LOW VISION & BINOCULAR VISION
CLINIC OF FLORIDA

2323 Curlew Road, 7A
Dunedin, FL 34698

P: 727-463-2579 F: 727-934-7229

Other locations: The Villages & Sun City Center

Welcome to our office!

Please complete the following; this will assist us in providing the best in vision care possible.

Today's date: _____ Full name of patient: _____

If patient is a minor:

Full name of parent or guardian and how related:_____

Mailing address: **Street: _____**
City: _____
State/Zip code: _____

Telephone number with area code: _____

Email address: _____ for use in sending out information and communications.

Patients date of birth: _____ Patient's Age: _____ Gender (circle): M F
Patients' occupation or grade in school: _____

SSN of patient: _____-_____-_____ SSN of parent or guardian: _____-_____-_____

New Patient's Only:

Who may we thank for referring you to our office? _____
If not referred, how did you choose our office for your needs? _____

What is the main reason for the eye/vision examination today? : _____
_____

Insurance

If you would like us to submit a claim to your medical insurance company please provide the following information. Note: if we will make a photocopy of the cards then you do not need to fill-in the information below.

Medical Insurance Co._____

Subscriber Name _____

Relationship to Patient_____

Insurance ID#_____ Group#_____

Subscriber Birth Date_____

Do you have a secondary insurance? If so, please complete the following:

Secondary Medical Insurance Co._____

Subscriber Name _____

Insurance ID#_____ Group#_____

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Patient Eye/Vision Information

Do you wear glasses? **Y N** **Age of current glasses_____**
Do you wear contact lenses? **Y N** **Type_____**
Have you had any eye surgeries? **Y N** **Type_____ Date_____**
Have you had any eye injuries? **Y N** **Describe_____**
Your age at first glasses prescription _____

Do you have any of the following eye conditions?

		Date of diagnosis	*Treatment*
Blurred or distorted vision	**Y N**	_____	_____
Double vision	**Y N**	_____	_____
Crossed eyes	**Y N**	_____	_____
Amblyopia or "lazy eye"	**Y N**	_____	_____
Sudden change/loss of vision	**Y N**	_____	_____
Glaucoma	**Y N**	_____	_____
Cataracts	**Y N**	_____	_____
Retinal Problems (e.g. AMD)	**Y N**	_____	_____
Lazy Eye	**Y N**	_____	_____
Dry Eye	**Y N**	_____	_____
Perm. Vision Loss	**Y N**	_____	_____

Patient General Health

How would you describe your general health? _____
Who is your primary care physician? _____ Date of last physical_____
What is the city and state location of your primary care physician? _____

Please indicate any current or past problems in the following health systems and medications you are taking as treatment.

		Diagnosis:	*List medication(s), strength and dosage:*
Gastrointestinal	**Y N**	_____	_____
Ear/ Nose/ Throat	**Y N**	_____	_____
Respiratory	**Y N**	_____	_____
Cardiovascular	**Y N**	_____	_____
Skin Problems	**Y N**	_____	_____
Musculoskeletal	**Y N**	_____	_____
Mental Health	**Y N**	_____	_____
Nervous System	**Y N**	_____	_____
Genitourinary	**Y N**	_____	_____
Endocrine (glands)	**Y N**	_____	_____
Blood/ Lymph	**Y N**	_____	_____
Psychiatric	**Y N**	_____	_____

Have you had a flu immunization? Yes____ If yes, when did you have it? _____ No____

Please list any allergies you have (include medication allergies): _____
_____

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Please list any surgeries (excluding eyes) you have had: _____

_____

Please list any injuries (excluding eyes) you have had: _____

_____

Please list any hospitalizations you have had: _____

_____

Patient Social History

Do you smoke? Y N

Family Eye Information

Please let us know if the following eye conditions are in the family:

relation to patient

Y N Glaucoma _____
Y N Macular Degen. _____
Y N Strabismus (eye turn)_____
Y N Amblyopia (lazy eye)_____
Y N Retinal Detachment_____
Y N Cataracts_____
Y N Blindness_____

Family Health History

Please let us know if the following medical conditions are in the family:

relation to patient

Y N Diabetes _____
Y N Hypertension _____
Y N Cardiovascular_____
Y N Stroke _____
Y N Cancer _____
Y N Other _____

(Reviewed by Edward Huggett, Jr., O.D.: _____)

**** Signature of patient (or parent/guardian): _____ Date: _____**

Reports

Would you like copies of any reports for yourself? □ Yes □ No
Would you like copies sent anywhere? (If so indicate where below)□ Yes □ No

Please indicate who you would like reports to go to (full name and mailing address is required):
Name:_____
Address:_____

Name:_____
Address:_____

(For additional reports please use the back of this form)

Note: reports may take up to 30 days from the time of request. Please plan accordingly if you need a report.

