V.I.P. Laser Eye Center

Clifford L. Salinger, MD Jill F. Rodila, MD

"Where Vision Is Precious and Safety comes First!"

Patient Information

PERSONAL INFORMATION **(Please Print Clearly)**

Name: _____ Date: _____

Date of Birth: _____ Age: _____ ◯ M ◯ F Social Security #: _____

LOCAL Address: _____
Street City State Zip

Phone: Home: _____ Cell: _____

Email Address: _____

OTHER Address: _____
Street City State Zip

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Care Physician: _____ Eye Doctors: _____

Specialists (Cardiology, etc): _____

Pharmacy Name & Phone #: _____

Referred by: Doctor (Name) _____ Friend/Relative: _____

☐ Internet ☐ Insurance Company: _____ Other: _____

Employer: _____ Occupation: _____

Who should we notify in an emergency while in the office (nearest relative or friend)?

Name: _____ Relationship: _____

Home Phone: _____ Cell / Work Phone: _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, co-pay, or any other balance not paid for by your insurance.
2. In order to control your cost of billings, we request that your charges, co-pays, co-insurance, etc. be paid at the time of each visit.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the health care financing administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. . .
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all Information necessary to secure the payment.

Signed: _____ Date: _____

11020 RCA Center Drive ▪ Suite 2001 ▪ Palm Beach Gardens, FL 33410
Phone: 561-624-7878 ▪ Website: www.VIPLaserEyeCenter.com

Eye History

Name: _____ Date: _____

Thank you for choosing V.I.P. Laser Eye Center for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? ◯ Yes ◯ No
2. Do you wear contact lenses? ◯ Yes ◯ No
3. Do you have problems reading? ◯ Yes ◯ No
4. Are you currently experiencing any eye symptoms? Please check all that apply:

☐ Eye pain ☐ Blurred Vision ☐ Eyelid Crusting ☐ Flashes of Light ☐ Halos
☐ Discharge ☐ Light Sensitivity ☐ Double Vision ☐ Decreased Vision ☐ Floaters

5. Have you ever had an eye injury? Please describe:

Type: _____ ☐ Right ☐ Left Date: _____
Type: _____ ☐ Right ☐ Left Date: _____

6. Have you ever had eye surgery? Please list type, which eye, and approximate dates:

Type: _____ ☐ Right ☐ Left Date: _____
Type: _____ ☐ Right ☐ Left Date: _____

7. Have YOU ever had any eye conditions (ie: glaucoma, cataract, wandering or "lazy" eye, herpes keratitis, retinal detachment, etc.) _____

_____

8. Are you currently using any EYE medications? Please list names and how often used:

_____

_____

9. What medications other than the above are you taking? Please list: _____

_____

_____

10. Are you being treated for any medical conditions? Please check all that apply:

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke
☐ Arthritis Other: _____

11. Are you allergic to any medications? ◯ Yes ◯ No

Please list: _____

_____

12. Do you have any food allergies? ◯ Yes ◯ No

Please list: _____

13. Do you have any family history of eye problems? ◯ Yes ◯ No

Please check and list relationship:

☐ Glaucoma Relationship: _____
☐ Cataract Relationship: _____
☐ Retinal Disease Relationship: _____

14. Please mark any of the following that you would like more information about:

☐ LASIK ☐ Cataracts ☐ Dry Eye Syndrome ☐ Cornea Transplant

Other: _____

MEDICAL HISTORY

Please answer the following questions about your Medical Status and History:

1. Have you ever had any surgery? ◯ Yes ◯ No - If Yes, please explain: _____

_____

_____

2. Have you ever been hospitalized? ◯ Yes ◯ No - If Yes, please explain: _____

_____

_____

Review of Systems:

Do you currently have any of the following problems?

Chronic fever, unexpected weight loss/gain, fatigue ◯ Yes ◯ No _____

Ear/nose/throat problems
(e.g. hearing loss, sinus problems, sore throat) ◯ Yes ◯ No _____

Heart Problems (e.g. chest pain, irregular heart beat) ◯ Yes ◯ No _____

Respiratory problems
(e.g. shortness of breath, wheezing, coughing) ◯ Yes ◯ No _____

Gastrointestinal problems
(e.g. heartburn, abdominal pain, diarrhea, vomiting) ◯ Yes ◯ No _____

Urinary problems
(e.g. pain or discomfort, blood in urine) ◯ Yes ◯ No _____

Skin problems (e.g. rashes, excessive dryness) ◯ Yes ◯ No _____

Musculoskeletal problems
(e.g. muscle aches, joint pain, swollen joints) ◯ Yes ◯ No _____

Neurologic problems
(e.g. numbness, weakness, headaches, paralysis) ◯ Yes ◯ No _____

