Orlando Eye Specialists

10815 Dylan Loren Circle
Orlando, FL, 32825
407-966-3770
407-930-1550
rsvp@orlandoeyespecialists.com
orlandoeyespecialists.com

1. Demographics:

Name _____ Last Name _____

Date of Birth _____ Sex _____ Social Security Number _____

Home Address: _____

City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address: _____ Occupation _____

Marital Status
☐ Single ☐ Married
☐ Widowed ☐ Divorced

Race
☐ Black ☐ White ☐ Asian
☐ Native American
☐ Refuse to Answer

Ethnicity
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Refuse to Answer

Primary Care Physician _____ Referring Physician _____

Pharmacy Name _____ Pharmacy Address _____ Pharmacy Phone Number _____

Emergency Contact Name _____ Emergency Contact Relationship _____ Emergency Contact Phone # _____

2. People Authorized to Discuss your Medical Care with Our Staff

	Name	Relationship
1		
2		

3. Primary Medical Insurance

Insurance company: _____ Address: _____

Group #: _____ ID#: _____

How much is your deductible?

Name of the Insured

4. Secondary Medical Insurance

Insurance company:

Address:

Group #:

ID#:

How much is your deductible?

Name of the Insured

5. Please Upload a Photo of your ID and Medical Insurance(s)

6. Eye health: Do you suffer from any of the following?

- ☐ None
- ☐ Macular Degeneration
- ☐ Dry eyes
- ☐ Eye Pain
- ☐ Flashes
- ☐ Amblyopia/Lazy Eye
- ☐ Glaucoma
- ☐ Red eyes
- ☐ Watery eyes
- ☐ Floaters
- ☐ Uveitis
- ☐ Other(s)
- ☐ Cataracts
- ☐ Itchy eyes
- ☐ Blurry Vision
- ☐ Lid Twitching
- ☐ History of Eye Trauma

If "other(s)", please specify

7. Eye health: Prior Eye Surgeries

- ☐ None
- ☐ Retina Surgery
- ☐ Other(s)
- ☐ Cataract Surgery
- ☐ Strabismus/Eye Muscle Surgery
- ☐ Glaucoma Surgery
- ☐ Lasik/PRK/RK

If "other(s)", please specify

8. Past Medical History

- ☐ None
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall Stones
- ☐ Gout
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ HIV
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Rheumatic Fever
- ☐ Sinusitis
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Other(s)

If "other(s)", please specify

_____

9. Past Surgeries

_____

_____

_____

_____

10. Please list any prescribed medications you take:

	Name	Dosage	Frecuency
1			
2			

11. Please list all non-prescription medications you take:

	Name	Dosage	How long?
1			
2			

12. Please list any supplements you currently take or have taken in the recent past:

	Name of supplement	Dosage	How long?
1			
2			

13. Your habits:

	How often?
Smoking	
Alcohol	
Recreational drugs	
Tea	
Coffee	

14. List all your allergies (e.g.: foods, medications, pollens, chemicals, molds, animal hair, etc.):

_____

_____

_____

_____

_____ _____

Signature Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the purposes of conducting and coordinating care, obtaining payment, and supporting health care operations of Orlando Eye Specialists, PA.

I acknowledge that I can obtain the Notice of Privacy Practices, which provides a comprehensive explanation of how my protected health information may be used or disclosed, at the office or at this webpage: https://orlandoeyespecialists.com/patientcenter/

I was given the opportunity to review the notice prior to signing this consent.

I understand that Orlando Eye Specialists, PA has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time to obtain the most current copy of the Notice of Private Practices.

I understand that I may request in writing restrictions on the use or disclosure of my protected health information. I also understand that Orlando Eye Specialists, PA is not required to agree to my requested restrictions, but are bound to abide by such restrictions upon agreement.

I understand that I may revoke my consent to use and disclose my protected health information upon written request. Any use or disclosure that has already occurred prior to the date the revocation request is received will not be affected.

As per HIPAA, Orlando Eye Specialists, PA reserves the right to decline service if the consent form is not signed.

I HAVE READ AND UNDERSTAND THIS CONSENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION IN ACCORDANCE TO THE NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient or Guardian Signature Date

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FINANCIAL POLICY

Orlando Eye Specialists, PA has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. The following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

INSURANCE

As a courtesy to our patients, we will file claims on all visits and procedures, whether they are delivered in our office or the hospital. When we file a claim on your behalf, it is with understanding that benefits will be assigned to Orlando Eye Specialists, PA (that is, the insurance company will pay Orlando Eye Specialists, PA directly). You are responsible for payment of all deductibles, co-insurance and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you. If there is a credit on the patient's account, please be advised that all patient refunds are sent for reimbursement every three (3) months. Please be aware that copays, co-insurance and deductibles will be collected BEFORE any services are provided.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

Patients that acquired their medical insurance through the Individual Marketplace must provide evidence of good standing with their current insurance plan. Proof of payment of your monthly premium must be presented prior to your appointment (i.e. bank statement, paper receipt, website printout, etc.). Patients unable to present this evidence will be required to pre-pay for the visit prior to seeing the doctor.

