FISHER EYE & LASER CENTER
Eye Care You Can Trust.

PATIENT REGISTRATION

****PLEASE PRINT****

LAST NAME **FIRST NAME** **MI**

Date of Birth Age SS#

Primary Physician Previous Eye Doctor

How did you hear about us?

❑ Yellow Pages ❑ Church Bulletin ❑ Advertisement ❑ Internet ❑ Friend/Family _____

❑ Referring Doctor _____ ❑ Other _____

Patient's Local Address

City State Zip Home Phone #

Cell Phone # Email Address (will remain inhouse)

Patient's Out of State Address What months are you out of state?

City State Zip Home Phone #

Marital Status Gender

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Male ❑ Female

Employer Occupation

Employer's Address Employer's Phone #

Emergency Contact Name Relationship Phone Number(s)

Primary Insurance Carrier Subscriber, if not patient

Secondary Insurance Carrier Subscriber, if not patient

PLEASE PRESENT YOUR PHOTO ID AND INSURANCE CARDS TO THE FRONT DESK.

Office Use Only

Date: _____

Initials: _____

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HEALTH HISTORY

****PLEASE PRINT****

LAST NAME	FIRST NAME	MI

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ❑ NO ❑ YES

Do you use tobacco products? ❑ NO ❑ YES If YES, what type, amount and for how long? _____

Do you drink alcohol? ❑ NO ❑ YES If YES, what type, amount and for how long? _____

Please list all **current medications**, including eye drops and non-presciption medications, in the space below.

❑ Check here if list given to staff

Please list all **allergies to medications or foods, and seasonal allergies,** in the space below.

Please list all dates and type of **surgery, including eye surgery,** in the space below.

GENERAL HEALTH

Do you currently have any problems in the following areas? **If YES, please provide additional information in the section below.**

	Yes	No	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES - Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases? **YES** (circle all that apply) **NO** **UNKNOWN**

Blindness / Cataract / Macular Degeneration / Glaucoma / Diabetes / Hypertension / Heart Disease / Stroke / Cancer / Thyroid Disease / Arthritis

Other heritable disease:

Patient's Signature _____ Date: _____

Physician's Signature _____ Date: _____

FINANCIAL POLICY

****PLEASE PRINT****

LAST NAME	FIRST NAME	MI

Medicare Part B
The Fisher Eye Center participates with Medicare Part B. We will accept assignment on all Medicare Part B claims. By accepting assignment, we agree to adjust your charges to reflect the Medicare approved amount. However, Medicare only pays 80% of the approved amount, and the remaining 20% is your responsibility. If you have supplemental insurance, we will bill your supplement insurance for the 20% balance. ***If there is any remaining balance after Medicare and the supplement insurance payment, it is the patient's responsibility.***

Private Health Insurance
As a courtesy to you, we will file claims with your insurance company. Please understand, however, that your insurance reflects a contract between you and the insurance company, not the Fisher Eye Center. You, as the patient, are ultimately responsible for your bill. ***Patients without health insurance will be expected to pay at the time of service or to make payment arrangements with the billing office. We may also collect at the time of service, any fee that will be paid directly to you from your insurance company, as well as any co-pay or deductible amounts.***

Managed Care Networks
Fisher Eye Center's providers participate with BCBS Florida and Community Health Partners (CHP). We will file claims to BCBS Florida and those CHP insurers and organizations with whom Fisher Eye Center's is contracted. Co-pays, co-insurance and/or deductibles will be due at the time of service.

Usual. Reasonable and Customary
Some insurance carriers have established "usual" and "reasonable and customary" maximum amounts that they will pay for specific procedures. These amounts may vary with each insurance company. Any amount considered in excess of the "usual" and "reasonable and customary" amount that is not paid by the insurance company, becomes the patient's responsibility.

Non-Covered Services
Not all services are covered by all insurance health plans. Some services may not be covered by your specific or individual policy. ***Services not covered or considered payable by the insurance company becomes the patient's responsibility.***

Vision Insurance
Routine vision exams where there is no medical complaint or diagnosis, will be filed to your vision plan if applicable. If you have a medical complaint or diagnosis, your exam will no longer be considered routine. In these instances, we are required to bill your examination to your medical insurance.

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to liquidate the account

I request that payment of authorized Medicare benefits be made on my behalf to FISHER EYE & LASER CENTER for any services furnished me by this provider.

I hereby assign and transfer any insurance benefit due me for the professional services that I have received, to the FISHER EYE & LASER CENTER.

I authorize the release of any medical information necessary to process insurance claims.