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If you would like a report for yourself or one sent to a third party please sign below to give us permission to release information about yourself or child to the above sources (Valid for 365 days only). This authorization may be revoked by you in writing at anytime.

Signature_____ Date: _____

patient or parent/guardian (if patient is a minor)

Financial Policy, Release of Information and Assignment of Benefits

Edward J. Huggett, Jr., O.D., P.A. is a provider for Medicare B and accepts assignment for that insurance plan only.

1) It is agreed by the Insured or Responsible Party: "Edward J. Huggett, Jr., O.D., P.A. extends the courtesy of filing to your insurance company. However, insurance coverage is a contract between the Insured and the insurance company, the Insured is ultimately responsible for the payment of services whether an authorization was obtained or not. I agree that all co-payments, deductible amounts or non-covered service fees are due to be paid within 30 (thirty) calendar days as invoiced."
2) I agree as the Insured/Responsible Party I will be required to pay for services as invoiced.
3) I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, interest fees, attorney fees, court costs and agency fees.
4) Any overpayments on your account will be refunded within 30 business days.

I hereby authorize my insurance company to make payment directly to Edward J. Huggett, Jr., O.D., P.A. for any services rendered to me. I authorize Edward J. Huggett, Jr., O.D., P.A. to release any information required by my insurance company, and their agents needed to determine these benefits for related services. A photocopy of this assignment shall be considered as effective and valid as the original."

Signature of Insured/responsible party:_____

Notice of Insurance Coverage

We will collect today $175.00 ($75.00 if you are using Medicare B) by credit card, check or cash. This is usually the entire fee generated but all fees will be submitted to your insurance company unless you direct otherwise. Your payment will be applied toward the refraction, office visit, eye exam and other services or testing if required. Any overpayment will be refunded to you within 30 business days.

A full listing of our fees is posted and available for review as needed.

Signature of responsible party: _____ Date: ____/____/____

Effective: January 01, 2017

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit Edward J. Huggett, Jr., O.D., P.A. we make a record of the information gathered during your visit. This information is used for a number of purposes. These uses are set forth below. You have certain rights regarding this information. Your rights regarding this information are set forth below. Finally, we have certain responsibilities regarding our use of your information. Our responsibilities are set forth below.

USES AND DISCLOSURES OF HEALTH INFORMATION

We are permitted by law to use your health information to provide treatment to you. For example, we will provide your physician and our other clinicians involved in your care and treatment with the information in our records to assist the physician in providing proper care to you. We will also provide this information to subsequent health care providers. These individuals may create additional information related to the care and treatment they provide you.

We are permitted by law to use your health information to obtain payment for our services. For example, we may send your insurance company or other payor a bill that may include your health information.

We are permitted by law to use your health information to perform our regular healthcare operations. For example, we may use your health information to assess the quality of care we provide in order to maintain our standards.

In addition to these uses and disclosures, we may use your information to contact you to provide appointment reminders to you or to advise you of treatment alternatives available to you. In order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded / artificial voice messages and / or use of an automatic dialing device as applicable.

We are permitted, and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

- To public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse, and other public health issues;
- To health oversight agencies, such as governmental auditors, the Florida Department of Health, and other agencies when required;
- To any individual when ordered by a court or other legal process to do so;
- To law enforcement officials when necessary for law enforcement purposes and required by law;
- To a coroner or medical examiner when necessary to enable them to perform their duties;
- To organ procurement organizations, to enable them to make suitability determinations; in cases of emergency;
- When otherwise required by law.

We will not use your information for any other purpose without your written authorization.

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A written authorization is required, for example, to disclose records to your employer for fitness for duty or other purposes. You have the right to revoke any authorization you provide us.

YOUR INDIVIDUAL RIGHTS

You have certain rights regarding your health information. These rights include:

- the right to obtain a paper copy of this notice;
- the right to inspect and copy your health information (copies are available for a reasonable fee);
- the right to request amendments to your health information you believe to be inaccurate;
- the right to obtain an accounting of our uses and disclosures of your health information, subject to certain exceptions;
- the right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request, unless the request related to disclosure to a health plan of information pertaining to items and services for which you have paid in full);
- the right to request that communications regarding your health information be sent by alternative means or at alternative locations.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your information in accordance with this notice. We are also required to provide you with this notice explaining our legal duties and privacy regarding your health information and to notify you of any breach of unsecured protected health information. We are required to abide by the terms of this notice.

We reserve the right to change the content of this notice and to make new provisions regarding your protected health information. We will provide you a revised notice during your first visit after the revisions are effective.

If you have any questions regarding this notice, have any complaints regarding your rights or our policy or wish to exercise any of your rights as described herein, you may contact Edward Huggett, O.D., 2323 Curlew Rd., Suite 7A, Dunedin, FL 34698.