EYE FLORIDA
ADVANCED MEDICAL • SURGICAL • AESTHETIC SERVICES

Ly T. Nguyen, M.D. • Board Certified Ophthalmologist • office: 407-891-2010 • fax: 407-891-8211 • www.eyeflorida.com

MEDICAL HISTORY FORM

NAME: _____ **GENDER: Male / Female SSN:** _____

DATE OF BIRTH: _____ **ADDRESS, CITY, STATE & ZIP CODE:** _____

CELL PHONE NUMBER: _____ **EMAIL ADDRESS:** _____ **PRIMARY CARE DOCTOR:** _____

INSURANCE CARRIER: _____ **PRIMARY MEMBER OF INS. NAME/DOB:** _____ **MEMBER ID:** _____

REFERRED BY: _____ **PHARMACY:** _____ **PHONE/ADDRESS:** _____

OCCUPATION: _____ **HOBBIES:** _____

CURRENT MEDICATIONS: _____

_____ **MEDICATION ALLERGIES:** _____

NAME OF RESPONSIBLE PARTY: _____ **REASON FOR YOUR VISIT TODAY:** _____

DO YOU WANT TO HAVE A REFRACTION (A DIAGNOSTIC TEST) TO UPDATE YOUR GLASSES? YES ____ NO ____ DO YOU HAVE A VISION INS PLAN? YES / NO
CONTACT LENS HISTORY: DO YOU CURRENTLY WEAR CONTACTS? YES ____ NO ____ WOULD YOU LIKE A CONTACT LENS EVALUATION TODAY? YES ____ NO ____

******Reviewed by FD _____*

DO YOU CURRENTLY, OR DID YOU EVER, HAVE PROBLEMS IN THE FOLLOWING AREAS? IF YES, PLEASE PROVIDE EXPLANATION:

MEDICAL HISTORY	YES	NO	EXPLANATION OF PROBLEM
Cardiovascular (Heart Disease, High Blood Pressure, etc.)			
Neurological			
Gastrointestinal			
Kidney, Bladder			
Skin			
Psychiatric			
Eyes, Ears, Nose, Throat			
Endocrine/ Diabetes /Thyroid Disease			
Respiratory			
Muscles, Bones, Joints			
Cancer			
List all major illnesses and injuries, including surgeries (other than eyes)			

OCULAR HISTORY	YES	NO	EXPLANATION
Glaucoma			
Macular Degeneration / OTHER			
List all eye surgeries (date/physician)			

FAMILY HISTORY	YES	NO	RELATIONSHIP TO PATIENT
Crossed Eyes / Blindness			
Glaucoma			
Retinal Disease / OTHER			

SOCIAL HISTORY

Do you drive? **YES /NO** Pregnant or Breast Feeding? **YES/NO**	Do you drink? **YES /NO** Do you smoke? **YES/NO**	**Single/Married/ Widowed**	**Weight:** _____ **Height:** _____

SIGNATURE OF RESPONSIBLE PARTY: _____ **DATE:** _____ ***REVIEWED BY DR*:** _____

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HIPAA NOTICE OF PRIVACY PRACTICES

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 **EYE FLORIDA** we are committed to treating and using protected health information about you responsibly. This HIPAA Notice of Privacy Practices 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 **September 9, 2011**, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit **EYE FLORIDA** 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 **EYE FLORIDA,** the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- 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,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided
- by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent
- That action has already been taken.

OUR RESPONSIBILITIES

EYF FLORIDA is to: (1) maintain the privacy of your health information, (2) provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, (3) abide by the terms of this notice, (4) notify you if we are unable to agree to a requested restriction, and (5) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose 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 have questions and would like additional information, you may contact Kissimmee Medical Eye Center's Privacy Officer in person or by phone at our main phone number. If you believe your privacy rights have been violated, you can file a complaint with the 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.

