ISLAND EYE SPECIALISTS

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PATIENT INFORMATION

Today's Date: _____ Account Number: _____

Patient Name: _____
First *Middle* *Last*

Address: _____
Street *City* *State* *Zip*

Date of Birth: _____ Age: _____ Social Security Number: _____ ☐ MALE ☐ FEMALE

Preferred Phone: (_____) _____ ☐ Home ☐ Cell Secondary Phone: (_____) _____ ☐ Home ☐ Cell

Email: _____ Driver's License Number: _____

☐ Check here if you ***DO NOT*** consent to receiving email/text messages, including appointment reminder messages

I authorize the practice to disclose or provide Protected Health Information to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication. This authorization is in effect until a written notification of revocation is received:

☐ Preferred Phone ☐ Secondary Phone ☐ Email listed above ☐ Mailing Address listed above

Primary Care Physician Name: _____ Address: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black
☐ White ☐ Native Hawaiian/Other Pacific Islander

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

PREFERRED PHARMACY

Pharmacy: _____ Address: _____

RESPONSIBLE PARTY*

Name: _____ Relation: _____ Phone: _____

**Only complete this section if the patient is NOT the responsible party*

Address: _____
Street *City* *State* *Zip*

HOW DID YOU FIND US?

☐ Doctor: _____ ☐ Insurance Referral

☐ Internet/Online ☐ Friend/Family ☐ Social Media ☐ Advertisement/Other

MEDICAL INSURANCE

PRIMARY Insurance Co.: _____ Member ID: _____ Group/Policy No.: _____

Policy Holder Name/DOB: _____ Relation to Patient: _____

Secondary Insurance Co.: _____ Member ID: _____ Group/Policy No.: _____

Policy Holder Name/DOB: _____ Relation to Patient: _____

My signature below indicates the above information is correct and accurate to the best of my knowledge.

Name: _____ **Signature:** _____ **Date:** _____

Medical History Questionnaire

Patient Name: _____ **Patient Date of Birth**:_____
First *Middle* *Last*

Current Height: _____ **Current Weight**: _____ **Do you currently wear**: ☐ Glasses ☐ Contact Le

In your own words, please describe the reason for your visit with us today: _____

_____

Allergies | Please list all known allergies to medication (including intravenous and contrast dye and anesthetics), and environmental allergens (including seasonal, food, and latex). ☐ **Check here** if you have no known allergies

Allergy	Reaction	Allergy	Reaction

Current Medications | Please list all your current prescribed medications (including eye drops or medical cannabis), over-the-counter medications, vitamins, and/or supplements. ☐ **Check here** if you are not on any medications

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Symptoms Review | Please select below any symptoms you are experiencing:

☐ Reading small print ☐ Reading traffic or street signs ☐ Driving at night/in bright light
☐ Watching Television ☐ Floaters or flashers ☐ Difficulty seeing steps/curbs
☐ Glare or Halo ☐ Dry, red, sandy, or itchy feeling ☐ Other: _____

Medical History | Please check below if **YOU** are experiencing or have experienced any of the following:

Y	N	Constitutional	Y	N	Cardiovascular	Y	N	Endocrine	Y	N	Integumentary
		Fatigue			Chest Pain/Pressure			Cold/Heat Intolerance			Hives
		Fever			Irregular Heartbeat			Diabetes			Rash

Y	N	HEENT	Y	N	Gastrointestinal	Y	N	Neurological	Y	N	Musculoskeletal
		Bulging Eyes			Abdominal Pain			Imbalance			Back Pain
		Hearing Loss			Constipation/Diarrhea			Headache			Joint Stiffness
		Sinus Problems			Nausea/Vomiting			Memory Difficulty			Muscle Weakness

Y	N	Respiratory	Y	N	Hematologic	Y	N	Genitourinary	Y	N	Psychiatric
		Asthma			Bleeding			Pain with Urination			Depressed Mood
		Coughing			Bruising			Blood in Urine			Irritability
		Wheezing			Tender Lymph Nodes						

