PATIENT REGISTRATION

DATE_____

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY_____ HOME ADDRESS_____

FIRST NAME_____MIDDLE_____ _____

LAST NAME_____ CITY_____STATE_____ZIP_____

SEX_____ DATE OF BIRTH_____ EMAIL_____

MARITAL STATUS MARRIED___ SINGLE___ HOME (____) _____

DIVORCE___ WIDOWED___ WORK (____) _____

EMPLOYED___ RETIRED___ FULL TIME STUDENT___ REFERRING PHYSICIAN_____

OTHER_____ HOW DID YOU HEAR OF US? _____

EMPLOYER_____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK STAFF

Commercial___ Medicaid___ Medicare___ Worker's Compensation___ Other_____

INSURANCE COMPANY_____

INSURED/CARD HOLDER'S NAME _____ RELATIONSHIP_____

POLICY#_____GROUP#_____ PHONE (___) _____

SECONDARY INSURANCE INFORMATION

Commercial___ Medicaid___ Medicare___ Worker's Compensation___ Other_____

INSURANCE COMPANY_____

INSURED/CARD HOLDER'S NAME _____

RELATIONSHIP_____

POLICY#_____ GROUP#_____ PHONE (___) _____

WORKER'S COMPENSATION INFORMATION

COMPANY NAME_____ COMPANY PHONE (___) _____

SUPERVISOR'S NAME_____ SUPERVISOR'S PHONE (___) _____

EMERGENCY CONTACT

FIRST NAME_____MIDDLE_____ HOME (____) _____

LAST NAME_____ WORK (____) _____

SPOUSE/GUARANTOR/RESPONSIBILITY

SOCIAL SECURITY_____ SEX_____ DATE OF BIRTH_____ ____

FIRST NAME_____MIDDLE_____ DAYTIME PHONE NUMBER (___) _____

LAST NAME_____ EMPLOYER_____

ADDRESS _____ ADDRESS _____

CITY_____STATE____ ZIP_____ CITY_____STATE_____ZIP_____

AUTHORIZATION TO PAY FOR BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his\her services as describe, realizing I am responsible to pay non- covered services. Also, I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____

Signature (Patient/Guarantor/Responsible Party or Parent if Minor) Date

Visual Health & Surgical Center

SPECIALISTS IN SIGHT

Information for Patients about our Practice

Founded in 1963, Visual Health is a modern multi-specialty ophthalmic facility equipped with the latest in diagnostic and treatment equipment. Our experienced staff includes 5 board-certified ophthalmologists, 2 optometrists and a plastic surgeon certified with the American Board of Plastic Surgery.

Many of our physicians are world renowned in their subspecialties and are asked to teach and share their expertise with other healthcare professionals here in the U.S. and abroad. We specialize in bifocal reduction, LASIK, cataract surgery, diabetic retinopathy, macular degeneration, corneal transplants and external eye diseases, eyelid surgery, glaucoma management and plastic surgery. We have multiple locations throughout Palm Beach and Broward counties for patient convenience.

Our practice participates with most major insurance carriers; therefore we are obligated to follow the policies of your plan regarding authorizations, verifications, co-pays, and deductibles. Co-pays are required prior to your physician visit, and you will be responsible for any deductibles that your coverage imposes. If you are unable to pay your co-pay at the time of your visit, a service charge will be added to your bill for the services on that day.

When required, patients will not be seen without a referral or an authorization, and it is the patient's responsibility to ensure that their Primary Care Physician or insurance plan has forwarded the appropriate documentation. This is done not only to ensure payment of claims but avoid the patient being responsible for all medical bills that might arise out of a problem discovered at an unauthorized visit.

POLICY AND PROCEDURES

Medicare: By signing this form, the patient authorizes payment of Medicare benefits to be made on their behalf to Visual Health, for services provided to the patient by Visual Health medical staff. The patient authorizes any holder of medical information about them to be released to the Center for Medicare and Medicaid Services and its agents, along with any information needed to determine these benefits or the benefits payable for related services.

The patient understands that their signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS1500 form or elsewhere on other approved claim forms, the signature authorizes releasing the information to the insurer or agency shown. Visual Health accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier. **This is a once in a lifetime signature on file.**

Financial Agreement: The patient understands that they are financially responsible for charges not covered by their insurance policy, including any co-insurance, co-payments, deductibles or any other charges that the insurance carrier declines to pay.