Signature below is only acknowledgement that you have received this HIPAA Notice of our Privacy Practices:

PATIENT'S NAME: _____ Responsible Party Signature: _____ Date: _____

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PATIENT NOTICE OF OFFICE POLICIES

*Dr. Ly Nguyen and the staff of **EYE FLORIDA** & dba RejuveRx MedSpa are here to serve the eye needs of every patient. We ask for your cooperation in adhering to the following Office Policies in order to better serve you and others like you.*

1. PAYMENTS & PATIENT FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges not covered by this assignment, including any insurance or co-payment, or for any charges, which the insurance carrier declines to pay. If you need to make special payment arrangements, please discuss this with our office staff during the visit. Cash, Visa and MasterCard are accepted. No personal checks will be accepted on NEW PATIENT. I authorize and request my insurance company to pay directly to the doctor, or ophthalmic group, insurance benefits otherwise payable to me. I understand that if for any reason my insurance company does not pay my bill within 90 days I will be fully responsible for payment. Any returned checks will incur a **$30.00** minimum returned check fee. In the event the account becomes delinquent and is turned over to a collections agency, there will be a **$50.00 fee for each account and that I am responsible for any collection, court, or attorney fees**. I also acknowledge that it is my responsibility to fully understand the rules and regulations of my insurance company.

2. NO SHOW/LATE CANCELLATIONS

If an appointment is missed or not cancelled with 24 hours prior notice to the scheduled time, a fee of $30.00 will be charged since that time slot cannot be filled by another person. All "no-show" or "late cancellation" fees are to be paid in full on or before the next visit. **Insurance will not reimburse the patient for this charge, nor will Dr. Ly Nguyen/St. Cloud Eye Center INC bill the insurance for it**. Our office staff makes appointment confirmation by phone as courtesy to our patient. Nevertheless, it is the patient's responsibility to remember his/her appointment date and time.

3. DILATION OF EYES

In order to perform a thorough eye examination, it may be necessary to put drops in your eyes which will dilate them. Dilation means that the pupils will become enlarged for a period of time letting in more light and potentially blurring vision particularly at near. A few patients have experienced concern regarding their ability to function after dilation. It has been our experience that the near vision is affected far more than the distance and that most individuals are able to "get around" although some caution is necessary in the presence of any decreased vision. Some patients express concern about driving after dilation. We encourage patients who have this concern to arrange for a driver when coming for an exam. Please note that dilation is necessary in order to perform certain diagnostic testing and to give the doctor a full and enlarged view of the retina, or the back of the eye. This is vital in evaluating and diagnosing the effects of many eye conditions including, but not limited to, cataracts, retinal diseases, and glaucoma. If you have further concern regarding this please do not hesitate to let us know.

4. REFRACTION

Refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. **Most medical insurance plans, including Medicare, do not cover routine refractions examination** (when no medical eye problem is known or suspected). The Health Care Administration/Medicare allows that we charge separately for that portion of the examination since it is a **NON-COVERED SERVICES**. If you are interested in your prescription from our practice, then a nominal fee **$35.00** will be due at the time of service.

5. MEDICAL RECORD RELEASE

Should you need copies of your records, please note the following in accordance with Florida Statute: For copies of chart pages, a minimum of ten (10) working days and not more than thirty (30) is required to process your request. A completed and signed record release must be done before any records are released. If records are not being directly released to another physician's office, there will be a fee of $1.00 per page for the first 25 pages and 0.25 cents per page after that, payable prior to release of your copies. Reproduction of photographic materials will require additional time over and above ten (10) days. Any reproduction of photographic materials will be billed to you at the cost of reproduction, payable prior to release.

6. REFERRALS

Please allow seven working days to coordinate referrals to other providers.

7. REFILLS & PRESCRIPTIONS

Please allow three working days for the coordination of refills and prescriptions with the pharmacy. Always contact your pharmacist first when refilling a prescription. The pharmacy will contact us for authorization if necessary. If you require a "stat-same day" refill for a written prescription, there will be a **$10.00 fee**.

8. DRIVER'S LICENSE FORMS

We will be glad to fill out driver's license forms at the time of your exam at no charge. If the request for completion is not done at the time of your exam, then please allow five (5) working days. Same day form completions (not at time of exam) will be charged **$10.00 fee**.

9. AFTER HOURS AND EMERGENCIES

In the event of an emergency situation, call 911 or go to the nearest Emergency Room. If you have an urgent concern that you need to discuss with the physician, please call our office to schedule your appointment. All phone message left in the voicemail will be returned within 24 hours by the office Monday – Friday.

