CHART#_____

DATE:_____

PATIENT DEMOGRAPHIC SHEET

PATIENT NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

ZIP CODE:_____ CITY:_____ STATE:_____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #:_____

HOME PHONE #:(_____) _____-_____ CELL PHONE #:(_____)_____-_____ PRIMARY: HOME/CELL

MAY WE LEAVE APPOINTMENT REMINDERS, ETC. ON YOUR ANSWERING MACHINE/VOICEMAIL? YES_____NO_____

SEX: (CIRCLE ONE) FEMALE MALE EMAIL ADDRESS:_____

RACE:_____ PRIMARY LANGUAGE:_____ LANGUAGE BARRIER?: YES NO

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OTHER

EMERGENCY CONTACT NAME:_____

RELATIONSHIP TO PATIENT:_____EMERGENCY CONTACT #:(_____)_____-_____

PRIMARY CARE PHYSICIAN:_____PHONE#:(_____)_____-_____

REFERRING DOCTOR:_____PHONE#:(_____)_____-_____

BUSINESS/EMPLOYER INFORMATION

NAME:_____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP:_____ PHONE#:(_____)_____-_____

RESPONSIBLE PARTY INFORMATION

NAME:_____ RELATIONSHIP TO PATIENT:_____

PHONE#:(_____)_____-_____ DATE OF BIRTH:_____/_____/_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

POLICY OR ID #:_____ GROUP#:_____

SUBSCRIBER'S NAME:_____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #:_____

PATIENS RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE COMPANY:_____

POLICY OR ID #:_____ GROUP#:_____

SUBSCRIBER'S NAME:_____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #:_____

PATIENS RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

CHART#_____

GAINESVILLE EYE ASSOCIATES
NOTICE OF PRIVACY PRACTICES

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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

CHART#_____

NOTICE OF INDIVIDUAL RIGHTS

Gainesville Eye Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Gainesville Eye Associates, Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative Date

CHART#_____

FINANCIAL POLICY

Thank you for choosing Gainesville Eye Associates as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim for you.

Referrals and Preauthorizations

Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring payment in full at the initial appointment. Extended payment arrangements may be available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

CHART#_____

Motor Vehicle Accident (MVA) and Third Party Billing
We do not do any third party billing. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Workers' Compensation
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Missed Appointments
Gainesville Eye Associates requires 24 business hours notice of appointment cancellation. Appointments missed and are not previously cancelled may be charged a fee of $50.00.

Returned Checks
The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

GAINESVILLE EYE ASSOCIATES, LLC. RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS SITE AT ANY TIME.

Patient Signature:_____Date:_____

CHART#_____

PERMISSION TO DISCUSS YOUR MEDICAL CARE

Patient Name (please print): _____Date of Birth:_____

This form does not apply to other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (which are allowed by federal law), and workers compensation agencies. We cannot release ANY of your medical information to any person or organization (including family members, spouse, etc) unless you list their names below.

I give permission to Gainesville Eye Associates to discuss the following medical and billing information about me **(check all that apply):**

- ☐ Scheduling/Appointment Information
- ☐ Medical Information (including symptoms, diagnosis, medications and treatment plan)
- ☐ Laboratory/Test Results
- ☐ Financial Details/Payment Information
- ☐ All of the above
- ☐ Other:_____

Gainesville Eye Associates has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may revoke or terminate this permission at any time by submitting a written revocation to Gainesville Eye Associates. I will contact the Gainesville Eye Associates Privacy Officer in writing to terminate the authorization.

This authorization expires:

- ☐ No expiration date
- ☐ Date Specified_____/_____/_____-unless revoked or terminated in **writing** by you or your patient personal representative.
- ☐ I decline permission to discuss any medical information

_____ _____ _____

Signature of Patient/Guardian Date Relationship to Patient

_____ _____

Staff Member Date

CHART#_____

GAINESVILLE EYE ASSOCIATES AND GAINESVILLE EYE CENTER, LLC

PATIENT NAME:			DATE OF BIRTH: _____/_____/_____	AGE:	SEX: M/F
Email Address:	WEIGHT:	HEIGHT:	PRIMARY PHONE #: (_____)_____-_____		

DO YOU HAVE A LIVING WILL? YES NO DO YOU HAVE A POWER OF ATTORNEY? YES NO

SURGERIES (LIST ALL OPERATIONS):_____

_____

MEDICAL HISTORY:	**CIRCLE**		**IF YOU ANSWER YES, PLEASE EXPLAIN**
1. High/Low Blood Pressure(# of years)_____	YES	NO	_____
2. High Cholesterol/Triglycerides	YES	NO	_____
3. Heart Attack, Chest Pain or Angina	YES	NO	_____
4. Heart Problems (Heart murmur, pacemaker, bypass surgery, heart failure, mitral valve prolapse)	YES	NO	_____
5. Stomach or Intestinal Problems (acid reflux, hiatal hernia, ulcers)	YES	NO	_____
6. Lung Problems (asthma, emphysema, persistent cough, chronic bronchitis, COPD)	YES	NO	_____
7. Sleep Apnea Do you use CPAP?	YES	NO	_____
8. Diabetes (insulin/oral meds) # of years_____ Type 1 or 2, Last Fasting BS_____ Last A1C_____	YES	NO	_____
9. Do you have an infectious disease (hepatitis, HIV/AIDS, MRSA,TB)	YES	NO	_____
10. Kidney Problems	YES	NO	_____
11. Thyroid Problems	YES	NO	_____
12. Blood Clots, Clotting Problems, Bleeding	YES	NO	_____
13. Stroke (numbness/weakness)	YES	NO	_____
14. Epilepsy or Convulsive Seizures	YES	NO	_____
15. Cancer	YES	NO	_____
16. Lupus	YES	NO	_____
17. Arthritis	YES	NO	_____
18. Rheumatoid Arthritis	YES	NO	_____
19. Psychological/Emotional Problems (depression, anxiety)	YES	NO	_____
20. Problems with Motion Sickness	YES	NO	_____
21. Problems with Anesthesia (you or blood relative)	YES	NO	_____
22. Females Only: Do you still have cycles?	YES	NO	_____
23. Males Only: Prostate Disease-enlarged/cancer	YES	NO	_____
24. Flu Vaccine	YES	NO	When?_____
25. Pneumonia Vaccine	YES	NO	When?_____
26. Shingles Vaccine	YES	NO	When?_____
DO YOU:			
27. Wear dentures or partials/crowns	YES	NO	
28. Drink alcohol or use drugs (how much)_____	YES	NO	
29. Smoke (how much) _____Quit (when)_____	YES	NO	
30. Communication barrier due to medical condition	YES	NO	