The patient also understands that, if for any reason, their insurance company does not pay for the services performed within 60 days they will be fully responsible for payment. Any returned checks will incur a $30.00 minimum returned check fee. In the event the account becomes delinquent and is turned over to a collection agency, the patient is responsible for any collection, court, or attorney fees.

It is the patient's responsibility, as the policyholder of the insurance, to fully understand the rules and regulations of their insurance policy.

_____**initial**

Canceling appointments: Visual Health & Surgical Center requires a 24 hour notice, prior to the appointment, in order to cancel a scheduled appointment. Failure to provide such notice will result in the patient being charged a $25.00 cancellation fee. Failure to show up at your appointment will also result in a $25.00 cancellation fee.

_____**initial**

Medical Record Copies: Please note the following in accordance with Florida Statues: For copies of chart pages, a minimum of ten working days and not more than thirty is required to process your request. These copies will be billed to you at $1.00 per page for the first 25 pages and .25 cents per page after that, payable prior to release of your copies. Reproduction of Photographic materials will require additional time over and above the ten days. Any reproduction of photographic materials will be billed to you at the cost of the reproduction, payable prior to release. Any retrieval of records in the offsite storage will be charged the retrieval fee.

_____**initial**

Refractions: The assessment of the appropriate eyeglass prescription is a NON-COVERED service at Visual Health. Refractions may be covered by your health or vision plan at another provider. If you are interested in your prescription from our practice, then a normal fee will be due at the time of service.

_____**initial**

Dilation of eyes: In order to perform a thorough eye examination, it may be necessary to put drops in your eye which will dilate them. Dilation means that the pupils will become enlarged for a period of time letting in more light and potentially blurring your vision, particularly up close. A few patients have experienced concern regarding their ability to function after dilation. It has been our experience that the near vision is affected more than the distance and that most individuals are able to "get around" although some caution is necessary. In the presence of any concern, please arrange for a driver when coming for an exam. We are also glad to phone a driver or cab, at your own expense, should you feel it necessary following your exam. Please note that dilation is necessary in order to give the physician a full and enlarged view of the retina, or back of the eye. This is vital in evaluating and diagnosing the effects of many types of conditions including, but not limited to, cataracts, retinal diseases, and glaucoma. If you have further concern regarding this, please let us know.

_____**initial**

_____ _____

Patient Signature or Authorized Party **Date**

Visual Health & Surgical Center

SPECIALISTS IN SIGHT

A PATIENT'S BILL OF RIGHTS

The offices of Visual Health & Surgical Center, present a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her physician, and the group organization. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is recognition of these factors that rights are affirmed.

The patient has the right:

1. To respectful treatment with concern for individual, cultural, or educational difference
2. To complete, up to date information about the condition, treatment, and outlook for recovery.
3. To know who is responsible for the care provided.
4. To personal privacy and confidentiality in communication and medical records.
5. To an explanation of the various types of care to be received.
6. To refuse treatment, except in some cases where life saving treatment is mandated.
7. To know of any affiliations your hospital and physician(s) have with other institutions and physicians.
8. To an itemized bill upon request as specified under section 395.301, F.S.

The patient has the responsibility:

1. To provide accurate and complete information about present complaints, past illness, hospitalizations, medications, and other health related matters.
2. To report any unexpected change in condition to the responsible physician.
3. To say whether a contemplated course of treatment and the patient's obligation in its administration are understood.
4. To follow the treatment plan recommended by the physician. The patient is excepted to follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels necessary.
5. To keep appointments or notify the appropriate person if it is not possible to do so.
6. To accept the consequences of choosing to ignore physician instructions or to refuse treatment.
7. To see that the financial obligations assumed in receiving health care are met as promptly as possible.

Patient Complaints:

If you are dissatisfied with any service you have received, please ask to speak to someone you are comfortable with so we may improve the quality of care.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to except. Within this facility, all activities must be conducted with an overriding concern for the patient an above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

Visual Health & Surgical Center

SPECIALISTS IN SIGHT

Dear Patient,

You will receive a complete eye examination today. If you desire, we will also perform a refraction. This test determines if a new prescription will improve your vision and which lenses to prescribe. Our refraction fee is $50.00 and is not covered by your medical insurance.

