

PATIENT REGISTRATION

Do you have an eye doctor? If yes, name of Eye Doctor:		Did your Eye Doctor send/refer you to the Filutowski Eye	
[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No Eye Doctor: _____		Institute? [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No	
Please indicate how you heard about us:		K92fm:	104.1fm
		106.7.fm	101.1fm
		Google	
Other Referral Source: _____			

Demographic Info

Last Name:		First Name:		MI:
DOB:	Sex: [<input type="checkbox"/>] M [<input type="checkbox"/>] F	Marital Status:		Race:
SSN (Required for reporting to Agency for Health Care Administration):				

Address

Local Address:		
City:	State:	ZIP Code:

Phone Numbers

Home Phone:	Mobile Phone:	Work Phone:
Where should we reach you during the day (8am – 5pm)? [<input type="checkbox"/>] Home [<input type="checkbox"/>] Mobile [<input type="checkbox"/>] Work [<input type="checkbox"/>] Other: (____) _____		
FEI may leave messages that might contain medical information at this number: [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No		Initials: <input style="width: 50px; height: 20px;" type="text"/>

Email

Email:	
FEI will use your email for business & personal correspondence only; we don't share email information with other entities.	
FEI may contact me via email [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No	I wish to receive monthly newsletters from FEI. [<input type="checkbox"/>] Yes [<input type="checkbox"/>] No

Billing Information (if different from above)

Billing address:		
City:	State:	ZIP Code:

Person to Contact in Case of Emergency: If the patient has a designated healthcare/financial surrogate or person with Power of Attorney, please provide a copy of the documentation for the patient's chart.

Last Name:	First Name:
Telephone #:	Relationship to Patient:

Medical Insurance: Please submit card(s) to receptionist.

Primary:	Secondary:
If this insurance information is incorrect, I understand charges are subject to patient responsibility.	
Initials: <input style="width: 50px; height: 20px;" type="text"/>	

Please complete the following if the insured person is NOT the patient:

Name of Insured Person:	DOB:
Relationship to patient: [<input type="checkbox"/>] spouse [<input type="checkbox"/>] parent	Phone # (if other than patient's):

IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Our doctors are here to provide you with the best medical care and their primary concern is your health and well-being. That is why it is very important for you to read and understand what your policy may or may not cover. We participate with numerous different insurance companies and each company has many different plans, therefore it is impossible for us to be aware of what each patient's particular plan will cover. FEI does not participate with Vision Plans.

We will verify your benefits and provide you with an ESTIMATE of what your patient responsibility will be. Again, this is only an ESTIMATE and true benefits cannot be determined until your insurance processes the claim. You are responsible for any additional patient responsibility once the explanation of benefits is received.

IMPORTANT NOTES: (1) PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S) & DRIVER'S LICENSE WITH YOU (2) PATIENTS CONFINED TO WHEELCHAIRS MUST BE ACCOMPANIED BY AN ABLE-BODIED ASSISTANT AT ALL TIMES

MEDICAL HISTORY INFORMATION

PA MRN
ASC MRN

Patient Information			
Last Name:		First Name:	
Today's Date:		Reason for Today's Visit:	
Are you pregnant or nursing? [] yes [] no		Number of Months:	
Are you HIV/ AIDS positive? [] yes [] no			
Patient's Height	ft	in	Patient's Weight lbs
			Patient's DOB

Eye Health History			
Previous Eye Injuries:	[] yes [] no	List:	
Previous Eye Surgery:	[] yes [] no	What:	When: Dr:
History Eye Disease:	[] yes [] no	What:	Treated With:
Family History of Eye Disease:	[] yes [] no	Who and What:	

General Health History			
Respiratory Difficulty (Asthma/Bronchitis/Emphysema)	[] yes [] no	Treated With:	
Anemia	[] yes [] no		
Convulsions/Epilepsy	[] yes [] no		
Fainting Spells	[] yes [] no		
CHF/Murmur	[] yes [] no	Treated With:	
Slow/Fast/Irregular Heart Rate	[] yes [] no	Treated With:	
Heart Attack(s)	[] yes [] no	When:	
Stroke(s)/TIA	[] yes [] no	When:	
Chest Pain/ Angina	[] yes [] no		
Heart Disease	[] yes [] no		
Angioplasty/Pacemaker	[] yes [] no		
Bypass Surgery	[] yes [] no		
High Blood Pressure	[] yes [] no	Treated With:	
Low Blood Pressure	[] yes [] no		
Diabetes	[] yes [] no	Treated With:	Last BSL: A1C:
Kidney Disease/Dialysis	[] yes [] no	Days of Dialysis:	
Thyroid Disease	[] yes [] no		
Difficulty Swallowing	[] yes [] no		
Other Medical Problems	[] yes [] no	List:	
Smoker	[] yes [] no	Years:	PPD:
Alcohol Use	[] yes [] no	Amount:	

