Central Florida Eye Specialists and Laser Center

Board Certified Ophthalmologists

Thomas M. Kropp, M.D.
Robert Cordero, M.D., F.A.C.S.
Kevin M. Barber, M.D.
Phillip J. Mackinder, O.D.

WELCOME TO OUR PRACTICE

It will be a pleasure for all of us at Central Florida Eye Specialists and Laser Center to serve as your vision caregivers. In order to mutually fulfill our goals and your healthcare needs, we ask that you take a few moments to complete the enclosed information packet. Your visit will flow smoothly and timely if you follow these suggestions:

1. Please arrive at the office 15 minutes prior to your appointment time.
2. Please refer to your insurance provider book to be sure the physician you are seeing participates with your insurance plan.
3. If you are in a wheelchair, please bring someone to assist you if needed.
4. If possible, please bring an interpreter if you do not understand or speak English.
5. Please bring the following items with you:
    a) Eyeglasses, sunglasses and/or contact lens and container.
    b) List of current medications (dosage and strength).
    c) Prior medical records, if available.
    d) Current insurance cards and authorization forms. If an authorization is required by your insurance plan, please contact your primary care physician prior to your appointment, to be certain the authorization has been forwarded to our office, or hand-carry a copy to us at your appointment time. **Without the authorization, you may not be able to be seen by our physicians until a later date.**
    e) Photo ID or utility bill showing current address.
    f) A Patient Medical Information form, completed on both sides and signed where applicable.
    g) Financial policy forms, completed and signed.
    h) For your comfort, we suggest you bring a sweater, as our office is sometimes cool.

It is the mission of this practice to provide the highest level of service and concern possible to those who choose to accept our care. We want to help every individual achieve a higher level of well-being by enhancing the health, appearance, comfort and function of their vision. In providing this level of care, we will strive to treat every patient, as we would want to be treated ourselves.

Thank you for choosing CENTRAL FLORIDA EYE SPECIALISTS AND LASER CENTER

Sincerely,

Physicians and Staff
CENTRAL FLORIDA EYE SPECIALISTS AND LASER CENTER

305 East New York Avenue, DeLand, FL 32724 (386) 734-2931 Fax (386) 734-2939
975 Town Center Drive, Suite 200, Orange City, FL 32763 (386) 917-0404

PLEASE COMPLETE BOTH SIDES

CENTRAL FLORIDA EYE SPECIALISTS AND LASER CENTER

PATIENT INFORMATION

PATIENT NAME: ______________________________ AGE: ________
FIRST MI LAST

ADDRESS: ______________________________

ZIP: __________ CITY: ______________________________ STATE: __________

HOME PHONE: ( ) ____________________ DATE OF BIRTH: ____________________

WORK PHONE: ( ) ____________________ S.S.#: ____________________

OCCUPATION: ____________________ SEX: ______ MARITAL STATUS: __S __M __D __W

EMAIL: ____________________ REFERRED BY: ____________________

IF PATIENT A MINOR, RESPONSIBLE PARTY NAME: ______________________________

ADDRESS: ______________________________

RESPONSIBLE PARTY S.S.#: ____________________ DATE OF BIRTH: __________

PATIENT OR RESPONSIBLE PARTY EMPLOYER: ______________________________

ADDRESS: ______________________________

CITY: ____________________ STATE: __________ ZIP: __________

SPOUSE NAME: ____________________ OCCUPATION: ____________________

EMPLOYER: ______________________________

ADDRESS: ______________________________

CITY: ____________________ STATE: __________ ZIP: __________

SPOUSE S.S.#: ____________________ SPOUSE DATE OF BIRTH: __________

INSURANCE INFORMATION

BRING INSURANCE CARDS

PRIMARY INSURANCE: ____________________ SECONDARY INSURANCE: ____________________

IF MEDICARE AND/OR PARTICIPATING INSURANCE PLANS:

"I authorize release of any medical information to the above insurance carrier to determine benefits payable."

"I request that payment be made on my behalf to Central Florida Eye Specialists, P.L. for any services furnished to me."

"I understand that **any charges not paid** by my participating insurance company after verification will be **my responsibility**."

SIGNATURE: **X** ______________________________ DATE: ____________________

IF SELF PAY:

"I understand that any charges will be my responsibility and payable on each visit unless prior arrangements are made."

SIGNATURE: **X** ______________________________ DATE: ____________________

WORKER'S COMPENSATION

(AS OF 03/01/09 WE ARE NO LONGER A PARTICIPATING PROVIDER OF WORKER'S COMPENSATION)

WERE YOU INJURED ON THE JOB? YES _____ NO _____ DATE OF ACCIDENT: ____________________

EMPLOYER NAME: ______________________________ PHONE NO: ____________________

ADDRESS: ______________________________

CITY: ____________________ STATE: __________ ZIP: __________

W/C CARRIER: ______________________________

ADDRESS: ______________________________

CITY: ____________________ STATE: __________ ZIP: __________

POLICY NO: ______________________________ AUTHORIZED BY: ____________________

"I hereby authorize payment directly to Central Florida Eye Specialists, P.L., and authorize release of any medical information to the above named insurance carrier to determine benefits payable."

