Associated Comprehensive EYE CARE

Patient Information Packet

Patient Demographics

Full Name: _____ Date of Birth: _____
(Last Name, First Name Middle Name) *(MM/DD/YYYY)*

Address: _____ City: _____ State: _____ Zip: _____-_____
(House Number & Street) *(eg Ocala)* *(2-Letter)* *(5-Digit Zip)* *(+4 Zip)*

Cell Phone: (_____) _____-_____ Would you like to receive text reminders from us? ☐ Yes ☐ No
(Leave blank for none) *(Check Yes or No)*

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext: _____ ☐ Can Call
(Leave blank for none) *(Leave blank for none)* *(Extension) (Can we call your Work)*

Email: _____ Can we send appointment reminders to this email? ☐ Yes ☐ No
(Leave blank for none) *(Circle Yes or No)*

Driver's License/State ID: _____ Issuing State: _____ Sex: ☐ Male ☐ Female
(Leave blank for none) *(2-Letter)* *(Check Male or Female)*

☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: _____
(Check an option) *(Last Name, First Name Middle Name)*

Insurance/Billing Information:

Primary Insurance Company Name: _____ ID/Member #: _____
(eg Florida Blue) *(Full Number From Insurance Card)*

Secondary Insurance Company Name: _____ ID/Member #: _____
(eg Florida Blue) *(Full Number From Insurance Card)*

Social Security Number (Needed for insurance/billing): _____-_____-_____
(123-45-6789)

Please bring your insurance cards with you to your appointment.

Referral Information:

☐ Family Member ☐ Insurance ☐ Physician: _____

☐ Office of Disability ☐ Television ☐ Website: _____

☐ Advertisement ☐ Phone Book ☐ Friend: _____

If child 17 or under Responsible Party Name: _____ DOB: _____
Address: _____ City: _____ State: ____ Zip: _____

Patient or Authorized Person's Signature

I authorize the release of any medical and/or other information necessary to *Associated Comprehensive Eyecare, PA* for the purpose of processing an insurance claim on my behalf or assisting in my medical care and/or treatment. I am also authorizing the physicians and/or assistants of *Associated Comprehensive Eyecare, PA* to provide me with medical care and/or treatment that the physicians and/or assistants deem necessary.

✖ _____

Patient Eye Problems *(present today, check all that apply)*:

___ Blood shot eyes
___ Blurred vision in distance
___ Blurred vision at computer
___ Bump on eyelid
___ Broken blood vessel in eye
___ Burning eyes
___ Cloudy vision
___ Crossed Eyes
___ Crusting
___ Discharge
___ Depth perception problems
___ Droopy eyelids
___ Dry eyes
___ Foreign body sensation
___ Flashing lights
___ Floaters
___ Glare
___ Gritty feeling
___ Halos around lights
___ Headache with eye pain
___ Irritation of eyelids
___ Itchy eyes
___ Loss of side vision
___ Loss of partial vision
___ Lump on eyelid
___ Night vision difficulties
___ Pain on eye movement
___ Pain in eye
___ Pain around eye
___ Red eyes
___ Red lids
___ Seeing "cobwebs"
___ Seeing "strings"
___ Seeing "spots"
___ Sensitivity to light
___ Eye turning in
___ Eye turning out
___ Eyes tearing excessively
___ Tired feeling eyes
___ Twitching eyelids
___ Watery eyes
___ Distorted Vision
___ Lazy eye
Other _____

Patient Eye Surgery *(check all that apply, then list dates)*:

___ Cataract Surgery *Dates:* _____
___ PRK *Dates:* _____
___ Retinal Detach Surgery *Dates:* _____
___ Glaucoma Surgery *Dates:* _____
___ Lid Surgery *Dates:* _____
___ Lasik *Dates:* _____
___ YAG (Post-Catar) *Dates:* _____
___ Lazy Eye Surgery *Dates:* _____
___ Crossed-Eye Surgery *Dates:* _____

Patient Eye History *(have/been told you have, check all that apply)*:

___ Eye Allergies
___ Cataracts
___ Bleeding in your eye
___ Blocked vessel in eye
___ Amblyopia
___ Corneal problems
___ Retinal problems
___ Dry eye syndrome
___ Eye trauma
___ Intraocular implants
___ Glaucoma
___ Diabetic eye disease

Patient Medical History *(have/been told you have, check all that apply)*:

___ Arthritis
___ Fibromyalgia
___ Migraines
___ Depression
___ Heart disease
___ Cancer
___ Systemic Lupus
___ Thyroid disease
___ Breathing problems
___ High blood pressure
___ Diabetes
___ Other: _____
___ Elevated Cholesterol
___ Stroke
___ Kidney Disease
_____

Family Medical/Eye History *(check all that apply)*:

	Father	Mother	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Arthritis								
Heart disease								
Breathing problems								
Elevated cholesterol								
Fibromyalgia								
Cancer								
High blood pressure								
Stroke								
Migraines								
Systemic lupus								
Diabetes								
Kidney disease								
Depression								
Thyroid disease								
Blindness								
Glaucoma								
Retinal disease								
Cataracts								
Macular degeneration								
Amblyopia								
Crossed eyes								
Retinal detachment								
Red, painful eyes								
Other: _____								

UNIVERSAL PATIENT AUTHORIZATION FORM FOR
FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND QUALITY OF CARE

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: Associated Comprehensive Eyecare, PA Phone: (352) 732-8404

Address: 2441 E Fort King St #100, Ocala, FL 34471-2558 Fax: (352) 732-0177

PURPOSE: To provide me with medical treatment and related services and products, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until my death or the day I withdraw my permission.

REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures above from the types of sources listed**.

X_____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Revocation": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.