WELCOME TO GULFCOAST EYE CARE!

GULFCOAST EYE CARE

YOUR APPOINTMENT IS ON _____ **AT** _____

WITH:

❍ Michael Manning M.D. ❍ Jason Handza M.D. ❍ Prabin Mishra, M.D. ❍ Steven Gross, M.D.

❍ Brenda Liffland O.D. ❍ Rebecca Sims O.D. ❍ Thahn Nguyen, O.D.

OFFICE LOCATION:

❍ Palm Harbor ❍ Pinellas Park ❍ St. Petersburg

To help prepare for your appointment at Gulfcoast Eye Care, please take a moment to review and complete the attached patient registration forms.

1. **Registration Form**
2. **Medical History**
3. **Authorization to Receive and Release Health Information**
4. **Notification of Refraction and Refraction Fee** - This form explains the difference between a medical exam and a routine exam and will help you understand how your visit will be submitted to insurance. It also explains what a refraction is and the fee, should your insurance company not cover it.
5. **Financial Agreement and Lifetime Signature Authorization** - This form outlines Gulfcoast Eye Care's financial policies that were developed in accordance with the Office of Inspector General as well as applicable State and Federal reimbursement guidelines.

In addition to the above papers, please bring the following items:

❍ Photo identification and current insurance cards

❍ A list of medications you are currently taking (please include dosage, frequency and method)

❍ Medical records from the doctor who referred you to us

❍ Current eyeglasses

Please plan to arrive at least 15 minutes before your appointment so we can finalize your paperwork upon your arrival. Please be prepared for your eyes to be dilated and allow approximately 1.5 – 2 hours for your appointment.

Sincerely,
Gulfcoast Eye Care

REGISTRATION FORM

GULFCOAST EYE CARE

PATIENT INFORMATION

❍ Mr. ❍ Mrs. ❍ Miss. ❍ Ms. ❍ Dr.

Name: _____ Date: _____
Last First Middle

Age: ____ Date of Birth: _____ Marital Status: _____ Social Security No.: _____

Do you live: ❍ Alone ❍ With Spouse ❍ At Care Center ❍ Other _____ Spouse's Name: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Phone – Home: _____ Cell: _____ Work: _____

Other Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Other Phone: _____

Occupation (if retired, list occupation prior to retirement): _____

Race: ❍ American Indian ❍ Asian ❍ African American ❍ Native Hawaiian ❍ Type-Unknown ❍ White

Ethnicity: ❍ Hispanic ❍ Non-Hispanic ❍ Type-Unknown Preferred Language: _____

How did you hear about us? (check any circles that apply)

❍ Physician Referral _____ ❍ Health Insurance ❍ Website ❍ Other _____

I AM INTERESTED IN THE FOLLOWING

❍ LASIK (Laser Vision Correction) ❍ Lipiflow/Dry Eye Treatment ❍ Eyelid Surgery

INSURANCE INFORMATION

Is Medicare your secondary payer as a result of TEFRA? ❍ Yes ❍ No

Are you currently a member of an HMO, HIP or other managed care plan? ❍ Yes ❍ No

Primary Insurance:

Private Insurance Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's SS#: _____

Relationship: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

ID#: _____ Group: _____

Secondary Insurance:

Private Insurance Name: _____ Insured's Name: _____

Insured's DOB: _____ Insured's SS#: _____

Relationship: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

ID#: _____ Group: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____ Phone Number: _____

MEDICAL HISTORY

GULFCOAST EYE CARE

Please check the appropriate box to indicate whether you now have, or have ever had, any of the following:

	YES/NO			YES/NO			YES/NO	
Diabetes	❍	❍	Arthritis	❍	❍	Kidney Failure	❍	❍
High Blood Pressure	❍	❍	Asthma	❍	❍	Bleeding Abnormalities	❍	❍
Heart Attack or Failure	❍	❍	Emphysema	❍	❍	Lupus	❍	❍
Irregular Heart Beat	❍	❍	Bronchitis	❍	❍	Cold Sores	❍	❍
Stroke	❍	❍	Ulcer/Diarrhea	❍	❍	Sinus Loss	❍	❍
Cancer _____	❍	❍	Depression/Anxiety	❍	❍	Hearing Loss	❍	❍
Hay Fever/Allergies	❍	❍	Kidney Stones	❍	❍	Weight Loss	❍	❍
Thyroid Problem	❍	❍						

Other Medical History or Surgeries: _____

Do any of your close relatives have:

❍ Glaucoma ❍ Retinal Detachment ❍ Macular Degeneration ❍ Diabetes: Type _____

❍ Other _____

YES / NO

Do you smoke? ❍ Yes ❍ No Have you formerly smoked? ❍ Yes ❍ No

Are you pregnant or nursing? ❍ Yes ❍ No

Do you drive? ❍ Yes ❍ No

Have you had LASIK/PRK/RK? ❍ Yes ❍ No Date: _____

Do you wear contacts? ❍ Yes ❍ No If yes... ❍ Hard Contacts/RGP ❍ Soft Contacts ❍ Toric ❍ Multi-focal

Have you had a Flu vaccine? ❍ Yes ❍ No Date: _____

Have you had a Pneumonia vaccine? ❍ Yes ❍ No Date: _____

Please list any eye surgery or laser treatment you have had: _____

Primary Physician: _____ Tel: _____

Date of Last Eye Exam: _____ Doctor: _____

How old are your current glasses? _____ Where were they purchased? _____

Preferred Pharmacy/Location: _____

MEDICAL HISTORY CONT.

