving an automobile or operating machinery, is not advised until the effects of the drops have worn off.

SIGNATURE_____DATE_____

REFRACTION SERVICE

One of the most important parts of your eye exam today is 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 refraction a vision service not a medical service. Our office fee for the refraction is $40.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your 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 this service and understand it is due at the time of service. I understand that any co-payment or deductible I have are not included in the refraction fee.

SIGNATURE_____DATE_____

LIFETIME AUTHORIZATION AND ASSIGNMENT

I certify that the information given to me in applying for payment under Title XVIII 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, its intermediaries or carriers any information needed for this or related Medicare claim. I understand Hernando Eye Institute is a contracted Medicare provider and does accept assignment as payment for 80% of Medicare's approved amount. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.
In the event that Hernando Eye Institute files my Insurance (Primary, Secondary, HMO, PPO, Workers Comp, ETC.) claim, the following applies: I authorize all benefits to be paid to Hernando Eye Institute/Leonard Cacioppo M.D./James Jachimowicz M.D. for services rendered. I understand and agree (regardless of insurance status) that I am ultimately responsible for any co-pays, deductibles, and/or services not covered by my insurance plan.

SIGNATURE_____DATE_____

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PATIENT PRIVACY

Please list the family member or significant other, if any, whom we may discuss your medical conditions, diagnosis, treatment, and payment with other than your emergency contact:

Name:_____ Phone Number:_____ Relationship:_____

FINANCIAL POLICIES

Payment Policy: Payment is due at the time of service for any responsible party amounts of all co-pays, deductibles, and/or any non-covered service.

Accepted Forms of Payment: Cash, Check, Money Order, Credit/Debit Cards, Care Credit

Non-Covered Services: Services can include but not limited to refractions, driver's license examination form, and any cosmetic procedure.

No Show Policy: There is a $30.00 fee for any missed or cancelled appointments not cancelled/rescheduled within twenty four (24) hours of scheduled appointment time.

Returned Check Fee: Checks returned unpaid from your bank for any reason including Non-Sufficient Funds must be paid within 5 business days in the form of cash or credit card for the amount of check plus a processing fee of twenty five dollars.

Collections Fee: At any time should you become delinquent on your account and reasonable payment arrangement could not be made or agreed to, your account will be forwarded to collection agency for legal action. All accounts directed to the collection agency will incur a fee of thirty five dollars. If you decide to pay upon your account after it is sent to our collection agency, you will be responsible for the amount of delinquency plus the collection fee. All fees must be paid in full before non-emergent services will be rendered.

Medical Record Fee: If, at any time, you need copies of your medical record under Florida Statue 64B8-10.003 we charge $1.00 per page for the 1st twenty five pages then twenty five cents per page thereafter. We will be glad to fax your records to a physician office as a courtesy to you at no cost, upon your written approval.

Refunds: Should your account have a credit balance, it will be referred to our patient accounts department for reconciliation. If a refund is due to the responsible party, we will submit a check to you within 7 – 10 business days. If a refund is due to your insurance company as the result of an overpayment, it will be refunded directly to your insurance company.

I have read the Hernando Eye Institute Financial policies and I agree to all policies set therein. I understand that it is my responsibility to ensure the payment for any and all services rendered to me.

SIGNATURE _____ **DATE** _____

HERNANDO EYE INSTITUTE
AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information_____
_____

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, mobile voice or text mail, email or with a household family member.

  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

  [ ] Please check here if you do not want us to leave a voice/text message on your mobile device.

  [ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email may be an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to authorize in writing the transmission of your healthcare information to you by unsecured email.**

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):_____

_____ _____ _____

Signature | Print name of person signing if other than patient | Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: _____ Date: _____

HERNANDO EYE INSTITUTE
Notice of Patient Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully
This Notice is effective March 1, 2013 and applies to all protected health information as defined by federal and state regulations. (Rev. 3/2013)

Understanding your health record/information:
What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating heath professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

Your Health Information Rights:
Although your health record is the physical property of this practice, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this practice

Our Responsibilities, we are required to:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".

To Report a Problem
If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Treatment, Payment and Health Operations:

Treatment: Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information maybe used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)

Communication with family: Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. as governed by federal/state law.

Research: We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may use or disclose your PHI as required by law or required by a court ordered subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

Authorization: We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.

HERNANDO EYE INSTITUTE
AUTHORIZATION FOR THE USE OF PHOTOGRAPHY, TESTIMONIALS AND MARKETING INFORMATION

In connection with the healthcare services that I, (patient name)_____, have received or shall be receiving, do hereby authorize photography (using current and accepted methods) may be taken of me or parts of my body (as defined by my healthcare provider), under the following conditions:

1. **My healthcare provider or staff member may take the photography or it maybe taken by a designee approved by my healthcare provider who has signed a HIPAA required Business Associate Agreement with my healthcare provider. This photography will be used for my medical records and may be shared with other healthcare professionals involved with my treatment.**

2. **[ ] Please check: If in the judgement of my healthcare provider, medical research, education or science will be benefited by it's use, such photography and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of medical education, knowledge and research. It is specifically understood that in any such publication or use, all reasonable effort will be made so that I shall not be identified by name. I understand I may be recognized and identifiable in the photography. All reasonable efforts will be made to avoid personal identification.**

3. **[ ] Please check: I authorize my healthcare provider to use testimonials given by me, or photography taken of me, for marketing purposes. I understand this information may be posted on the providers website or used as directed by my healthcare provider. This information will be used only in a professional and ethical manor as directed by my healthcare provider. I have the right to request that my healthcare provider inform me prior to using any information for marketing or non-healthcare related purposes.**

4. **[ ] Please check: I authorize my healthcare provider to send information to me, either electronically or through a mail service, about products or services the practice may now or in the future offer that may be of interest to me.**

5. **I understand I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization, or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, we must receive the revocation in writing. The revocation must include:**
   - **The patient's full name and address**
   - **The patient's desire to revoke this authorization**
   - **The effective date of this revocation**
   - **The patient's and/or patient's agent/representative's signature**
   - **The relationship to the patient, if applicable**

   ****We will accept written revocations of this authorization by Certified U.S. mail only.**

This Authorization shall be non-expiring except as listed below.

If this authorization is to be used solely for marketing purposes, then this authorization shall expire on: DATE_____. After this date, we can no longer use or disclose your protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Patient's Signature **Patient's Agent/Representative's Signature & Relationship**

_____ _____

Signature of Witness **Date**