Please check YES or NO and sign bellow:

_____ YES, I would like a refraction today to see if my vision can be improved.

_____ NO, I do not want a refraction with an updated prescription.

I will pay for the refraction fee by:

Cash _____ Check _____ Credit Card _____

Signature: _____Today's Date: _____

Signature: _____Today's Date: _____

Signature: _____Today's Date: _____

Signature: _____Today's Date: _____

Signature: _____Today's Date: _____

Signature: _____Today's Date: _____

Visual Health & Surgical Center

SPECIALISTS IN SIGHT

New Technology Information & Update Form

We pride ourselves at Visual Health & Surgical Center to bring the latest information, treatment and technological advancements to all of our patients. We are making several technological improvements over the next several months and we would like to take an opportunity to inform our patients of new services and request information from them.

We are hoping to greatly enhance our ability to communicate to you by e-mail or through our website. During the next few weeks you will be able to fill out forms and print them and carry them to your next appointment. In order to do some of these tasks we will need a current e-mail address. Please fill out the information below and thank your participation.

Name: _____

E-mail Address _____

Tel: (____) _____

For Office Use Only
MR#_____

Visual Health & Surgical Center

SPECIALISTS IN SIGHT

Insurance Waiver

Dear Patient:

Please be advised that all services that we provided for you in our offices will be billed to your insurance carrier unless you have specifically asked us not to. You may become the liable party should your insurance carrier fail to pay us for the service.

Also, please be aware of what is covered and what is not covered under your particular insurance plan. WE DO NOT PRE-VERIFY BENEFITS FOR ALL OF OUR PATIENTS AND THE SERVICES WE PROVIDE. If there is a service that is not covered by your insurance company, you will become the liable party should your insurance company not pay.

Due to the ever growing and changing insurance markets, we are unable to verify if we are participating with your insurance company. It will be left up to you to pre-verify that we are participating with your insurance company or their network. If we do not participate with your insurance plan, you will be responsible to pay for the service being rendered.

My signature indicates that I have read, understood and accepted the above insurance waiver for all my services.

_____ _____

Patient Name Date

_____

Signature of Patient

_____

MR#

2889 10th Avenue North, Lake Worth, FL 33461
102 Coastal Way, Jupiter, FL 33477
2540 NE 9th Street, Ft. Lauderdale, FL 33304
Tel. (561) 964-0707

Visual Health & Surgical Center

SPECIALISTS IN SIGHT

Consent for Dilating Eye drops

Dilating eye 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. This will allow your ophthalmologist to better examine your retina and optic nerves.

Dilating drops frequently blur vision for a length of time that varies from person to person. During this time period you may find bright lights bothersome. You should wear your sunglasses if possible. “Disposable” sunglasses are available at the appointment check out area, please ask the clerk for a pair of them. It is not possible for your ophthalmologist to predict how much your vision will be affected. Although some people feel comfortable driving after dilation, because driving may be difficult immediately after examination, it’s best you make arrangements not to drive yourself.

I hereby authorize the doctor’s of Visual Health & Surgical Center and/or such assistants as may be designated by these doctors to administer dilating eye drops to me as part of my eye examination today and as part of future eye examinations should he feel that they are needed to diagnosis and treat my eye condition. I am not aware of any allergies that I may have to dilating eye drops.

Patients signature: _____ Date: _____

Witness: _____

Visual Health & Surgical Center

SPECIALISTS IN SIGHT

NOTICE OF HEALTH INFORMATION PRACTICES

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices Visual Health.

I understand that Visual Health is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at Visual Health and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Visual Health., but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that Visual Health is required to maintain the privacy of my health information. Visual Health will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by Visual Health. staff and physicians; billing to myself or a third-party payer; in addition, business associates of Visual Health., may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/ or law enforcement purposes.

Visual Health may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Practices of Visual Health.

HIPAA CONTACT LIST

Visual Health its Associates and Staff have my permission to speak to the following family members/friends in reference to my medical care:

_____Relationship _____

_____Relationship_____

_____Relationship_____

Visual Health; its Associates and Staff have my permission to leave a message on my home answering machine _____YES_____NO, and /or to call me at my place of work _____YES_____NO

_____

Signature