OCALA EYE, P.A.

001

PATIENT INFORMATION RECORD

CHART # _____ DR #_____ DATE: _____

PATIENT'S NAME (PLEASE PRINT)	SS #	BIRTH DATE	AGE	SEX M F
MAILING ADDRESS PERMANENT TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE #	
EMAIL ADDRESS		CURRENT HEARING AID USE? Y / N		
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG?	BUSINESS PHONE	
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE	

MARITAL STATUS					SPOUSE OR PARENT'S NAME	SS #	BIRTH DATE
S	M	W	D	SEP			

The Federal Government requires us to ask the following as part of the American Recovery and Reinvestment Act.			
RACE (Please circle one):			
American Indian or Alaskan Native Alone	Asian	Black or African American	Native Hawaiian or other Pacific Islander
White	Other	Unknown or Decline to provide	
Ethnicity (Please circle one):			
Hispanic or Latino	Non-Hispanic or Non-Latino	Unknown or Decline to provide	
Language Preference (Please circle one):			
English	Spanish	Other:	

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU		PHONE #	
REFERRING PHYSICIAN		PHONE #	HOW DID YOU HEAR ABOUT US?
PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP CODE	HOME PHONE #

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE	ID/POLICY #	GROUP #
SUBSCRIBER'S NAME	SS #	BIRTH DATE
INSURANCE ADDRESS:		
SECONDARY / SUPPLEMENT INSURANCE	ID/POLICY #	GROUP #
SUBSCRIBER'S NAME	SS #	BIRTH DATE

I hereby authorize all licensed professionals employed by Ocala Eye to perform such professional diagnostic, laboratory, medical, and surgical procedures as are necessary in their judgement and to render such care and services as are customary and necessary.

Signature_____ Date_____

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ D.O.B. _____ DATE: _____

Date of last eye exam: _____ Referred by: _____

PREFERRED METHOD OF CONTACT: ☐ Home phone ☐ Cellphone ☐ E-mail ☐ Mail ☐ Text ☐ Other: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____ FAX: _____

RACE: Please pick one ☐ American Indian or Alaskan Native Alone ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Unknown or Decline to provide

ETHNICITY: Please pick one ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown or Decline to provide

PREFERRED LANGUAGE:

Do you have any **ALLERGIES** to any medications (including eye drops, food, animals, hay fever, etc.)? ☐ YES ☐ NO

IF YES, list all the medications, substances, and type of allergic reactions:

_____

_____

Please list all **MEDICATIONS** that you currently take and for what reason you are taking them, including **EYE MEDICATIONS** and over the counter meds (list the strength and how often you take it):

Medications and reason	**Strength (dose)**	**Frequency (how often)**

EYE HISTORY : Have you ever been told you have any of the following eye conditions?

	YES	NO	Explanation (year diagnosed, dates of surgery/laser)
Do you currently wear glasses?	☐	☐	If yes, how long have you had current pair? ___yrs
Amblyopia (a lazy eye)	☐	☐	
Cataracts	☐	☐	
Glaucoma (high eye pressure, optic nerve damage, visual field defects)	☐	☐	
Macular degeneration	☐	☐	
Retinal tear or detachment	☐	☐	If yes, how was it treated ? [ ] Freezing/laser [ ] Surgery When? _____
Strabismus (crossed eyes)	☐	☐	
Other	☐	☐	

MEDICAL HISTORY AND REVIEW OF SYSTEMS: Have you ever been **DIAGNOSED** with any of the following illnesses or do you **CURRENTLY** have any **SYMPTOMS/PROBLEMS** in any of the following areas? Please check the box if listed, or write in the diagnoses under "other".

SYSTEM	SYMPTOMS/PROBLEMS	YES	NO
GENERAUCONSTITUTIONAL	Fever	☐	☐
HEAD,EYES, EARS, NOSE, THROAT	Sinus problems	☐	☐
	Hearing loss	☐	☐
RESPIRATORY	Asthma	☐	☐
CARDIOVASCULAR	Arrhythmia	☐	☐
GASTROINTESTINAL	Vomiting	☐	☐
METABOLIC/ ENDOCRINE	Heat intolerance	☐	☐
NEUROLOGICAL	Balance disturbances	☐	☐
INTEGUMENTARY	Dry skin	☐	☐
	Rash	☐	☐
MUSCULOSKELETAL	Joint swelling	☐	☐
HEMATOLOGIC/ LYMPHATIC	Bleeding	☐	☐
OTHER (Anything for which you see a health care provider on a regular basis)			

Please also **list any surgeries** you have had and approximate date of the procedure.