Past Ocular and Surgical History | Please check if <u>you</u> have received treatment (including eye drops and medical cannabis) or had surgery for any of the following conditions (note type):

Yes	No	Surgery, Type, Year	Yes	No	Surgery, Type, Year
☐	☐	Cataract: _____	☐	☐	Cornea: _____
☐	☐	Glaucoma: _____	☐	☐	LASIK: _____
☐	☐	Oculoplastic: _____	☐	☐	Retina: _____
☐	☐	Other: _____	☐	☐	Other: _____

Personal and Family Health History | Please check if you or a family member have/have had any of the following or please. Please check here if: ☐ NO RELEVANT PERSONAL HISTORY ☐ NO RELEVANT FAMILY HISTORY

	Self	Mother	Father	Sibling		Self	Mother	Father	Sibling
Allergies	☐	☐	☐	☐	Heart Disease	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	Lazy Eye	☐	☐	☐	☐
Corneal Disease	☐	☐	☐	☐	Macular Degeneration	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Migraines	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	Retinal Disease	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	Diabetes	☐	☐	☐	☐
Cancer, please note type(s): _____						☐	☐	☐	☐
Auto-Immune Disorder, please note type(s): _____						☐	☐	☐	☐
Other, please specify: _____						☐	☐	☐	☐
Other, please specify: _____						☐	☐	☐	☐

Other History

Females: Are you currently pregnant? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No IF YES: ☐ Former user ☐ Current use – daily ☐ Current use – occasional

Tobacco Product used: ☐ Cigarette ☐ Cigar/Cigarillo ☐ Pipe ☐ Snuff/Chew ☐ Smokeless ☐ Other: _____

Do you drink alcohol? ☐ Yes ☐ No IF YES, ____ drinks per: ☐ Day ☐ Week ☐ Month ☐ Year

Do you consume caffeine? ☐ Yes ☐ No IF YES: ☐ Coffee ☐ Energy drinks ☐ Soda ☐ Tablets ☐ Other: ____

Occupation: _____ Status: ☐ Full time ☐ Part Time ☐ Retired/Other

Married: ☐ Yes ☐ No

Informed Consent for Dilated Eye Examination

In the course of your care, whether today or in the future, it is important for the doctor to evaluate your retina, macula, and optic nerve by viewing the back part of your eye using a dilated examination. Dilating eye drops are used to enlarge the pupil of the eye to allow the physician to fully see these areas of your eyes.

Dilation frequently changes and/or blurs vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible to predict to what degree your vision will be affected. Driving may be difficult after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements. Some patients do drive after dilation with the assistance of temporary sunglasses, which we will provide to you after your examination. Though rare, adverse reactions, such as a rise in eye pressures causing pain, may be triggered by the dilating drops. It may be necessary to lower this pressure by using eye drops, oral medication, and/or laser treatment. There is also the possibility of an allergic reaction to the dilating drops.

The decision to undergo dilation is yours. You may choose to not have the dilation performed; however our doctors recommend that dilation be performed to better examine your eyes for possible disease.

Your initials below indicates that you have read and understand the risks and benefits associated with the use of dilation drops to complete a dilation examination, and hereby authorize the Island Eye team to administer dilation drops and proceed with the dilated examination.

INITIALS: _____

My signature below indicates the above information is correct and accurate to the best of my knowledge.

Name: _____ Signature: _____ Date: _____

Financial Policy

Patient Name: _____ **Patient Date of Birth:** _____

Financial Policy and Outstanding Balances | The patient is responsible for payment of all charges associated with the patient's visit at Island Eye Specialists (IES) and all subsidiaries of Island Eye Specialists. As courtesy and for your convenience, we will bill your insurance company if you have provided us with all the requested insurance information. You are responsible for your deductible, co-payment, co-insurance, and non-covered service(s) at the time the service(s) are rendered. If you are uncertain of your coverage, please contact your insurance company directly. If you choose not to bill your insurance company for care provided, it is understood that you assume financial responsibility for all charges. The patient agrees that in return for the services provided to the patient by IES, the patient will pay the patient's account at the time service is rendered or will make financial arrangements satisfactory to IES for payment. If an account is sent to an attorney for collection, the patient agrees to pay collection expenses and attorney's fees as established by the court and not by a jury in any court action. The patient understands and agrees that if the patient's account is delinquent, the patient may be charged interest at the legal rate. Patients who have outstanding balances will be billed monthly. All balances are due 30 days from the billing statement date and must be paid prior to any future services being rendered.