SIGNATURE: **X** ______________________________ DATE: ____________________

MEDICAL INFORMATION ON BACK **-OVER-**

CENTRAL FLORIDA EYE SPECIALISTS AND LASER CENTER

305 E. New York Ave., DeLand, FL 32724 (386) 734-2931
975 Town Center Dr., Ste. 200, Orange City, FL 32763 (386) 917-0404
1900 N. Orange Ave., Orlando, FL 32804 (407) 896-1400

MEDICAL INFORMATION

PATIENT: ____

ALLERGIES: ____

____

____

____

LIST ANY EYE INJURY, DISEASE OR SURGERIES:

__________________________________DATE: ______________

__________________________________DATE: ______________

__________________________________DATE: ______________

MEDICATIONS

NAME:	**DOSAGE:**

SOCIAL HISTORY:

Married ________ Single ________ Divorced ________ Widowed ________ No. of Children ________

Occupation: ____

Tobacco: Yes ________ No ________ Alcohol: Yes ________ No ________ Drug Abuse: Yes ________ No ________

How Much? ______________________ How Much? ______________________ Type? ____________________________

FAMILY HISTORY:

Does anyone in your immediate family have evidence of:

	Yes	Relation:
Heart Disease	____	____________________
Glaucoma	____	____________________
Diabetes	____	____________________

OTHER SURGERY YOU HAVE HAD:

__________________________________DATE: ______________

__________________________________DATE: ______________

__________________________________DATE: ______________

HAVE YOU EVER BEEN TREATED IN THE PAST FOR:

Diabetes How long? ______________	Y/N
Migraine Headaches	Y/N
Hepatitis	Y/N
Joint Disease	Y/N
GI Disease	Y/N
Cardiovascular Disease	Y/N
High Blood Pressure	Y/N
Cancer	Y/N
Hearing Problems	Y/N
Gout	Y/N
Kidney Stones	Y/N

ROS: DO YOU CURRENTLY HAVE PROBLEMS WITH:

Constitutional Symptoms (e.g., fever, weight loss)	Y/N
Cardiovascular (Heart)	Y/N
Respiratory (Breathing)	Y/N
Urinary Problems	Y/N
Musculoskeletal	Y/N
Integumentary (Skin)	Y/N
Neurological	Y/N
Psychiatric	Y/N

Please explain any yes answers to the above:

____

____

____

Next of kin to notify in case of an emergency: ______________________________________ Phone #: ________________________

CENTRAL FLORIDA EYE SPECIALISTS AND LASER CENTER
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 and your understanding about our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICE IS RENDERED.
We accept cash, personal checks, MasterCard, Visa and Discover. Returned checks are subject to a service charge of $20.00 or 5% of the face value of the check, whichever is greater and you will lose your privilege to write checks in our office.

SUPPLEMENTAL INSURANCE POLICY – We file supplemental insurance for surgical procedures only. WE DO NOT FILE SUPPLEMENTAL INSURANCE FOR OFFICE VISITS.

CANCELLED APPOINTMENTS – Patients who do not cancel appointments within 24 hours may be discharged from the practice after the third no-show.

BLUE CROSS/BLUE SHIELD PPC COVERAGE – CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with these insurance companies we file your insurance.

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 your Medicare. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays. Please bring your Medicare Explanation of Benefits (EOB) showing you have met your deductible.

WORKER'S COMPENSATION – We are not participating providers of Worker's Compensation.

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 will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. Your 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 (e.g., refraction).**

We must emphasize that as your medical care providers, our relationship and concern is with your and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED. Unpaid accounts over 60 days old are subject to a $5.00 late payment fee each month the balance remains unpaid. 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 do 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**

CENTRAL FLORIDA EYE SPECIALISTS AND LASER CENTER

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION
I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT
I, the below name subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE
Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services, its intermediaries or carriers any information needed for this of a relation Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me. NOTE: We are not a participating provider of the Medicaid program.

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.

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, coinsurance, or any other balance not paid by my insurance or third payer within a reasonable period of time, not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees and costs of collection.

Date: ____________________ Patient: ______________________________________
Signature

SUBSCRIBER (if different from patient): ______________________________________
Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE MEDIGAP (SECONDARY INSURANCE) SIGNATURE

______________________	______________________	______________________
NAME OF BENEFICIARY	HEALTH INSURANCE COMPANY	MEDIGAP POLICY NUMBER

I request that payment of authorized MEDIGAP benefits be made on behalf to CENTRAL FLORIDA EYE SPECIALISTS AND LASER CENTER for any services furnished me by Thomas M. Kropp, M.D., Robert Cordero, M.D., Kevin M. Barber, M.D. or Phillip J. Mackinder, O.D. I authorize any holder of medical information about me to release to Central Florida Eye Specialists, P.L. any information needed to determine benefits or the benefits payable for related services.

SUBSCRIBER'S SIGNATURE: ______________________________________ DATE: __________________

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PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: ____________________________ Chart #____________

I give permission to Central Florida Eye Specialists and Laser Center to release any of my personal health information*, including any medical information in my chart, to:

1) Name ____________________________ Phone #____________

Relationship to Patient ____________________________________

2) Name ____________________________ Phone #____________

Relationship to Patient ____________________________________

3) Name ____________________________ Phone #____________

Relationship to Patient ____________________________________

4) Name ____________________________ Phone #____________

Relationship to Patient ____________________________________

*Personal health information may consist of laboratory reports, biopsy reports, surgery related information, surgical results, etc.

____ By initialing here, I give Central Florida Eye Specialists and Laser Center permission to leave personal health information on my answering machine.

Signature of Patient: ____

Witness: _______________________________ Date: _____________

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LIFETIME PATIENT CONSENT FORM

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 at the address below 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 health care 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.

Patient Name: ____

Signature: ____

Relationship to Patient: _________________________________

Date: ____________________________

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