The Eye Clinic of Florida

PLEASE PRINT CLEARLY

Last Name_____ First Name_____ MI_____ Preferred Name _____

Local Address_____

City_____ State_____ Zip_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

SS# _____ Date of Birth_____ Age_____

Sex ☐ M ☐ F Marital Status: S M D W E-mail Address: _____

Spouse's Name____ _____ Spouse SS#_____ DOB_____

Pharmacy Name_____ Location_____ Phone #_____

Primary Care Physician_____ Phone #_____

Are you a year round resident? ☐ Yes ☐ No

Northern Home Address_____

City_____ State_____ Zip_____

Northern Phone_____

Northern Eye Doctor _____Phone #_____

EMERGENCY CONTACT OR NEXT OF KIN (other than someone at same address)

Name_____ Relationship_____

Home Phone_____ Work Phone_____

REFERRAL INFORMATION

Whom may we thank for referring you to our office? Please Specify. _____

☐ My Optometrist ☐ Newspaper ☐ Health Fair ☐ My Family Physician ☐ Local Daily News ☐ Self

☐ Web Site ☐ Family Member ☐ Television ☐ My Insurance Plan ☐ Patient/Friend ☐ Yellow Pages

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

Last Name_____ First_____ MI_____

Address_____

City_____ State_____ Zip_____

Relationship to Patient_____ Phone #_____

PAYMENT INFORMATION

How will you be paying for today's visit?

☐ Cash ☐ Check Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Care Credit

☐ I have insurance ☐ I do not have insurance ☐ Worker's Compensation ☐ Other

If Worker's Compensation, please provide the following information:

Date of Injury_____ Claim #_____ Contact_____

Employer_____ Phone #_____

Address_____ City_____ State_____ Zip_____

W/C Insurance_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Specify injury: _____

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

Medicare #_____ Medicaid # (QMB Only, per federal regulation) _____

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. Initial: X_____

MEDICARE LIFETIME AUTHORIZATION (If you have Medicare, please sign)

Beneficiary's Name_____ HIC #_____

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 HCFA 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 X_____ Date_____

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, and Care Credit. 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 don't 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.

WORKER'S 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 are 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 on 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 **X**_____ Date_____

Witness _____ 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 and 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 eye glasses 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 $ 45.00 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 $ 65 – 110 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

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of **The Eye Clinic of Florida's** Notice of Privacy Practices effective September 23, 2013.

Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (patient name).
I have received a copy of **The Eye Clinic of Florida's** Notice of Privacy Practices effective September 23, 2013.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 23, 2013 given to individual on _____ (date).

☐ In person ☐ Mailing ☐ E-mail ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ E-mail _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____