GULFCOAST EYE CARE

MEDICATION / OTC SUPPLEMENTS	DOSAGE	FREQUENCY	ROUTE *(oral, nasal, IM, drops, topical)*	MEDICATION IS TAKEN FOR

Do you currently or have you ever taken tamsulosin (Flomax)? ❍ Yes ❍ No

Please list any allergies to medication(s): _____

_____

_____

_____

_____

NOTIFICATION OF REFRACTION AND REFRACTION FEE

GULFCOAST EYE CARE

WHAT IS A REFRACTION?

A refraction is a vision test that determines your best-corrected visual acuity. This test is performed on your first visit, your annual visit, and anytime that your vision decreases significantly.

WHY IS A REFRACTION NECESSARY?

A refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. For example, if a patient is experiencing blurred vision or a decrease in vision, a refraction would be necessary to see if this is due to a need for glasses or due to a medical concern. A refraction is also necessary to prove to the insurance the need for cataract surgery, as we must prove that your vision cannot be simply improved with a glasses prescription.

REFRACTION FEE

The Refraction fee is $40.00. This amount is in addition to the office visit copay and/or deductible. Payment is due at the time services are rendered.

WHO PAYS FOR A REFRACTION?

Although a refraction is a vital test for the care of your eyes, a refraction is a non-covered service with Medicare and most medical insurance plans. If you are here today for a routine vision exam and have vision insurance, we will bill your vision plan for the refraction. However, if today's exam includes medical treatment and testing and/or if the doctor feels that the refraction cannot be performed today, you will be asked to return to the office for a follow-up appointment to complete the refraction test.

ACKNOWLEDGEMENT

The refraction fee is due and payable even if you do not receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses. **It is important to understand that if you decline, we may not be able to determine the cause for your decrease in vision.** By signing this form, you acknowledge to proceed with the refraction test, and acknowledge the $40.00 refraction fee is due at the time of service.

Patient Signature: _____ Date: _____

FINANCIAL AGREEMENT AND LIFETIME SIGNATURE AUTHORIZATION

GULFCOAST EYE CARE

Gulfcoast Eye Care (GEC) [Corporation name: Pinellas Eye Care, P.A.] is a privately-owned medical facility that provides medical services on a fee-for-service basis. GEC relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. GEC receives no federal, state or other third-party funding; as such, GEC does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

Upon obtaining a copy of your insurance card(s), GEC will verify your eligibility and benefits including deductibles, copayments, coinsurance responsibility, etc under your health insurance company, and GEC will submit claims for all medically necessary services to your health insurance company. **Please note that payment is ultimately due from you in the event that your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium. etc...**

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore coinsurance percentages cannot always be accurately calculated for pre-payment. A GEC statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

> *Please note that GEC medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.*

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65. No. 194, Oct. 5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom GEC will seek reimbursement for medical services, prohibit the routine discounting of published fees, "insurance-only billing" or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) GEC and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e. cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc), GEC accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

GEC **does not accept litigated cases** and services are not provided on a contingency basis under any circumstances.

GEC is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

For your convenience, GEC accepts cash, check, money order and credit cards. In addition, GEC offers financing options through third party lenders.

I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all of my financial obligations to Gulfcoast Eye Care. My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.

Patient Name _____ Date _____

Patient/ Power of Attorney Signature _____

GEC Employee Name _____ Date _____

GEC Employee Signature _____

Failure to honor your financial obligations to GEC in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care.

AUTHORIZATION TO RECEIVE/ RELEASE HEALTH INFORMATION

GULFCOAST EYE CARE

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

❍ Yes ❍ No Home Phone: _____ ❍ Yes ❍ No Cell Phone: _____

May we contact you at your place of employment? ❍ Yes ❍ No

If so, may we leave a message? ❍ Yes ❍ No If yes, Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

❍ Yes ❍ No If yes, please provide...

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? ❍ Yes ❍ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? ❍ Yes ❍ No

I hereby authorize Gulfcoast Eye Care to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions.

I authorized you to use and disclose my contact information to your internal staff for the purpose of marketing communications or promotions pertinent to me.

This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Gulfcoast Eye Care's Notice of HIPAA Privacy Policy. **A copy of this policy will be provided to me upon request.**

Patient Signature: _____ Date: _____

Witnessed By: _____