DOCTORS SURGERY CENTER

MEDICAL EYE ASSOCIATES

AMERICAN OPTICAL

PATIENT REGISTRATION FORM

Today's Date: _____ Soc Sec # _____

Patient's Name: _____ (First) _____ (MI) _____ (Last) / _____ (Preferred Name)

Date of Birth: _____ Age: _____ Sex: _____ Race: _____ Ethnicity: _____

Address: _____ City _____ State _____ Zip _____

Home#: _____ Cell#: _____ E-mail: _____

Marital Status: _____ Spouse's Name: _____ Phone#: _____

Preferred Language: _____ Employer: _____ Work#: _____

Have you been seen by another eye doctor? _____ **For this similar condition?** _____

Referred By: _____ Phone#: _____

Family Physician Name: _____ Phone#: _____

Insurance Information

Principal Insurance Name: _____

Insurance Policy Holder's Name: _____ Date of Birth: _____

Insurer's Social Security: _____ Ins ID#: _____

Secondary Insurance Name: _____

Insurance Policy Holder's Name: _____ Date of Birth: _____

Insurer's Social Security: _____ Ins ID#: _____

Is this problem related to a MOTOR VEHICLE ACCIDENT: _____ WORK REALTED INJURY: _____

Emergency Contact

In case of emergency, please contact: _____ Phone#: _____

Relationship to you: _____ Address: _____

Name of family member NOT residing with you: _____ Phone#: _____

Relationship to you: _____ Address: _____

PLEASE NOTE: PAYMENT IS EXPECTED AT TIME OF SERVICE

- ☐ I certify that the information I provided is correct.
- ☐ I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company.
- ☐ I authorize payment of medical payments to Eye Center, Inc. for any services rendered to me by any doctor of the Eye Center Inc. I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, co-insurance and referrals.
- ☐ I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of the service provided. I authorize use of this form on all my insurance submissions.
- ☐ I understand **I am responsible** for my bill. I permit a copy of this authorization to be used in place of the original.
- ☐ I understand I am subject to be charged a $25 (twentt-five dollars) cancellation / no-show fee for canceling my appointment without giving a 24-hour notice.

_____ _____

Signature of Patient or Legal Guardian (Signature on file for payment authorization) Date

NOTE: ANY UNPAID BALANCES FROM PREVIOUS VISITS, OR NON ALLOWED CHARGES/NON-COVERED SERVICES MUST BE PAID IN FULL TODAY. I request that authorized Medigap benefits (if applicable) be made on my behalf to Medical Eye Associates. I authorize Medical Eye associates to contact the State Ins. Commissioner on my behalf in which state my insurance company domiciles to collect their payment. SIGNING THIS FORM CERTIFIES YOUR AGREEIANCE WITH ALL THE STATEMENTS ABOVE. If you disagree with any statement, please discuss with us before signing.

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Financial Policy-Third Party Financing & Credit Card Guarantee

Dear Patient:

As we approach a new year at Medical Eye Associates, Inc., we have had to evaluate each area of our business.

One significant expense for our business is the accounts that go unpaid each year. Unfortunately, that is a cost we have to pass on to our patients, such as you.

Because of this expense, the management of Medical Eye Associates, Inc. has decided to revise billing for co-pays and insurance deductibles effective immediately. You now have three payment options:

1. Each time you make an office visit, you can pay at the time of the visit. If you have insurance, we will estimate the amount to be covered by your insurance, and You can pay the difference. Once your insurance company pays, we will refund any excess, or bill you for any shortfall.

2. As an alternative to this, you can sign up for our new service with Care Credit. Care Credit works like a credit card, except there is no interest if you pay the charge within 12 months. We can provide you a brochure and Care Credit application.

3. You can guarantee your account with a credit card. With this plan, we will continue to bill just as we have done in the past. However, with the credit card guarantee, you give us permission to charge your credit card if we don't receive payment by the due date.

This policy is being applied to all our patients, regardless of their past credit record. With this change we can continue to supply quality medical care at competitive fees. We trust you will understand the need for this policy.

_____ _____

Patients Signature Date

Kissimmee Office
921 North Main St.
Kissimmee, FL 34744
407-933-7800

www.MedEyeDoc.com
Fax: 407-933-8657

Orlando Office
1525 South Orange Ave.
Orlando, FL 32806
407-423-2400

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSES AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Medical Eye Associates is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all protected health information.

During the course of the serving your interests it may be necessary to share information with other health care providers or business associates. The following are examples of instances where information may be shared.

- Medical Treatment
- Payment
- Health Care Operations
- **Appointments and Patient Reminders**
- Emergency Situations
- Research
- Require By Law
- To Avoid a Serious Threat to Health or Safety
- Organ and Tissue Donation
- Worker's Compensation
- Public Health Risks
- Investigation and Government Activities
- Lawsuit and Disputes

Here at Medical Eye Associates we are committed to obeying all Federal, State and Local laws and regulations regarding privacy practices. If any uses or disclosures other than the ones listed above are needed, the information will only be given on an individual basis as provided by law and may revoke this written authorization.

If you have any questions or comments regarding your Protected Health Information feel free to contact our Compliance officer at 407-933-7800.

