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

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

14543 Cortez Boulevard • Brooksville, Florida 34613 • 352-596-4030

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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:_____ Race:_____
Month/Day/Year

Marital Status: (Please Circle) S M W D Emergency Contact:_____
Name Phone

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

Employed By:_____ Telephone:(___)_____

Address of Employer:_____

Spouse/Nearest Relative:_____
Name Phone Number If spouse, DOB

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

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 $29.00 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** _____