

# The Eye Clinic of Florida

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Local Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex  M  F Marital Status S M D W E-mail Address: \_\_\_\_\_

Employed By \_\_\_\_\_ Position \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse SS# \_\_\_\_\_ DOB \_\_\_\_\_

Current Eye Doctor \_\_\_\_\_

Are you a year round resident?  Yes  No If not, please circle months that you are in Florida:  
Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

Northern Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Northern Phone \_\_\_\_\_

## EMERGENCY CONTACT PERSON (other than someone at same address)

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## REFERRAL INFORMATION

Whom may we thank for referring you to our office? \_\_\_\_\_

- |   |  |                                     |  |   |
|---|--|-------------------------------------|--|---|
| <input type="checkbox"/> My optometrist | <input type="checkbox"/> News-Press        | <input type="checkbox"/> Seminar    | <input type="checkbox"/> My family physician | <input type="checkbox"/> Local Daily News       |
| <input type="checkbox"/> Web site       | <input type="checkbox"/> Family member     | <input type="checkbox"/> Town paper | <input type="checkbox"/> Coupon/Mail         | <input type="checkbox"/> Another patient/friend |
| <input type="checkbox"/> Television     | <input type="checkbox"/> My insurance plan | <input type="checkbox"/> Radio      | <input type="checkbox"/> Yellow pages        | <input type="checkbox"/> Self                   |

## ACKNOWLEDGMENT

I acknowledge that the information stated above is true to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**RESPONSIBLE PARTY** (If patient is responsible, please put same on Last Name line.)

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

**PAYMENT INFORMATION**

How will you be paying for today's visit?  Cash  Check Credit Card:  MasterCard  Visa  Discover

I have medical insurance  I do not have insurance  Worker's Compensation  Other \_\_\_\_\_

**INSURANCE INFORMATION** (We will copy the front/back of your insurance cards)

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Are you retired?  Yes  No If retired, is Medicare your primary insurance?  Yes  No

Retirement Date \_\_\_\_\_ Primary Insurance \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ SS# \_\_\_\_\_ DOB: \_\_\_\_\_

**I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.** This assignment will remain in effect until revoked by me in writing.

**MEDICARE LIFETIME AUTHORIZATION**

Beneficiary's Name \_\_\_\_\_ HIC Number \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ahad Mahootchi, MD, P.A. for any services furnished to me by that physician/supplier/provider of care. I authorize any holder of medical information about me to release to HCF A and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize financial information and reports of my evaluation, treatment and any follow-up evaluation to be sent to or discussed with my referring doctor, the doctor requesting consultation, my family physician, as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify to you.

Beneficiary's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDIGAP AUTHORIZATION**

I request that payment of authorized Medigap benefits be made on my behalf for any services furnished me by that physician. I authorize. any holder of medical information about me to release to Medigap carriers any information needed to determine these benefits or the benefits payable for related services. This authorization applies to all occasions of service until it is revoked in writing by me.

Beneficiary's Signature \_\_\_\_\_ Date \_\_\_\_\_

**COMMERCIAL INSURANCE AUTHORIZATION**

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Ahad Mahootchi, MD, P A.

Patient or Guarantor Signature: \_\_\_\_\_ Date \_\_\_\_\_

# The Eye Clinic of Florida

## DILATION, REFRACTION & CONTACT LENS EVALUATION FEES

### Patient Acknowledgment Regarding Precautions Following Dilation

It may be necessary to dilate your eyes during the course of 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. We provide free disposable sunglasses or dark sunglass inserts. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or that you wait until your eyes return to normal so that you can drive safely.

### Refraction Service and Fee

- ✓ A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses.
- ✓ A refraction is NOT a covered service by Medicare or most insurance plans. These plans consider a refraction a "vision" service not a "medical" service.
- ✓ We will NOT file the charge for a refraction with a health insurance plan unless we know that your plan covers the refraction charge.
- ✓ Our office fee for a refraction is \$ 35.00 and this fee is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

### Contact Lens Evaluation and Fee

- ✓ If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine the present appropriateness of your lenses.
- ✓ The fee for this service is \$ 35 - 90 and is collected in addition to the fee for an eye examination without contact lenses.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or a contact lens evaluation, if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction fee or contact lens evaluation fee.

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Signature (Legally Responsible Adult for minor)

\_\_\_\_\_  
Staff Witness

# The Eye Clinic of Florida

## Financial Policy/Insurance Waiver

As your physicians, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assurance of your understanding about our payment policy.

**We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize however, that:**

- 1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.**
- 2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (i.e., refraction).**

**PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICE IS RENDERED** We accept cash, personal checks, MasterCard, Visa, Discover. Returned checks are subject to a service charge as allowed by law and you will lose your privilege to write checks in our office. If a returned check is not paid after ten days, it will be referred to the State Attorney for collection.

**SUPPLEMENTAL INSURANCE POLICY** Payment is due at the time of service if you do not have a medigap policy. We will file with your insurance for your reimbursement.

**CANCELLED APPOINTMENTS** Patients who do not cancel appointments may be discharged from the practice after the third no-show. We charge \$50 for a non-cancelled appointment.

**MEDICARE** Your deductible and 20% of the allowable charges are due at the time of service. Since we are a Medicare provider we will file with Medicare. Please bring your Medicare Explanation of Benefits showing you have met your deductible.

**WORKERS' COMPENSATION** We will call your employer for authorization prior to your appointment. We will file with your company's insurance carrier. In the event your claim for this illness or condition is denied by the Worker's Compensation Board as not being related to your employment, you agree to pay the usual and customary fees for services rendered to you in this case.

**HMO POLICIES** If we are participating with your HMO plan, we file your insurance claim. You are responsible for all applicable co-pays and/or deductibles, which is payable BEFORE you are treated.

**CHILDREN OF DIVORCED PARENTS** PAYMENT IS DUE AT THE TIME OF SERVICE, no matter who is responsible by order of the divorce decree.

### **FINANCIAL AGREEMENT**

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.** On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies can arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

**I have read and understand the above Financial Policy/Insurance Waiver.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# The Eye Clinic of Florida

## PATIENT'S ACKNOWLEDGMENT OF RECEIPT OF NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. This form is valid until your personal revocation.

I hereby acknowledge that I received The Eye Clinic of Florida (Ahad Mahootchi, MD, PA) Medical Information Privacy Notice for my review prior to receiving services through The Eye Clinic of Florida.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If there is a spouse, family member, or other person that you would like your health information released to, please fill out and sign below.

I authorize  all my health information  restricted information including \_\_\_\_\_  
be released to the following:

1. \_\_\_\_\_ Relationship \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_

3. \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_