FAMILY HISTORY M = mother F = father B = brother S = sister GP = grandparent C = child

DISEASE	YES	NO	RELATIONSHIP	DISEASE	YES	NO	RELATIONSHIP
Blindness	☐	☐	oM oF oB oS oGP oC	Cataracts	☐	☐	oM oF oB oS oGP oC
Glaucoma	☐	☐	oM oF oB oS oGP oC	Macular Degeneration	☐	☐	oM oF oB oS oGP oC
Cancer	☐	☐	oM oF oB oS oGP oC	Diabetes	☐	☐	oM oF oB oS oGP oC
Heart disease	☐	☐	oM oF oB oS oGP oC	Kidney disease	☐	☐	oM oF oB oS oGP oC
Hypertension	☐	☐	oM oF oB oS oGP oC	Arthritis	☐	☐	oM oF oB oS oGP oC
Lupus	☐	☐	oM oF oB oS oGP oC	Stroke	☐	☐	oM oF oB oS oGP oC
Thyroid disease	☐	☐	oM oF oB oS oGP oC	Other	☐	☐	oM oF oB oS oGP oC

SOCIAL HISTORY

Have you ever smoked? ☐ YES ☐ NO Age started: ____ Age stopped: ____

Tobacco Type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chewing ☐ Smokeless ☐ Snuff

ADVANCE DIRECTIVES (check all that apply)

I have: ☐ Living Will ☐ Power of Attorney (POA) Type of POA _____

I am interested in receiving information regarding Advance Directives ☐ Yes ☐ No

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Name: _____

Email address: _____

REFRACTIVE SURGERY EVALUATION QUESTIONNAIRE

1. How did you hear about Ocala Eye? _____

2. Do you currently or have you taken any of these in the past 6 months:

Amiodarone ☐	Imitrex ☐	Treximet ☐
Cordorazone ☐	Acutane ☐	
Axert ☐	Frova ☐	
Amerge ☐	Zomig ☐	
Relpax ☐	Sansert ☐	

3. Do you have a pacemaker? ☐ Yes ☐ No

4. (If patient is female) Are you or have you been pregnant/nursing in the last six months? _____
   Are you planning a pregnancy in the near future? _____

5. How long have you been wearing?

Glasses: _____

Contact Lenses:
Gas Permeable (hard) _____
Soft/Disposable_____

6. What type of work do you do? _____

7. What type of hobbies do you have? _____

8. How do your glasses/contacts affect your participation in work/leisure activities?

   _____

9. What prompted you to consider having refractive surgery? _____

   _____

10. What are your expectations from the surgery? _____

RN Initials _____

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Ocala Eye, we are committed to treating and using protected health information about you in a responsible manner. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Ocala Eye, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Ocala Eye, the information belongs to you. You have the right to:

- Inspect and copy your health record as provided for in 45 CFR 164.524 and 42 USC § 17935(e). To the extent that Ocala Eye maintains an electronic health record, you have the right to obtain a copy of such information in an electronic format and to direct Ocala Eye to transmit such copy directly to an entity or person you designate, provided that such designation is clear, conspicuous, and specific,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528 and 42 USC § 17935(c),
- Receive confidential communications of your protected health information,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 and 42 USC § 17935(a). You should be aware that Ocala Eye is not required to agree to a requested restriction, unless the disclosure for which restriction is requested is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of treatment) and the information pertains solely to a health care item or service for which Ocala Eye has been paid out of pocket in full,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to protected health information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. You may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to you or asking for one at the time of your next appointment.

We will not use or disclose for marketing purposes or sell your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at (352) 622-5183.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the Privacy Officer and/or OCR is listed below:

Privacy Officer
Ocala Eye
3130 S.W. 32nd Avenue
Ocala, FL 34474

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Care Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We may use and disclose medical information about you to doctors, nurses, technicians, or other health care professionals who are involved in taking care of you. Health care professionals may also share medical information in order to coordinate the different services you need, such as lab work and x-rays, or the provision of a prescription(s).