YOUR PRIVACY

Your medical records are strictly private. No information will be given to others without your written permission, except as required by law. Please see **HIPAA** notice for further details.

I authorize *Eye Florida & dba RejuveRx MedSpa* to discuss my medical records with:

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE NUMBER:** _____

PRINT PATIENT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

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An Important Message to Our Patients

Please be aware that due to the constant changes in insurance policies and regulations, it has become increasingly difficult to interpret each individual insurance policy. **We do try to contact your insurance to get an estimate for services as a courtesy, but per your insurance company, it is not a guarantee of payment. We cannot be held accountable for the amount quoted, as it is only an estimate provided to us by your insurance company.** It remains your responsibility to know and understand your individual policy, including your co-pays and deductibles. There is no standard policy for each insurance company; your policy was written per the options available to and offered by your employer.

Please do not be upset with our office if your insurance does not cover all of our services. Insurance policies typically have deductibles, co-pays, or co-insurances and may also have exclusions or waiting periods. Some may require that you get a referral from your primary care doctor in order to see a specialist. Our providers are considered ophthalmology specialists and your visit may require a referral and **specialist copay.**

Your individual insurance policy is between you and your insurance company and not between the insurance company and the doctor. ***It is your responsibility to let us know your INSURANCE policy requirements.***

All co-pays and coinsurance payments are due at the time of service. If your policy has a deductible you will be responsible for all charges incurred at your visit(s) until the deductible has been met. Please check your policy if you are unsure about your deductible requirements. Deductibles are concurrent with your policy plan year; once a new plan year begins, a new deductible must be met. This applies to all services, including exams, procedures, diagnostic testing, surgery, frames/lenses, contact lens fitting.

Certain procedures/testing may require pre-certification by your insurance company or may need to be performed at a special facility. **Lab fees for in office minor procedures are not included in your office visit** and will be billed out separately by the lab.
If you are unsure of any aspect of your coverage, please call the member service number on the back of your insurance card. The member services representative will be able to assist you with any questions you may have.

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to **ST CLOUD EYE CENTER INC d/b/a EYE FLORIDA** for any covered services furnished by PROVIDERS EMPLOYED BY **ST CLOUD EYE CENTER INC.** I agree to pay to St. Cloud Eye Center INC, the deductible and/or coinsurance on my claim or any other charges not paid or denied by my insurance plans regardless of billings reasons.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete**. I ACKNOWLEGE THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE PLAN BENEFITS AND REQUIREMENTS. I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service. IF I FAIL TO PROVIDE REFERRAL WITH AUTHORIZATION NUMBER FROM MY PRIMARY CARE PHYSICIAN AT TIME OF SERVICE I AGREE TO BE RESPONSIBLE FOR ALL FEES RELATED TO SERVICES RENDERED BY ST. CLOUD EYE CENTER INC.**

I acknowledge having received 1) a copy of EYE FLORIDA INC's Notice of Privacy Practices (NPP), and 2) EYE FLORIDA INC's Office Policy including Financial Policy.
PATIENT'S NAME: _____ **PATIENT'S SIGNATURE / DATE**_____

If Responsible Party, Please Complete: NAME: _____ RELATIONSHIP _____

Reason for Patient's Inability to Sign: ____ MINOR ____ OTHER: PLEASE EXPLAIN _____

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Name:_____ **DOB:**_____ **CHART NO:**_____

DILATING EYE DROPS CONSENT FORM

INFORMATION REGUARDING DILATING EYE DROPS

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

Dilating droops frequently blur vision for a length of time which varies from person to person and may make bright light bothersome. It is not possible for your ophthalmologist/optometrist /eye care provider to predict how much your vision will be affected. Driving may be difficult immediately after an examination, it is best you make arrangements not to drive yourself.

Adverse reaction, such as acute-closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Ly Nguyen / Dr. Jose Flores / Eye Florida Associates and /or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to perform a comprehensive eye exam, retina exam, and/or optic nerve exam to address and/or diagnose my eye conditions.

_____ _____

Patient's Signature (or person authorized to sign for patient) **Date**