The Practice provides the form to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signed: _____ Date: _____

Witness: _____ Date: _____

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PATIENT INFORMATION DISCLOSURE

AUTHORIZATION

Please list below the names of persons who are authorized to receive information from Medical Eye Associates, Doctors Surgery Center, and American Optical concerning your diagnoses, treatment, and prognosis for purposes other than treatment and payment. When authorized persons request healthcare information pertaining to you, they will be required to present a photo I.D. When authorized persons inquire via telephone, your name, date of birth and social security number will be verified. Authorized names shall remain on file until you request removal.

Por favor enliste los nombres de las personas autorizadas a recibir información de Medical Eye Associates, Doctors Surgery Center, and American Optical con referencia a su diagnóstico, tratamiento y pronóstico por otr interes que no sea relacionado con su tratamiento y pago. Cuando la(s) persona(s) autorizadas que pidan su información deben presenter una identificación con foto. Cuando estas personas pidan sus archivos medicos deben tener consigo su nombre, número de telefono, fecha de nacimiento y seguro social para verificación. Estos nombres permaceran en su archive medico hasta que usted pida su remoción.

NAME (Nombre) **RELATIONSHIP TO PATIENT (Relación con paciente)**

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature (Firma de Paciente) **Date (Fecha)**

Patient Name: _____ **Acct#:** _____

(Nombre de Paciente)

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PATIENT STATEMENT

I _____, certify that I am not a member of any Health Maintenance Organization (HMO) that does not have a participating provider agreement with Medical Eye Associates, Doctors Surgery Center and American Optical.

I also certify that if I enroll in any Health Maintenance Organization (HMO) that Medical Eye Associates, Doctors Surgery Center and American Optical does not have a participating provider agreement with, I take full responsibility for the entire amount of any charges with either of the above named provider.

Patient: _____ Date: _____

Witness: _____ Date: _____

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DECLARACIÓN DE PACTIENTE

Yo _____, certifico que no soy miembro de ninguna organización de mantenimiento de la salud (HMO) que no tenga un acuerdo de proveedor con Medical Eye Associates, Doctors Surgery Center y American Optical.

También cerifico que si enlisto en cualquier organización de mantenimiento de la salud (HMO) con la cual Medical Eye Associates, Doctors Surgery Center y American Optical no tenga un acuerdo de proveedor, tomo completa responsabilidad del monto complete por cualquier cargo con cualquiera de los abastecedores mencionados anteriormente.

Paciente: _____ Fecha: _____

Testigo: _____ Fecha: _____

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Advanced Notice of Patient Responsibility
Non-Covered Services

During your examination, the physician may find it medically necessary to perform a test called a refraction using corrective lenses to find out your best achievable vision. Routinely, prescriptions are not given each time a refraction is performed. When patients ask for glasses, the refraction is used to write an eyeglass prescription. Medicare, as well as, other insurances, considers corrective lenses and refraction to be a routine service. Routine services are considered non-covered, therefore, it is the responsibility of the patient.

If you elect to receive the test for the purpose of obtaining a prescription at the time of the service, or at a later date for this purpose, the cost of the refraction will be your responsibility and payment will be required.

Currently our fee is $40.00

Patient: _____ Date: _____

****

Notificación de Responsabilidad de Paciente
Por ervicios no cubiertos

Durante su examinación, el doctor puede conseguir medicamente necesario hacer un examen llamado refracción utilizando lentes correctivos para conseguir su mejor vision possible. Normalmente, prescripciones no se entregan al paciente cada vez que una refracción es efectuada. Cuando el paciente pide espejuelos de corrección, la refracción es utilizada para escribir una prescipción para los mismos. Medicare, al igual que otros seguros, consideran espejuelos de corrección y la refracciones servicios rutinarios. Estos son catagorizados bajo servicios de no covertura. Por lo tanto, la responsabilidad cae completamente en el paciente.

Si usted escoge recibir este examen para el propósito de obtener espejuelos de corrección en el día de servicio o a una fecha futura, el costo de la refracció sera completa responsabilidad suya y el pago requerido en el momento de servicio.

Nuestro cargo en este momento es $40.00

Paciente: _____ Fecha: _____

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INSURANCE TERMINOLOGY FOR PATIENTS

PARTICIPATING PROVIDER:	Any doctor who agrees to accept the Medicare allowable (not the Medicare payment) as payment in full.
MEDICARE ALLOWABLE:	The amount Medicare allows for a particular charge which may be equal to or less than the doctor's charge.
MEDICARE PAYMENT:	Medicare pays 80% of the allowable amount after the $ 155.00 deductible has been met.
MEDICARE DEDUCTIBLE:	Medicare requires that you pay the first $ 155.00 they have allowed for charges submitted on an annual basis.
MEDICARE CO-PAYMENT:	What's left after Medicare pays their 80% of the allowable. You are responsible for the 20% balance due under co-payments.
OUT-OF-POCKET EXPENCE:	Medicare requires that you pay $ 155.00 deductible, plus 20% of the allowable amount.
SUPPLEMENTAL INSURANCE:	You may purchase a separate insurance policy that may pay your out-pocket expense (Medicare deductible and co-payment) in part or in full, depending on the terms of your policy.

_____ _____

Patient Signature Date

EYE DROPS

In order to perform a thorough evaluation of the health of your eyes, it is sometimes necessary to dilate the pupils with eye drops. Please be advised of the potential for significant decrease in vision after dilating drops and driving may be difficult.

_____ _____

Patient Signature Date