RIVERSIDE EYE
AND LASER SPECIALISTS

PATIENT INFORMATION TODAY'S DATE_____

Name_____ Date of Birth_____ Age _____

If minor, parent/guardian name: _____

Street Address: _____

City, State, Zip:_____

Home Phone #: _____ Cell/Alternate #: _____

Email Address: _____ May we email you? Y N

*Do you authorize Riverside Eye and Laser Specialists to send you appointment notifications via text messaging? Y N

Sex: M F Marital Status: [ ] S [ ] M [ ] D [ ] W Social Security #: _____

Race: _____ Ethnicity: Hispanic Not Hispanic Other

Preferred Language: English Spanish Other:_____

How did you hear about us?_____ Referring Physician:_____

Primary Care Physician: _____ Pharmacy: _____

Emergency Contact: _____Relation: _____Phone Number: _____

Employer: _____Occupation:_____

Work Number: _____

Would you like us to communicate to any other family members, Power of Attorney, or other individuals pertaining to your medical records, treatment plan, billing/insurance questions, appointments, etc.? If so, please list below:

Name and Relation: _____

Do you allow us to release your medical records to a referring physician or primary care physician if they request such to jointly treat your medical condition: If so, please INITIAL HERE: _____

Primary Insurance:

Insurance Company: _____ Policy #:_____Group #: _____

Are you the subscriber or dependent for this plan? _____

Secondary Insurance:

Insurance Company: _____ Policy #:_____Group #: _____

Are you the subscriber or dependent for this plan? _____

If you are the dependent on any insurance plan listed above, please complete the following information:

Subscriber name: _____ Relation:_____

Subscriber DOB: _____ Subscriber SSN: _____

I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, private or government insurance and other health plans to the party who accepts assignment. I authorize payment of medical benefits to undersigned physician or supplier for service(s) described. This assignment will remain in effect until revoked by me in writing. I authorize the release of any medical or other information necessary to process this claim.

Signed (Insured or Authorized Individual)_____ Date_____

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HEALTH QUESTIONNAIRE

Patient Name: _____ DOB: _____

Do you currently use tobacco products? YES NO Cigarettes Chewing Tobacco Cigars

If yes, how many packs do you smoke per day: _____less than 1 ____1 pack ____2 packs ____3 packs ____ more than 3 packs

If yes, how long have you used tobacco products? _____

Have you ever used tobacco products? YES NO

If yes, for how many years? _____ When did you quit?_____

Do you drink alcohol? YES NO Frequency: _____ Do you currently drive? YES NO

Last Flu shot: _____ Last Pneumonia Vaccine: _____

Do you have any special living arrangements? Assisted Living Walker Wheelchair Other: _____

List your medication allergies: _____

Review of Eye History:

Do you have any known eye disease?_____

_____

Have you had eye surgery, eye laser, or other eye procedure? List types, dates, and surgeon's name:

_____

_____

Do you take any eye drops or supplements? Please list: _____

_____

Has anyone in your family been diagnosed with any of the following eye diseases? [ ] Glaucoma_____

[ ] Macular Degeneration_____[ ] Retinal Detachment_____ [ ]Blind_____

Please list all major surgeries and dates: _____

_____

Review Of Overall Health: Please circle all that apply

General: Fever, Chills, Weight Gain, Weight Loss, Fatigue, Headache, Scalp Tenderness, Jaw Pain, Other _____

Ear, Nose & Throat: Sinusitis, Hearing Loss, Chronic Cough, Dry Mouth, Difficulty Swallowing, Other_____

Cardiovascular: High Blood Pressure, Heart Attack, Pacemaker, Stroke, TIA, Murmur, CHF, Irregular Heart Beat, Peripheral Vascular Disease, Carotid Artery Occlusion, Other_____

Respiratory: COPD, Asthma, TB, Shortness of Breath, Oxygen Dependence, Other_____

Gastrointestinal: GERD, Ulcers, Colitis, IBS, Abdominal Pain, Other_____

Genital, Kidney & Bladder: Enlarged Prostate, Incontinence, Kidney Stones, Renal Failure, Dialysis, Other_____

Muscle and Skeletal: Gout, Arthritis, Joint Pain, Osteoporosis, Other_____

Skin: Skin Cancer, Acne, Warts, Psoriasis, Rash, Other_____

Neurological: Dementia, Parkinson's, Multiple Sclerosis, Weakness, Numbness, Other_____

Endocrine: Diabetes (type ___), Hypothyroid, Hyperthyroid, Other_____

Blood& Lymph: Cholesterol, Anemia, Hemophilia, Sickle Cell, Leukemia, Other_____

Psychiatric: Anxiety, Depression, Insomnia, Other_____

Allergy/Immunology: Allergies, Lupus, Sjogrens Syndrome, Rheumatoid Arthritis, Other_____

HIV, Hepatits C, Cancer- type and location_____

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PRESCRIPTION, OVER THE COUNTER, AND SUPPLEMENT MEDICATION LIST

Patient Name: _____ **DOB:** _____

*If you have a copy of your medications please provide it to the staff so that they may make a copy. If you have a list you do not need to fill out this form

DRUG NAME (Please print)	**DOSAGE**	**FREQUENCY**	**ROUTE** (Oral, Nasal, IM, Drops, Topical, Suppository)

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Consent For The Use of Dilating Eye Drops

Dilating eye drops are used to enlarge the pupils, allowing our physicians to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating eye drops will usually cause blurred vision. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired as a result, varies from person to person. It is not possible for your ophthalmologist to predict how much or how long your vision will be affected.