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business associates: There are some services provided in our organization through contracts with business associates. Examples include NextGen Software Company, Credit Bureau, web-based appointment reminders/communication system, transcription service, and consultants. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Appointment and Appointment Reminders: We may ask that you sign in at the Receptionist's desk on the day of your appointment at Ocala Eye. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with Ocala Eye or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, text, and may involve the leaving an e-mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others.

Emergencies: We may use or disclose your protected health information in an emergency situation. If this happens, your physician will try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, the health information relevant to that person's involvement in your care or payment related to your care.

Research: With your authorization, we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Treatment Alternatives: We may contact you about treatment alternatives, other health-related benefits or services that may be of interest to you.

Fundraising activities: We may use and disclose your contact information to raise money. If you do not want to be contacted for fundraising efforts, you must notify us.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Breach Notification

Federal law requires that you be notified without unreasonable delay in the event of a breach of unsecured protected health information. (A breach is an acquisition, access, use, or disclosure of protected health information in a manner which is not permitted under applicable law which compromises the security or privacy of the information.) We will notify you of a breach no later than 60 days from our discovery of the breach, unless another time frame is specified by applicable law. This notice will be given to you by first class mail to the last known address. If the breach includes protected health information for more than 500 individuals, we are required to notify the media as well as Department of Health & Human Services.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that an Ocala Eye staff member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Ocala Eye will do everything possible to ensure your privacy. Maintaining both the confidentiality and the privacy of our patient's personal and medical information is of utmost importance to the staff of Ocala Eye.

NOTICE OF PRIVACY POLICIES

FOR

OCALA EYE, P.A.

and our Affiliates:

OCALA EYE OPTICAL, INC.

OCALA EYE SURGERY CENTER, INC.

Revision Date 9.2013

Acknowledgement of Receipt of Privacy Notice


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I have been presented with a copy of Ocala Eye's **Notice of Privacy Polices**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and if I have a request for restriction(s) concerning the use of my personal medical information, I will submit my request in writing to the Privacy Officer of Ocala Eye.

Print Name:_____

Signed: _____ Date:_____

If not signed by the patient, please indicate your relationship to the patient (e.g. spouse)

Relationship: _____
Witnessed by: _____

IF PATIENT REFUSES TO SIGN, DOCUMENT YOUR ATTEMPT TO OBTAIN A SIGNATURE.

[ ] Patient refused to sign this Acknowledgement.
[ ] Other_____

Date:_____ Time:_____ Employee Name:_____

MEDICAL/FINANCIAL RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize
Patient Name

Ocala Eye, P.A. to release information about my medical and financial records if requested by:

Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number

_____ _____
Signature of Patient or Legal Guardian Date

001

OCALA EYE, P.A.

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name *(print)*

Medicare/ Insurance Policy Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Ocala Eye, for services furnished me by Ocala Eye. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly 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 CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Ocala Eye accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS 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 Ocala Eye, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Ocala Eye 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 Ocala Eye for reimbursement for services rendered, and (2) any health care provider for continued patient care. Ocala Eye 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.

4. **OTHER INSURANCE:** I understand that Ocala Eye maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. Ocala Eye 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 Ocala Eye if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Ocala Eye's contracts with health care service plans (i.e., HMOs, PPOs) relate only to 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 Ocala Eye to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Ocala Eye, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Ocala Eye for payment. If an account is sent to an attorney 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 Ocala Eye. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Ocala Eye. *However, it is understood that the undersigned andlor the patient are primarily responsible for the payment of my bill.*

7. I understand that situations may arise where an overpayment may result from billing or payment errors. In these cases, I understand that any amounts owed to me will be refunded promptly. If, however, there is an overpayment at the time that there is a balance due to a related entity of Ocala Eye, including Ocala Eye P.A., Ocala Eye Surgery Center, or Ocala Eye Optical, then I consent to the transfer of funds to the related entity in order to retire any amount owed to that related entity.

Patient Signature or Authorized Party

Date