REFERRALS

You are required to know whether or not your insurance requires a referral/authorization and obtain that referral/authorization before you are scheduled to see our physicians. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor your wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits. Our office will not see a patient who does not have a valid referral.

REFRACTION CHARGE

For patients whose insurance does not cover refractions, we ask that payments be made at the time the new prescription for eyeglasses is dispensed. The refraction fee is $40.00.

APPOINTMENTS

Please call at least 24 hours ahead of time if you must cancel an appointment. There is a $40.00

administrative fee if you fail to show up for a scheduled appointment or cancel with less than 24 hours' notice. A patient who arrives 15 or more minutes after their scheduled appointment time will be considered a No Show. NO EXCEPTIONS.

PROCEDURES AND SURGERIES

If you "No Show" to a procedure or laser treatment in the office your account will be charged an administrative fee of $60.00. If you "No Show" to a surgery your account will be charged an administrative fee of $100.00.

RETURNED CHECKS

Your account will be charged a $30 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and the fee.

PAST DUE ACCOUNTS

Patients, who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligations to us, may be turned over to a collection agency. Patients who have allowed their accounts to be turned to a collection agency or small claims court will be permanently discharged from the practice. You agree to reimburse us the fees of any collection agency or small claims court, which may be based on a percentage at a maximum of 25 % of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

NON-COVERED SERVICES

You have scheduled a visit with one of our physicians and that the physician believes to be relevant to evaluate, monitor and protect your health. However, Medicare and certain other insurance companies will only pay for services that they determine to be "reasonable and necessary". If Medicare or any other insurance determines that your visit with our physician or physician assistant is not "reasonable and necessary", they will deny payment for that service. Sometimes insurance companies will not cover an office visit prior to a procedure when the patient comes to the doctor with no symptoms and is requesting a screening procedure. Denial of payments by your insurance company does not mean that you do not need to visit a physician or physician assistant beforehand.

Our doctors recommend an office visit prior to the performance of any procedure, in order that the patient's general health may be evaluated and so that the patient is well informed about any recommended procedure. We are required to inform you that your insurance company may not cover the office visit and that you will be responsible for payment.

OTHER CHARGES

Copies of Medical Records will have an administrative fee of $1 per page up to $25. After that, it will be $.25 per page. Forms to be completed by the provider (i.e. DMV forms) will have a one-time charge of $15.00. Any other forms (i.e. certifications, disability paperwork, and letters) will have a one-time charge of $75. Patient that request to have an after-hours phone conversation with our physician (expect for post surgical patients within the global period) will be charged $50 after-hours fee.

Patient Portal Communications, emails or HIPAA secured texting requesting medical advice from our provider will be billed in accordance with with CMS coding rules.

CODE OF CONDUCT:

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Orlando Eye Specialists, PA expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff. The following behaviors are prohibited:

• Possession of firearms or any weapon

• Physical assault, arson or inflicting bodily harm

• Throwing objects

• Climbing on furniture

• Cellphone conversations or loud cellphone noises inside the clinical areas

• Making verbal threats to harm another individual or destroy property

• Intentionally damaging equipment or property

• Theft

• Making menacing gestures

• Attempting to intimidate or harass other individuals

• Making harassing, offensive, or intimidating statements, or threats of violence through phone calls,

letters, voicemail, email, or other forms of written, verbal or electronic communication

• Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language, or sexuality

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice. Adults are expected to supervise children in their care.

PATIENT STATEMENT

I authorize my insurance company to make payment directly to Orlando Eye Specialists, P.A. for medical services I receive. I understand that I am financially responsible for payment of all non-covered services, co-payments, co- insurance, deductibles, and any other charge(s) my insurance company deems my responsibility. In the event my account should become delinquent for a period of thirty (30) days or more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs and/or attorney's fees involving the attempt to collect debt.

Patient or Guardian Signature

Date

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Chronic Conditions and Medication Refill Policy

Patients that are being treated for a chronic condition (i.e. Glaucoma) at Orlando Eye Specialists, PA are expected to attend their scheduled follow up visits in order to receive additional medication refills. No refills will be issued without the appropriate follow up without exceptions. Appropriate medical management of chronic conditions cannot be achieved without the required follow up exams. Patients that refuse or fail to attend their follow up visits could be permanently discharged from the practice.

I hereby understand the importance of my follow up exams and acknowledge that no refills will be sent to my pharmacy if I fail to see my doctor as scheduled.

Patient or Guardian Signature

Date

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CONSENT FOR THE ADMINISTRATION OF MEDICATIONS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

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

I hereby authorize Javier Pérez MD, FACS and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

INFORMED CONSENT FOR THE ADMINISTRATION OF MEDICATIONS TO CHILDREN

I give my permission for eye medication to be administered to my son/daughter. I understand that these medications are for the purpose of his/her diagnosis and treatment.

I realize in that in the course of this diagnosis and treatment my child may need to be restrained by being held during the administration of drops or examination. In that event, I understand that I am responsible for the restraint and holding of my child.

_____ _____

Patient or Guardian Signature Date