Psychiatric problems (e.g. depression, anxiety) ◯ Yes ◯ No _____

Family and Social History:

Do any medical or eye diseases run in your family? ◯ Yes ◯ No - If Yes, please explain
(e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)

_____

_____

Do you smoke? ◯ Yes ◯ No, how much _____

Do you drink alcohol? ◯ Yes ◯ No, how much _____

If employed, how many hours per week do you work? _____

Comments: _____

_____

_____

Multiple Authorization Agreements

Name: _____ Social Security #: _____

1. **RELEASE OF INFORMATION:** Cornea & Refractive Consultants (VIP Laser Eye Center) may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Cornea & Refractive Consultants (VIP Laser Eye Center) for reimbursement for services rendered, and (2) any health care provider for continued patient care. Cornea & Refractive Consultants (VIP Laser Eye Center) may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data, or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

2. **NON-COVERED SERVICES:** I understand that Cornea & Refractive Consultants (VIP Laser Eye Center) contracts with health care service plans (i.e., HMOs, PPOs) that state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all Items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include but are not limited to services not specified as being covered In the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Cornea & Refractive Consultants (VIP Laser Eye Center) to obtain necessary health care service plan authorizations.

3. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Cornea & Refractive Consultants (VIP Laser Eye Center), for services furnished me by Cornea & Refractive Consultants (VIP Laser Eye Center). I authorize any holder of medical Information about me to, release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Cornea & Refractive Consultants (VIP Laser Eye Center) accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

4. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms; my signature authorizes release of the information to the Insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Cornea & Refractive Consultants (VIP Laser Eye Center), if possible or otherwise to me.

5. **OTHER INSURANCE:** I understand that Cornea & Refractive Consultants (VIP Laser Eye Center) maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Cornea & Refractive Consultants (VIP Laser Eye Center) has no contract, expressed or Implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Cornea & Refractive Consultants (VIP Laser Eye Center) if I belong to a plan that does not appear on the above mentioned list.

6. **FINANCIAL AGREEMENT:** I agree that In return for the services provided to the patient by Cornea & Refractive Consultants (VIP Laser Eye Center), I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Cornea & Refractive Consultants (VIP Laser Eye Center) for payment. If an account is sent to an attorney or collection agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by, the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Cornea & Refractive Consultants (VIP Laser Eye Center). If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Cornea & Refractive' Consultants (VIP Laser Eye Center). However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Signature: _____ Date: _____

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Cancellation Policy

Here at Cornea & Refractive Consultants (V.I.P. Laser Eye Center), we strive to schedule our patients in a timely manner. Our doctors give every one of our patients generous time and attention. We ask that you carefully consider your schedule when making your appointments to avoid last minute cancellations or no shows. Please call our office at least 24 hours prior to your scheduled appointment time to avoid the $20.00 fee. I agree that there will be a $20.00 fee charged to me for missed appointments or appointments cancelled within less than 24 hours notice.

Refraction Fee

Please be advised that eye refraction is NOT a covered service by Medicare nor by most insurance companies. This is the test to determine the best potential vision of each eye, as well as the eyeglass prescription. Our doctors feel that evaluation of the best corrected vision is an essential measurement to determine the health of the eye and unless a patient is 20/20 with or without correction, we may perform a Refraction as part of your examination and for some problem – oriented visits when indicated.

The fee for this part of the examination is $50.00 due at the time of the visit. This is not covered by insurance.

Dilation Consent Information

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is sometimes important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil and allow a better view of the inside of your eye, enabling us to detect any ocular pathology such as cataracts, glaucoma, macular degeneration, etc. As with many medications, there are some side effects of the drops used to dilate the pupil. These include temporary sensitivity to light and blurred vision; especially at near (in many cases the distance vision will be minimally affected). The side effects usually last several hours but rarely more than 6-8 hours. Driving may be more difficult, you may want to have someone available to drive you home if your eyes are dilated.

Signature: _____

Print Name: _____

Date: _____

Patient Consent Form

By signing this form, you are granting consent to Cornea & Refractive Consultants (V.I.P. Laser Eye Center) to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature: _____

Print Name: _____

Date: _____

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Exception to the Release of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

Street City State Zip

Exception for Disclosure: (Individuals or means whereby PHI may be released)

I authorize the following people to be involved in my care that may require a disclosure of PHI:

Individual's Name (Please Print)	Relationship to Patient

_____ _____

Signature of Patient Date of Request

For Practice Use Only:

_____ _____

Signature of Employee Receiving Request Date Received

Request for exception has been: ◯ Approved ◯ Denied

Reason for denial: _____

_____

_____

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