Palm Beach Eye Center

The Eye Center for Children and Adults

Mr. Mrs. Ms. Dr. **DOB:** **SSN:**

NAME: **EMAIL:**

STREET ADDRESS **APT**

CITY **STATE** **ZIP**

HOME PHONE **CELL PHONE** **WORK PHONE**

EMERGENCY CONTACT **PHONE NUMBER**

How were you referred to our office:

- □ Previously Patient
- □ Yellow Pages
- □ Insurance Plan
- □ PBEC Website
- □ Lecture
- □ Health Fair
- □ Doctor – Name: _____
- □ Friend/Family – Name: _____
- □ Attorney – Name: _____
- □ Search Engine: _____
- □ Journal/Magazine/Newspaper: _____
- □ OTHER (please explain): _____

List the names we can fully discuss your medical condition with:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

REASON FOR VISIT:

Routine - No Particular Problems	Diabetic Eye Exam	Referred by Physician
Possible Medical or Surgical Problem	Contact Lenses	Study Participant

Other, Please Explain:

CHECK IF YOU HAVE THE FOLLOWING PROBLEMS:

Blurr/Fuzzy Vision	Tearing or Discharge	Burning	Itching	Redness
Floaters/Cobwebs	Flashing lights	Problems with Glasses		

Other, Please Explain:

What are your allergies? Please specify.

I hereby authorize that payment from my medical insurance program or my Medicare benefits be made directly to Palm Beach Eye Center, INC, for any unpaid bills for services provided to me on or after today. I understand that I will be financially responsible for any balance not covered by my insurance carrier.

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 payable for related services.

Signature_____ Date_____

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A **refraction** is an essential part of your eye examination to determine the health of your eyes. It is the test to determine your best vison, eyeglass prescription and the shape of your eyes.

Please help us by placing a check next to the following statements if it applies to you.

1.____ I am being evaluated for **cataract surgery** or **cataracts**.

2.____ I have **double vision**.

3.____ I have new **eye strain** and/or **headaches**.

4.____ I recently had a **stroke** or **loss of vision**.

5.____ I currently wear **contact lenses** and **request a new prescription or renewal of my current prescription,** or want to wear contacts lenses.

6.____ I am here for a **change in my vision**.

7.____ I would like a **new eyeglass prescription**.

8.____ Myself or my child is being treated or evaluated for **decreased vision** or the **eyes are not in alignment**.

9.____ I am here for an annual eye exam or another eye condition.

If you have placed a check on any of 1-8, a refraction is required. Please check one of the following:

_____ I wish to have a thorough and complete examination, as well as diagnosis and treatment plan, and I accept the refraction and agree to pay the $70 fee.

_____ I have checked boxes 1-8, yet I am refusing refraction. I understand this will prevent my doctor from giving me a proper diagnosis and treatment plan, and I will not be seen today. I accept responsibility for any delay to treatment.

_____ I have checked box 9 and a refraction is not required but strongly recommended for the annual examination.

SIGNATURE: _____

NAME: _____

DATE: _____

CONSENT FOR DILATING EYE DROPS

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. While dilated you may experience glare, difficulty focusing and contrast. It is not possible for your ophthalmologist to predict how much your vision will be affected. However, we advise not to operate any motorized vehicle or machinery as well as getting assistance with electric wheelchairs due to the risk of falling and/or injury. Because operating any motorized vehicle may be difficult after an examination, it is best if you make arrangements not to drive yourself.

Adverse reactions occur rarely, however dilating drops can provoke acute angle-closure glaucoma, allergic reactions, increased blood pressure, irregular heart rates, dizziness, and increased sweating. This is extremely rare and treatable with immediate medical attention. If your child is dilated and you notice any agitation or unusual response contact us or the emergency room immediately. Additionally we recommend sun glasses which we can provide to you

I hereby authorize Palm Beach Eye Center and/or such assistants as may be designated by to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

NON-HMO PATIENTS

I certify that I am not a member of any Health Maintenance Organization (HMO). If I am enrolled in an HMO or fail to get proper authorization prior to treatment, I agree to take full responsibility of any charges that I may incur.

_____ _____

Signature of Patient Date

HMO PATIENTS

I certify that I am a member of the Health Maintenance Organization listed below. I am aware that it is my responsibility to make sure that I have proper authorization in order for services to be covered. I will take full responsibility for any charges, which are not covered due to lack of proper authorization.

Name of HMO of which I am currently a member_____

_____ _____

Signature of Patient Date

I certify that I am enrolled in an Health Maintenance Organization (HMO), which Palm Beach Eye Center, Inc. may or may not have a participating provider agreement. I prefer to be seen without waiting for the necessary authorization. I will take full responsibility for the entire amount of any charges that I may incur.

_____ _____

Signature of Patient Date

_____

Witness

SKILLED NURSING FACILITY PATIENTS

I certify that I am not currently admitted or reside in a skilled nursing facility.

_____ _____

Signature of Patient Date

_____

Witness

Palm Beach Eye Center

NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY

This Notice is Effective as of: September 23, 2013

This is only a summary of our Notice of Privacy Practices. The complete notice is available so you may learn how we use and disclose medical information about you and your rights concerning these uses and disclosures. You may request a printed copy (*there is an associated fee*) or obtain a copy of this notice on our website; *www.palmbeacheyecenter.com.*

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record. (There are fees associated with copying the records)
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights at:

Jay S. Wallshein, M.D.
5057 S. Congress Ave, Suite 403, Atlantis, FL 33461 (561) 433-5200

By Signing below I acknowledge I have received the summary of Palm Beach Eye Center, Inc. Notice of Privacy Practices and was offered the full Notice upon request effective September 23, 2013.

Patient Name: _____
Signature:_____ (please print)
Date: _____

I am a parent or legal guardian of the above named patient. I have received the summary of Palm Beach Eye Center, Inc. Notice of Privacy Practices and was offered the full Notice upon request effective September 23, 2013.

Signature:_____ Date: _____
Relationship to patient: ___Self ___Parent ___Legal Guardian

Palm Beach Eye Center

EASY PAY FORM

REQUIRED
Must be filled out in entirety

Patient Name _____ **DOB** _____

If we are a participating provider for you health insurance, we will file insurance claims to your company. However, if a service performed by your doctor is denied, not a covered service or you are found to have a deductible or co-insurance amount, you will be responsible for paying the balance with the Easy Pay Form.

WHAT IS THE EASY PAY FORM? WHY IS IT NECESSARY?

Occasionally you will have deductibles and co-insurance obligations unbeknownst to us that have been set by your insurance company, leaving a balance on your bill. We will always attempt to warn you if we believe a service may not be covered. However, ultimately the insurance contract is between you and your insurance company.

If we receive notice that there is a balance on your account; payment will be processed with the Easy Pay Form. Please complete the information below to authorize future payment for any balance which will be out of pocket expense, as determined by your insurance company only. Your billing information will be kept confidential and be guarded by the same privacy standards used for your medical records.

I authorize Palm Beach Eye Center to keep my signature on file and to charge my credit card for the patient responsibility portion of any balances incurred by me.

_____

Cardholder's Signature