FILUTOWSKI EYE INSTITUTE

OFFICE USE

PA MRN

PATIENT REGISTRATION

Do you have an eye doctor? If yes, name of Eye Doctor: [ ] Yes [ ] No | Eye Doctor:_____ | Did your Eye Doctor send/refer you to the Filutowski Eye Institute? [ ] Yes [ ] 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: [ ] M [ ] F	Marital Status: --	Race: --
SSN (Required for reporting to Agency for Health Care Administration):			

Address

Local Address:		
City:	State: Florida	ZIP Code:

Phone Numbers

Home Phone:	Mobile Phone:	Work Phone:
Where should we reach you during the day (8am – 5pm)? ☐ Home ☐ Mobile ☐ Work ☐ Other:		
FEI may leave messages that might contain medical information at this number: [ ] Yes [ ] No		Initials:

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 [ ] Yes [ ] No	I wish to receive monthly newsletters from FEI. [ ] Yes [ ] No

Billing Information (if different from above)

Billing address:		
City:	State: Florida	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:

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

Name of Insured Person:	DOB:
Relationship to patient: [ ] spouse [ ] 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

FILUTOWSKI EYE INSTITUTE

MEDICAL HISTORY INFORMATION

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Patient Information			
Last Name:	First Name:		MI:
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			

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Patient's Name: Patient's DOB:

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.****

FILUTOWSKI EYE INSTITUTE

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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***

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

FILUTOWSKI EYE INSTITUTE, P.A., LAKE MARY SURGICAL CENTER, SUNRISE SURGICAL CENTER

☐ *Initial*

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:

- 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.

☐ *Initial*

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.

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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PA MRN

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***

FILUTOWSKI EYE INSTITUTE

OFFICE USE

_____
COUNSELOR

_____
PA MRN

VISION CORRECTION SURGERY ASSESSMENT

HELP US GET TO KNOW YOU

Name:	Today's Date:	
Occupation:	Date of Birth:	Weight: lbs
How long have you been considering vision correction surgery?		
Why are you interested in vision correction surgery?		

Check any frustrations below that you have with glasses

- ☐ Fogging up when you open the oven/dishwasher/car
- ☐ Not being able to wear sunglasses
- ☐ Slipping down your nose or hurting your nose
- ☐ Not being able find your glasses because you can't see
- ☐ Not being able to see in the shower or pool
- ☐ Other: _____
- ☐ N/A: I don't wear glasses

Check any frustrations below that you have with contacts

- ☐ Loosing a contact at work and having to go home
- ☐ Getting make-up, soap, sunscreen etc. in your contacts
- ☐ Only being able to swim with goggles
- ☐ Dry eyes or itching/irritation
- ☐ Forgetting contacts/solution/a case while on vacation
- ☐ Other: _____
- ☐ N/A: I don't wear contacts

Without glasses or contacts can you see well enough to…

- ☐ yes ☐ no Read the alarm clock when you wake up
- ☐ yes ☐ no Drive in an emergency
- ☐ yes ☐ no Rescue a family member in case of a fire or an emergency
- ☐ yes ☐ no Cook a meal
- ☐ yes ☐ no Navigate an unknown area/new city

What lifestyle limitations are you currently dealing with because of your glasses or contact lenses?

_____

_____

What limitations are you currently dealing with at work because of your glasses or contact lenses?

_____

_____

Why haven't you had vision correction surgery yet? _____

HELP US GET TO KNOW YOUR VISION

When was the last time you wore contact lenses? _____ **What kind of lenses were they?** [ ] hard [ ] soft

Your distance prescription in glasses/contacts has been stable (hasn't changed) in how many years? _____ years

Do you have prism in your eyeglasses? ☐ don't know ☐ yes ☐ no

Have you been pregnant or nursing within the last six weeks? ☐ yes ☐ no

Do you have keratoconus? ☐ yes ☐ no

Have you had herpes simplex infection of your eye in the past? ☐ yes ☐ no

Do you have nighttime visual symptoms such as glare, halos, or starbursting? ☐ yes ☐ no

If yes: ☐ mild ☐ moderate ☐ severe

Have you had previous eye surgery? ☐ yes ☐ no

If yes, please explain: _____

Perfect vision after vision correction surgery cannot be guaranteed. Are you willing to accept this fact? ☐ yes ☐ no

HELP US SAY THANK YOU

Who is your eye doctor? **Did they refer you to us?** ☐ yes ☐ no

How did you hear about us?

- ☐ Radio
  - Which station:____
- ☐ Word of Mouth
- ☐ Google
- ☐ Facebook
- ☐ Instagram
- ☐ Friend/Family Member
  - Awesome! Who is it: _____