Driving, even in low-light conditions, may be difficult or impossible after an examination with dilating drops, and, if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

I_____ (Patient Name)

hereby authorize Dr. Agee and/or her ophthalmic assistants or nurses to administer dilating eye drops during the course of my treatment. I understand that these eye drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating eye drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated or by wearing sunglasses while driving.

Patient (or patient's authorized representative):

_____Date:_____

Witness:

_____ Date:_____

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STATEMENT OF POLICIES

Payment is due at the time of your exam: Due to the increasing costs of providing medical care, we require patients to pay their co-pay, deductible, and all out of pocket expenses before they leave the office. Patients with no insurance are expected to pay at the time of service for all care rendered. Self pay patients will be given cost information at the time of scheduling and will be required to bring the full amount due at the time of the appointment, unless prior arrangements have been made. Failure to pay at the time services are rendered will result in a $25 billing charge. Any previous balances are expected to be paid at the time of service. We accept cash, check, and credit cards.

Patients on HMO Policies: Patients on an HMO policy are required to present a referral from the Primary Care Physician on every visit to our office. It is the patient's responsibility to ensure the office has this before services are rendered. We cannot bill your insurance without the referral. If you are having surgery we will assist in getting pre-certification or prior approval for your procedure.

Non-Covered Services: If we suspect that your insurance company may not cover a service, we will ask that you sign a form in advance acknowledging that you have been advised the service may not be covered and that you will be financially responsible. All cosmetic surgery, refractive surgery, and elective procedures must be paid 1 week prior to services being rendered.

Billing to your Insurance: Our office will bill all covered services to a Primary and Secondary Insurance policy. We do not bill to more than two insurance carriers. By giving us your insurance information, you authorize our office to request payment be sent directly to us. We will also make reasonable appeals for payment when necessary. We will give insurance carriers a maximum of 90 days to pay the claim. Failure for them to pay in a timely manner will result in the balance being turned over to you.

Unpaid Claims: After 120 days if the balance on your account has not been paid, and a payment arrangement has not been set up, the balance will be forwarded to a collection agency. The patient is responsible for any collection charges, attorney fees, court costs, and finance charges that accrue. Continued access to the practice will be terminated if billing policies are ignored.

Refraction Policy: It may be necessary for our office to perform a Refraction Test. While Medicare and most major insurance carriers do not cover this test, it is necessary to determine your visual acuity. This test can be used to determine your need for glasses, but it can also detect vision loss. Some of the time vision loss is slow and progressive and the patient may not even notice; that is why a physician will check the patient's vision by refracting them. This test can also uncover other problems a patient may not be aware of. This test is charged separate from the exam because Medicare has deemed that a refraction is not a "medical service". However, this is the ONLY way to detect some types of vision loss. The Office of Inspector General has deemed that not charging a patient for a service is an "inducement" to the patient, and therefore illegal, which is why we charge for this service to be done. **The fee for a refraction is $40, and due at the time of service, in addition to any copays or deductibles.**

Cancellations: If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel or reschedule the appointment. Failure to do so **WILL** incur a $25.00 charge to your account for the missed appointment.

Forms: There is a $25.00 fee for all disability, FMLA and other forms that you need to have filled out by the physician. Please allow 72 hours for these forms to be completed. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc. This charge will be determined by the information requested.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND UNDERSTAND THE STATEMENT OF POLICIES, AND AGREE TO ABIDE BY THEM.

Patient Signature: _____ **Date:** _____

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Authorization for the Use or Disclosure of Protected Health Information (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office by mail at 1034 Riverside Ave, Jacksonville, FL 32204, phone at 904-354-2114, or by email at info@riversideeyeandlaser.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands the following:
• Protected health information may be disclosed or used for treatment, payment, or health care operations.
• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
• The Practice reserves the right to change the Notice of Privacy Policies.
• The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
• The patient may revoke this Consent in writing at any time and all future disclosures will then cease
• The Practice may condition treatment upon execution of this Consent agree that Dr. Brittany Agee, MD (Riverside Eye and Laser Specialists), may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefits payers for treatment purposes.

Patient Signature:_____Date: _____

Assignment of Benefits
I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Dr. Brittany Agee, MD. I hereby authorize said assignee to release all information necessary to secure payment. I understand that I am financially responsible for all charges not paid by said insurance, including, but limited to, noncovered services, such as refractions, certain diagnostic tests, and cosmetic procedures. A photocopy of this assignment is to be considered as valid as an original. The assignment will remain in effect until revoked by me in writing.

Patient Signature:_____Date: _____

For Our Medicare Patients
After you are seen by the doctor, Riverside Eye and Laser Specialists will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare forms submitted for you by our office.

Signature of Medicare Beneficiary: _____