_____ _____

Signature of Patient (or responsible party) **Date**

Refraction Policy

PLEASE PRINT

LAST NAME	FIRST NAME	MI

What is a Refraction?
Refraction is the process of determining the amount of nearsightedness, farsightedness and astigmatism, that is required, to obtain your best-corrected vision. This process is needed to create a glasses and/or contacts prescription.

Why is it necessary?
Refractions are sometimes necessary, depending on the patient's diagnosis and/or complaints, at the time of their exam. For example, if a patient is experiencing blurred vision or decreased visual acuity, a refraction is needed to help determine if the decreased vision is associated with a medical condition or the need for an updated glasses prescription.

How much is the refraction?
The charge for this service is **$48.00**.
Medicare and most medical insurances will NOT cover the routine refraction portion of your exam. We are *required by Medicare* to charge separately for the refraction portion of your examination, given that it is considered a non-covered service.

What if I do not want the refraction?
At the beginning of your exam, let your technician know that you decline to have a refraction. If you opt out of having this test, you will NOT be given an updated glasses prescription. We recommend getting your prescription filled, within 60 days of service date. We will guarantee prescriptions with a 60-day grace period. After 60 days, there will be an additional fee for all glasses checks and/or remakes, to verify your prescription.

Acknowledgement:
I have read the above information and understand that the refraction could be a non-covered benefit. If the test is performed or I fail to decline the test, prior to it being done, I am responsible for the fee.

_____ _____

Signature of Patient (or responsible party) **Date**

HIPAA
Disclosure of Information

****PLEASE PRINT****

LAST NAME	FIRST NAME	MI

RELEASE OF INFORMATION TO OTHERS

- ❑ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
  - ❑ Spouse_____
  - ❑ Child(ren)_____
  - ❑ Other_____
- ❑ Information is not to be released to anyone.

This Release of Information will remain in effect until revoked by me. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact.

The following information WILL NOT be disclosed without a proper Authorization to Disclose PHI: acquired immunodeficiency syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse.

I understand that I have a right to verbally revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire at the time of discharge or end of treatment.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

If I have questions about the disclosure of my health information, I can contact the privacy officer at 239-431-7070.

MESSAGES

Please call ❑ my home ❑ my work ❑ my cell

If unable to reach me:

- ❑ you may leave a detailed message
- ❑ please leave a brief message asking me to return your call for details

_____ _____

Signature of Patient (or responsible party) **Date**

HIPAA – Consent for Use and Receipt of NPP

PLEASE PRINT

LAST NAME	FIRST NAME	MI

The patient above hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Fisher Eye & Laser Center in order to carry out treatment, payment and healthcare operations. The patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information, the patient has a right to review this document prior to signing this consent.

Fisher Eye & Laser Center has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the patient has a right to obtain a copy of the revised Notice.

At all times the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective *except* to the extent that Fisher Eye & Laser Center has already taken action in reliance upon this Consent.

Fisher Eye & Laser Center may refuse to treat the patient if he/she (or authorized representative) does not sign this Consent form. Fisher Eye & Laser Center has the right to refuse further treatment after the time this Consent is revoked (except to the extent Fisher Eye & Laser Center is required to provide treatment under the law).

Fisher Eye & Laser Center has published a HIPAA 'Notice of Privacy Practices' (NPP).

ACKNOWLEDGEMENT
I have been informed and provided a copy of the NPP, if requested.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEVIED A COPY OF THIS CONSENT, AND AM THE PATIENT OR AUTHORIZED TO ACT ON THEIR BEHALF TO SIGN THIS SEALED DOCUMENTVERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____
Patient (or Legally Authorized Representative) **Date**

_____ _____
Relationship to Patient (if Signed by Another Party) **Date**

_____
Employee Initials

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SPEED Questionnaire

****PLEASE PRINT****

LAST NAME	FIRST NAME	MI

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please *answer the following questions by placing an **X** in the box that best represents your answer*. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

Symptoms	At this visit		Within past 72 hours		Within past 3 months	
	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue (Tiredness)						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	0 Never	1 Sometimes	2 Often	3 Constant
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue (Tiredness)				

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	0 No Problems	1 Tolerable not perfect, but not uncomfortable	2 Uncomfortable irritating, but does not interfere with my day	3 Bothersome irritating and interferes with my day	4 Intolerable unable to perform my daily tasks
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue (Tiredness)					

4. Do you use eye drops for lubrication? ❑ **No** ❑ **Yes** **If yes, how often?** _____

Office Use Only

Total SPEED score (Frequency + Severity) = _____ / 28

_____ Date

_____ Tech initials