_____

Patient's Signature Date

_____

Doctor's Signature Date

OFFICE USE ONLY

DATE OF SURGERY:
PROCEDURE:
PT INFORMED: NPO, DRIVER NEEDED, PRE-OP
GTTS AS INSTRUCTED BY SURGEON
ARRIVAL TIME:
NURSE:
ANESTHESIA:

PATIENT STICKER

CHART#_____

GAINESVILLE EYE ASSOCIATES AND GAINESVILLE EYE CENTER, LLC

PATIENT NAME:	BIRTHDATE: ____/_____/_____	AGE:	SEX: M F

LIST ANY PROBLEMS YOU ARE HAVING WITH YOUR EYES OR YOUR GLASSES:_____

_____

PAST EYE SURGERIES:_____

_____

DO **YOU** HAVE A HISTORY OF ANY OF THE FOLLOWING:	**CIRCLE**		**IF YOU ANSWER YES, PLEASE EXPLAIN**
1. Do you have cataracts?	YES	NO	_____
2. Have you had cataract surgery? (if so when, where, and what surgeon?)	YES	NO	_____ _____
3. Glaucoma? (if YES, type of treatment/drops)	YES	NO	_____
4. Trauma/Injury (when/what type of injury)	YES	NO	_____
5. Ocular Herpes	YES	NO	_____
6. Severe Dry Eyes	YES	NO	_____
7. Retinal Detachment	YES	NO	_____
8. Macular Degeneration	YES	NO	_____
9. Abnormal vision during youth	YES	NO	_____

FAMILY HISTORY:			**RELATIONSHIP TO YOU**
1. Eye diseases/blindness (cataracts, macular degeneration, retinal detachment, glaucoma)	YES	NO	_____ _____ _____
2. Diabetes, Heart disease, hypertension	YES	NO	_____
3. Other _____			
_____			

HAVE YOU EVER USED:			**WHEN/HOW LONG**
Restasis	YES	NO	_____
Xiidra	YES	NO	_____
Refresh	YES	NO	_____
Systane	YES	NO	_____
Other: _____			

_____

Patient's Signature Date

_____

Doctor's Signature Date

CHART#_____

GAINESVILLE EYE ASSOCIATES AND GAINESVILLE EYE CENTER, LLC
PATIENT MEDICATION LIST

Patient Name:_____ Date of Birth:_____/_____/_____

Primary Care Physician:_____ Phone#:(_____)_____-_____

Referring Physician:_____ Phone#:(_____)_____-_____

Pharmacy:_____ Phone#:(_____)_____-_____

Allergies: (list all allergies, including food, latex and medications) Please include reactions to items you listed as allergies, i.e., rash, fever, nausea/vomiting, etc.) or No Allergies._____
_____
_____

Please list all medications you are currently taking. (Including vitamins, herbal supplements, antacids or OTC (over the counter) medications or, see attached list

NAME OF MEDICATION/VITAMINS/HERBAL SUPPLEMENTS/ETC.	DOSE	FREQUENCY TAKEN (Once/Twice a day, etc.)

OFFICE USE ONLY:

Date:_____

Reviewed By:_____

This is an updated medication list.

PATIENT LABEL HERE

CHART#_____

REFRACTION POLICY

1. What is a refraction?

Refraction is the process of determining the eye's refraction error, or need for corrective glasses and/or contact lenses.

2. Why is it sometimes necessary?

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. **For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery.** We must prove that your vision cannot be simply improved with a glasses prescription. As you can see, a refraction is an essential part of an eye exam; however, Medicare and most insurance companies DO NOT cover the charge for a refraction.

3. Will I be notified in advance if I need it?

Yes, **ONLY** if the doctor or technician is qualified to tell you if this procedure is necessary. They will let you know if this procedure is necessary **BEFORE** it is done. You will be given the option to accept or decline the service.

It is important to understand that if you decline we may not be able to determine the cause for your decrease in vision.

4. How much is the procedure?

Our office policy is to charge $25.00 for this procedure in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. If your insurance pays the fee we will gladly refund you this prepaid $25.00 amount once we receive payment from your insurance.

NOTE: This fee is due and payable **whether or not** you receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses. However, the fee covers the doctor and/or technicians' time and effort in achieving this process.

ACKNOWLEDGMENT

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 the service. I understand the co-pay and deductible are separate from, and not included in, the refraction fee.

_____ _____

Patient Signature Patient Name / DOB (please print)

_____ _____

Staff Member Date

STAFF ONLY

☐ Deferred By Patient