Infection Health History			
History of Hepatitis	[] yes [] no	Type:	Active Now: [] yes [] no
History of Tuberculosis	[] yes [] no	Active Now: [] yes [] no	
History of antibiotic-resistant infection (MRSA, VRE, etc)	[] yes [] no	When:	Date Last Tested:
History of staph infection	[] yes [] no	When:	Date Last Tested:
Shingles	[] yes [] no		
C-Diff	[] yes [] no		

Patient's Name:

Patient's DOB:

PA MRN

ASC MRN

Additional Information

Disease or Condition not Listed:

Physicians & Pharmacy

Name of local eye doctor(s) who have treated you:

Primary Care Physician:

Phone:

Cardiologist:

Phone:

Emergency Contact:

Phone:

Preferred Pharmacy

Phone:

Allergies and Medications

Prescription Eye Drops yes no Reaction:

Prednisone Allergy yes no Reaction:

Betadine Allergy yes no Reaction:

Blood Thinners yes no List:

Latex Allergy yes no List: Reaction:

Other Allergies yes no List: Reaction:

Current Medications	Strength	Dosage	Frequency

This section to be completed by ASC staff

[x] _____ (LPN / RN / CRNA / MD) _____
Review of Information Date

[x] _____ (LPN / RN / CRNA / MD) _____
Update (if within 30 days) Date

**** Note: all wheelchair bound patients must be accompanied by an able-bodied assistant at all times who will be responsible for transferring the patient.****

FINANCIAL POLICY

Payment in full is due at the time of service at the Filutowski Eye Institute (FEI) unless this office participates with your insurance company or arrangements have been made prior to your appointment. We accept cash, check, Visa, MasterCard, Discover and American Express.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. You are responsible for knowing which physicians in our practice are participating with your insurance company. You are responsible for knowing what diagnosis and/or procedure(s) may or may not be considered for payment. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than supply factual information. You are responsible for any charges not paid by your insurance company within 60 days. (See also: "Important Information Regarding Insurance Billing" on Patient Registration form.)

ROUTINE EYE EXAMS: Patients are encouraged to have regular eye exams to check the health of their eyes. However, you should be aware that if you do not have any visual complaints or eye disease, medical insurance may not pay for the exam and any charges incurred will be your responsibility.

Please initial below to indicate you understand and agree to the following statements.

FEE FOR REFRACTION (\$50): (For medical/surgical purposes, not for glasses prescriptions) is a billable service NOT COVERED by health insurance and is therefore 100% my responsibility.

I understand that if I cancel an office visit appointment with less than 48 hours notice or do not show up, I will be charged a \$50 cancellation fee. I understand that if I cancel my surgery with less than 1 week notice, I will be charged a \$100 surgery cancellation fee. I understand that if I do not show up to my surgery, I will be charged a \$200 surgery no-show fee. I understand and agree to pay these fees if assessed.

FEI will file claims only with insurance companies with whom we participate. We will file with no more than two (2) insurance companies. If you have additional coverage, you are responsible for filing the claim.

PATIENT STATEMENT:

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. I understand that I have 30 days to pay off my balance before interest is applied at 18% per year. I certify that this information is true and correct to the best of my knowledge. I will notify FEI of any changes in my health status or the above information.

PATIENTS WITH MEDICARE COVERAGE: I certify that the information given by me in applying for payment under Title XVIII of the Medicare Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize such physician to submit a claim to Medicare.

NON-MEDICARE PATIENTS: I authorize the release of all medical information to my insurance company/companies and request that payment of my insurance benefits be sent directly to Filutowski Eye Institute (unless payment in full has been made at the time of service).

Patient Name (print):

Patient (or Guardian) Signature

Date

OFFICE USE
PA MRN

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:
FILUTOWSKI EYE INSTITUTE, P.A., LAKE MARY SURGICAL CENTER, SUNRISE SURGICAL CENTER

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

Initial

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers (insurance companies).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I may request a copy of your Notice of Patient Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization 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 a current copy of the Notice of Privacy Practices.

Initial

I understand that I may request in writing that Filutowski Eye Institute (FEI) restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand FEI is not required to agree to my requested restrictions, but if FEI does agree then FEI is bound to abide by them.

Initial

For patients who bring companions to their appointments: I understand that my private health information may be discussed at any time during any interaction between myself and the staff of FEI. If I allow my companions to be present during such interactions, my companions may be exposed to my private information. It is MY responsibility to exclude my companions from such conversations between myself and FEI staff if I do not wish my companions to be exposed to my private information.

