V.I.P. Laser Eye Center

Clifford L. Salinger, MD   Helayna E. Brown, MD

"Where Vision Is Precious and Safety comes First!"

Información – Nuevo Paciente

Información Personal **(Letra de molde)**

Nombre: ____ Fecha: _______________

Fecha nacimiento: _____________ Edad: _____ M / F Numero Seguro Social_________________

Dirección: ____
Calle   Cuidad   Estado   Código Postal

Teléfono: Casa: ____________________________ Celular: _____________________________

Dirección del Email: ________________________________@____________________________

Estado Civil: • Soltero-a • Casado-a • Viudo-a • Divorciado-a

Empleador: ____________________________________ Ocupación:______________________

Dirección del Empleador___________________________ Teléfono: ______________________

Referido por: Doctor _______________________ • Amigo/Pariente: ________________________

• Internet • Periódico Páginas Amarillas Televisión • Otro: _____________________________

Seguro(s)____

En caso de emergencia – a quien hay que notificar:

Nombre: ___________________________________ Parentesco: _________________________

Teléfono: Casa _____________________________ Celular:_____________________________

Acuerdos y compromisos financieros:

1. Por favor recuerde que el seguro está considerado un método de reembolso al paciente por facturas pagadas al doctor y no son sustitutos de pago. Algunas compañías pagan cantidades fija por ciertos procedimientos y otras pagan un porcentaje por el cargo. Es su responsabilidad pagar por cualquier cantidad que ha sido deducida u otra cantidad que no haya sido pagado por su seguro
2. En orden para controlar los gastos de facture, nosotros pedimos que los cargos, o deducibles sean pagados a la conclusión de cada visita.
3. Pido que el pago de Medicare autorizado y beneficios del seguro sean pagado y enviado a mí, por los servicios prestados. Autorizo que cualquier información médica concerniente a mi cuidado de salud pueda sea revelada a la administración, sus agentes u otra seguro que pueda tener, si la información es necesaria para determinar los beneficios o los beneficios pagaderos por servicios prestados. . .
4. Este acuerdo permanecerá en efecto hasta que yo lo revoque por escrito. Una copia foto estática de este acuerdo es considerada tan válida como un original. Entiendo que yo soy responsable financieramente por todos los cargos de facturas pagados o no por el seguro. Por tanto autorizo al asignado a dar información necesaria para asegurar el pago del mismo.

Firma: ____ Fecha: _________________________

11020 RCA Center Drive ▪ Suite 2001 ▪ Palm Beach Gardens, FL 33410
Phone: 561-624-7878 ▪ Fax: 561-626-5848 ▪ Website: VIPLaserEyeCenter.com

HISTORIA DEL OJO

Nombre: ____ Fecha: _______________________

Gracias por haber escogido nuestra oficina para el cuidado de sus ojos. Para servirle mejor, por favor conteste las siguientes preguntas:

1. ¿Usted usa espejuelos? ____ Sí ____ No
2. ¿Usted usa lentes de contacto? ____ Sí ____ No
3. ¿Usted tiene problemas cuando lee? ____ Sí ____ No

4. ¿Usted está experimentando cualquier de estos síntomas? (Circule donde aplique)

Dolor en el Ojo   Vista Borrosa   Parpados Arenosos   Destello de luz   Halos

Secreción   Sensibilidad a la luz   Visión Doble   Disminución de Vista

5. ¿Ha tenido herida en su ojo? Por favor describa:
   Tipo: ____ Derecho/Izquierdo Fecha:_________
   Tipo: ____ Derecho/Izquierdo Fecha:_________

6. ¿Ha tenido cirugía en su ojo?
   Tipo: ____ Derecho/Izquierdo Fecha:_________
   Tipo: ____ Derecho/Izquierdo Fecha:_________

7. ¿Ha tenido cualquier condición ocular? (por ejemplo: glaucoma, catarata, rotura de la retina, etc.)
____
____

8. ¿Está usando en estos momentos medicinas oculares? (Por favor anote los nombres y frecuencia)
____
____

9. ¿Está siendo tratado por cualquiera estas condiciones medica? (Por favor circule donde aplique)

Diabetes   Enfermedad Corazón   Presión Arterial Alta   Embolia

Artritis   Otras: ____

10. Medicinas que toman para las mencionadas (por favor anótelas) ______________________________
____
____

11. ¿Tiene alergia a alguna medicina? Por favor anótela: ____
____

12. ¿Tiene alergia a alguna comida? Por favor anótela: ____
____

13. ¿Algún familiar ha tenido problema ocular?

____ Glaucoma Parentesco:____________________________
____ Catarata Parentesco: ____________________________
____ Enfermedad Retina Parentesco: ____________________________
____ Degeneración Macular Parentesco: ____________________________

14. Por favor circule cualquiera de los siguientes que le gustaría tener más información:

____ LASIK ____ Keroplastia Conductiva ____ Síntomas de los Ojos Secos

Otras: ____

Historial Medico

Por favor conteste las siguientes preguntas acerca de su estado medico e historial:

1. ¿Ha tenido alguna vez cualquier tipo de cirugía? ____ Si ____ No (Si así es, por favor explique)

____
____
____

2. ¿Ha sido hospitalizado alguna vez? _____Si _____No (Si así es, por favor explique)

____
____
____

Análisis de los Sistemas:

Tiene en este momento o ha tenido cualquiera de los siguientes problemas:	**Si**	**No**	**Si así es, por favor explique:**
Fiebre crónica, perdida/ganancia de peso inesperado, fatiga……….	☐	☐	____________________
Problemas de oído/nariz/garganta (pérdida auditiva, garganta adolorida, etc.)	☐	☐	____________________
Problemas Cardiaco (angina, dolor de pecho, palpitaciones, etc.) ………………	☐	☐	____________________
Problemas Respiratorios (asma, falta de aire, etc.)……………………………	☐	☐	____________________
Problemas Gastrointestinales (acidez, dolor estomacal, diarrea, etc.)…………	☐	☐	____________________
Problemas urinarios (dolor o incomodidad, sangre en la orina, etc.)………………	☐	☐	____________________
Problemas de la piel (resequedad)………………………………………	☐	☐	____________________
Problemas músculos esqueléticos (dolores en los músculos, etc.)…………	☐	☐	____________________
Problemas neurológicos (adormecimiento, parálisis, dolores en la cabeza, etc.).	☐	☐	____________________
Problemas psiquiátricos (depresión, ansiedad, etc.)………………………	☐	☐	____________________

Historial Social y de la Familia:

¿Su familia tiene enfermedades de los ojos (diabetes, presión arterial alta)? ____ Sí ____ No
Si así es, por favor explique: ____
____
¿Usted fuma? ____ No ____ Si, ¿cuánto fuma? ______________________________
¿Bebe alcohol? ____ No ____ Si, ¿cuánto bebe? ______________________________
¿Si tiene empleo, Cuantas horas trabaja por semana? _________

____
FIRMA FECHA

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, is 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.

Signed: ____________________________________ Date: ________________________

Cancellation Policy

Here at Cornea & Refractive Consultants (V.I.P. Laser Eye Center), we strive to schedule our patients in a timely manner. Dr. Salinger gives every one of our patients his 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. Dr. Salinger feels 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 some one 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: ____

Date: ____

V.I.P. Laser Eye Center

Clifford L. Salinger, M.D. - Medical Director

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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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