GLAUCOMA SPECIALISTS OF SOUTH FLORIDA

PATIENT REGISTRATION

Referred by:_____Phone #_____

Patient Name:_____Date of Birth:_____Age_____Gender M F

Marital Status: Single____Married____Divorced____Widowed____S.S #_____

Home Address:_____City:_____State:_____Zip Code: _____

Home Phone:_____Cell Phone: _____

E-mail address:_____May we use your e-mail to send messages or appointment reminder: **YES OR NO**

Employer/Parent's Employer:_____Occupation: _____

Work Phone:_____May we call your work or leave voice mail message at work or at home: **YES OR NO**

Spouse name (Parent name if minor):_____Spouse/Parent Work Phone: _____

Person to notify in case of emergency (other than spouse):_____

Phone number(s)_____ Relationship: _____

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Glaucoma Specialists of South Florida to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected healthcare information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of a person(s) whom you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, or friend)

Name of person or Entity:	**Relationship:**

By signing this form, I acknowledge and agree to all which is stated below:

Upon my request, a copy will be provided of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read, understand, and consent to use and disclosure of protected health information about myself for treatment, payment, and health care operations. I authorize the release of any medical information necessary to process all claims, and I authorize the release of payment for medical benefits to GSOSFL. I understand I am financially responsible for all charges incurred in the that my insurance denies payment. I am aware there may be an additional collection and/or attorney's fees if my account is referred to collection. For patients covered by Medicare, the patient will be responsible for the 20% of the Medicare allowable charges as well as any deductibles, coinsurance, and uncovered charges that apply. My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.

_____**Date** _____

Signature of the Patient or Patient Legal Representative

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PATIENT FINANCIAL AGREEMENT

Please remember that medical insurance is considered a method of deferred payment and is not a substitution for payment. Although we verify your insurance coverage, verification of benefits is not a guarantee of payment from your insurance company. I agree that in return for the services provided to me by **GSOSFL**, I agree to pay all patient Responsibility due at the time service is rendered any co-payment/co-insurance or deductible owed as determined by my contract with my insurance carrier. I further understand that there is a $20.00 charge if we need to send a statement for any amounts of money due not paying at the time of your visit. I agree to pay past due balances that are due and payable at the time of service. I agree it is my Responsibility to pay for all charges in full if the insurance information I provide proves false or otherwise ineffective. I understand and agree that if my account is delinquent, I may be turned over to a collection agency. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

NON-COVERED SERVICES

I understand that **GSOSFL** contracts with health care service plans (i.e. HMOs, PPOs) that relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full Responsibility for all items or services, which are determined by the health care service plans not to be covered. 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 benefits summary the health care plan furnished to the patient. Examples of possible non-covered services, Tear Osmolality (Dry Eye) /Anterior Segment OCT (angle-closure glaucoma). These tools are used to assist in diagnosing and treatment plan. Some healthcare plans determine these services to be a non-covered service.

HMO REFERRALS

It is the patient's Responsibility to follow all guidelines of your insurance company, including obtaining referrals as necessary if your coverage is through an HMO. If payment is denied for lack of authorization, I understand that I am responsible for payment in full. You must inform our office before receiving service if your insurance coverage is through an HMO. Information regarding any change in your insurance coverage must be provided before receiving service. If the authorization is not provided by yourself or through your insurance carrier, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

SELF-PAY ACCOUNTS

Self-pay accounts are patients who are covered by carriers that the Practice does not participate in or patients without an insurance card on file or at the time of service. The undersigned agrees that he/she is individually obligated to pay the full charges at the time of service.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the Practice does not participate in are considered a self-pay account. It is your Responsibility to inform us of any changes with your insurance carriers, to confirm the Practice's participation, and your eligibility before each visit. The undersigned agrees that they are individually obligated to pay the full charges of all services rendered to them by **GSOSFL** if they belong to a plan in which **GSOSFL** does not participate.

RETURNED CHECKS

All returned checks will be assessed a **$40.00** fee.

I have read and understand the financial policy of the Practice, and I agree to be bound by its terms. I also understand and agree that the Practice may amend such terms from time to time.

Signature:_____ Date: _____

GLAUCOMA SPECIALISTS OF SOUTH FLORIDA

Patient Name:_____ Date:_____

Primary Care Physician: _____ **Physician Phone:_____**

PHARMACY INFORMATION:

Preferred Pharmacy:_____Address_____Phone #_____

Drug Plan Name and I.D. # _____

Please list any medications you are allergic to_____

Medication List: _____

_____

_____

Social H.X.:

Alcohol: Non-Drinker _____ Daily Drinker _____ Social Drinker _____

Smoke: Never smoked _____ Former smoker _____ Smokes _____ Daily _____ Occasionally _____

MEDICAL HISTORY

Please circle "Yes" or "No" as they relate to your past medical history. Please do not leave any blank.

Diabetes: YES NO

If YES, when was your last B/S (A1C) _____

Heart Attack / Stent: YES NO

Thyroid Disease: YES NO

Stroke: YES NO

Hypertension: YES NO

Asthma: YES NO

MS: YES NO

Coronary Artery: YES NO

Arthritis: YES NO

Cancer: YES NO

HIV/AIDS: YES NO

Other: _____

GLAUCOMA SPECIALISTS OF SOUTH FLORIDA, PA.

Dear Patient: Please read the following and sign at the bottom of the page.

We have a Cancellation Fee for missed appointments and/or procedure visits. When patients miss appointments, we miss opportunities to see other patients who require our services.

Cancellation Policy Office Visits

If you miss or cancel an appointment and do not provide 24 hours advance notice, you will be charged $50.00. You will not be able to reschedule in the office until the bill is paid.

We do recognize that unforeseen events can occur. On a case-by-case basis, we can waive the fee if there is a valid emergency. After the third missed office visit, you may be asked to leave the Practice and seek care elsewhere after a 30-day transition period.

Cancellation Policy Procedures Visits

There will be a $100.00 cancellation fee if you cancel a procedure with less than 48 hours advance notice. This includes any procedures in the office or at any outpatient surgery facility.

Precautions Following DILATION

It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. Patients should wear sunglasses and be cautious walking and going up or downstairs. We recommend not driving or operating dangerous machinery immediately after dilation. We recommend that someone drive you home or wait until your eyes return to normal so you can drive safely.

I acknowledge that I have reviewed and read the above. I also understand that the Practice may amend such terms from time to time.

Patient Signature: _____ Date: _____

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REFRACTION FEE

A refraction is an essential part of a yearly eye examination. It is the testing required to determine your best-corrected visual acuity, and the findings can be used to provide you with a new glasses prescription. Refractions are NOT a covered service by Medicare and most medical insurance plans. These plans consider a refraction a "vision" service, not a "medical" service. We do not participate in any vision plans.

Our office fee for a refraction is $65.00, and this fee is collected at the time of service. In addition to the refraction fee, you will also be responsible for your co-payment and any deductible your plan may require.

Refractions are not done as a stand-alone appointment, and they always require an eye examination at the time of this testing.

If you decline to have a refraction performed, you will not receive a new glasses prescription and we will not be able to provide you with one in the future from today's appointment.

I also understand although I declined refraction, a diagnostic refraction may be required for medical reasons, and a glasses the prescription will not be provided.

_☐_ I would like to have the refraction done today.

_☐_ I declined the refraction today.

_☐_ I decline and will see my Optometrist for my glasses prescription.

Signature:_____ Date:_____