Initial

I authorize FEI staff to leave messages pertaining to my appointments (FEI staff will not leave messages containing private medical information) by the following methods and assume responsibility to notify them whenever this information changes:

- Home phone/answering machine: yes no
- Work phone/voicemail: yes no
- Cell phone/voicemail: yes no

I authorize access to my protected health information for the following persons (optional):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand my rights as listed above. I authorize FEI to leave messages at the phone numbers indicated above and share protected health information for the above persons.

Patient Name (print): _____

Patient Signature: _____ Date: _____

***** OFFICE USE ONLY *****

I attempted to obtain the patient’s (or legal guardian’s) signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:
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CONSENT FOR DILATING EYE DROPS

In order to thoroughly examine your eyes and diagnose certain eye diseases such as glaucoma and macular degeneration, it is usually necessary to administer dilating drops. Dilating drops enlarge the pupil of the eye to allow for the examination of the inside of your eye; without pupil dilation, the doctor gets only a limited view of the eye. These drops usually cause blurred vision and make reading and focusing on near objects difficult or impossible until pupils return to normal size. The length of time that vision will be blurred and the degree of eyesight impairment varies from person to person. It is not possible to predict how much or how long your vision will be affected.

Driving even in low-light conditions may be difficult or impossible after an examination with dilating drops, and, if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

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.

PATIENT STATEMENT

I, (print name) _____, hereby authorize the Filutowski Eye Institute's staff doctors, technicians, or other assistants to administer dilating eye drops during the course of my treatment. I understand that these eye drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating eye drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated or by wearing sunglasses while driving.

If I am aware of any reason that I cannot or should not receive dilating drops, I agree to inform the clinic staff and my eye doctor *before any eye drops are administered* during the course of my exam.

Patient signature (or patient's authorized representative)

Date

Witness Signature

Date

CATARACT CONSULTATION QUESTIONNAIRE

Patient Name: _____

VISUAL FUNCTIONING

Because of your vision, do you have difficulty (even with glasses) with the following activities?

- | | | |
|---|---------|--------|
| 1. Reading small print, such as medicine bottles or food labels? | [] yes | [] no |
| 2. Reading a newspaper or book in good lighting? | [] yes | [] no |
| 3. Seeing your cell phone or tablet? | [] yes | [] no |
| 4. Recognizing people's faces? | [] yes | [] no |
| 5. Seeing steps, stairs, or curbs? | [] yes | [] no |
| 6. Reading street signs, road signs, or store signs? | [] yes | [] no |
| 7. Doing fine handwork like sewing, knitting, crocheting, or carpentry? | [] yes | [] no |
| 8. Writing checks or filling out forms? | [] yes | [] no |
| 9. Playing games such as bingo, dominoes, or card games? | [] yes | [] no |
| 10. Taking part in sports like golf, tennis, or bowling? | [] yes | [] no |
| 11. Cooking? | [] yes | [] no |
| 12. Reading captions on television? | [] yes | [] no |

SYMPTOMS

Have you been bothered by...

- | | | |
|---|---------|--------|
| 1. Poor night vision? | [] yes | [] no |
| 2. Seeing starbursting, rings or halos around lights? | [] yes | [] no |
| 3. Glare caused by headlights or bright sunlight? | [] yes | [] no |
| 4. Hazy and/or blurry vision? | [] yes | [] no |
| 5. Poor vision in low or dim light? | [] yes | [] no |
| 6. Poor color vision? | [] yes | [] no |

Continued on next page →



DRIVING

- 1. Do you currently drive a car? yes (continue) no (skip to #4)
- 2. How much difficulty do you have driving during the day because of your vision?
 No difficulty A moderate amount of difficulty
 A little difficulty A great deal of difficulty
- 3. How much difficulty do you have driving at night because of your vision?
 No difficulty A moderate amount of difficulty
 A little difficulty A great deal of difficulty
- 4. Have you stopped driving because of your vision? yes no only at night
- 5. If you have stopped driving (day or night), when did you stop?
 less than 6 months ago 6-12 months ago more than 1 year ago

WHICH EYE DO YOU FEEL IS MORE AFFECTED BY THE SYMPTOMS INDICATED?

- Both eyes equally affected
- Right eye more than left Left eye more than Right
- Right eye only (left eye not affected) Left eye only (right eye not affected)

Cataract surgery can usually be safely POSTPONED until you feel you need better vision. If new glasses DO NOT improve your vision and the only way to see better is cataract surgery, do you feel your vision is bad enough to consider cataract surgery now?

Right Eye yes no **Left Eye** yes no

This form was read to the patient by: _____

Patient Signature: _____

Date: _____

Reviewed By (Counselor): _____

Date: _____