Payment Methods Accepted | We accept cash, check, and most major credit cards (Visa, MasterCard, American Express, Discover, etc.) and CareCredit. There is a $25 fee for all returned checks.

Assignment of Benefits | 1 – Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Island Eye Specialists (IES), for services furnished to me by IES. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. IES accepts the charge determination of the Medicare carrier as the full charge, and I am only responsible for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. **2 – MediGap**: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to IES if possible, or otherwise, me.

Release of Information | Island Eye Specialists (IES) may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable under contract to IES for reimbursement for services rendered, and (2) any healthcare provider for continued patient care. IES may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

Other Insurance | I understand that Island Eye Specialists (IES) maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that IES has no contract, either expressed or implied, with any plan that does not appear on that list. The patient or patient's responsible party agrees that they are individually obligated to pay the full charges of all services rendered to the patient by IES if the patient belongs to a plan that does not appear on the above-mentioned list.

Non-Covered Services | I understand that Island Eye Specialists's (IES) contracts with health care service plans (i.e. HMO', PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the patient or patient's responsible party accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan furnishes to the patient, and treatment or tests not authorized by the health care service plan. The patient or patient's responsible party agrees to cooperate with IES to obtain necessary health care service plan authorizations.

My signature below indicates my full understanding of, and agreement with, this financial policy

Patient or Responsible Party Signature: _____ Date: _____

Privacy Practices and Release of Information

Privacy Practices

Island Eye Specialists's Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI). The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our notice, you may receive a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment, or healthcare operations. The law does not require Island Eye Specialists to agree to this restriction, but if we do, we shall honor that agreement.

I acknowledge that I have been made aware of Island Eye Specialists's privacy practices. I understand that a copy of the Notice of Privacy Practices is available upon my request.

By signing this form, you consent to our use and disclosure of Protected Health Information (PHI) about you for treatment, payment, and healthcare operations. You have the right to revoke this Acknowledgement. Any revocation must be in writing and signed by you. Such revocation will not affect any disclosures we have already made in reliance on your prior Acknowledgement. Island Eye Specialists provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Release of Information

I authorize the Island Eye Specialists to release my Protected Health Information (PHI) to the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Important Information

You have the right to terminate this authorization at any time by submitting a written and signed notice to our office. The revocation takes effect once it is received by our office, and does not apply to actions already taken before the revocation is received. You have the right to receive a copy of your signed authorization upon your request. Your signature below confirms your authorization and your understanding of this policy and your rights.

Patient Name: _____ Patient Date of Birth: _____

Patient/Responsible Party Signature: _____ Date: _____

Credit Card on File Policy

Thank you for choosing Island Eye Specialists for your eye care needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. With the changing environment in healthcare, more responsibility of payment is being placed on the patient in the form of copays and deductibles. Thus, it has become necessary to ensure we have a guarantee of payment on file in our office.

Effective**, January 1,2024**, Island Eye Specialists will require all patients keep an active credit card on file with us. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of patient responsibility. Circumstances when your card would be charged include but are not limited to:

- missed co-payments, deductible and co-insurance
- any non-covered services and/or denial of services allocated to patient responsibility
- any amount not paid by your insurance 60 days after a corrected claim has been file

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.
If you have any questions about this payment method, do not hesitate to ask.

Please read through the following FAQ section for further information.

Why the Change? With the changing environment in healthcare, more responsibility of payment is being placed on the patient in the form of copays and deductibles. Thus, it has become necessary to ensure we have a guarantee of payment on file in our office.

But I Always Pay My Bills, Why Me? Unfortunately, this is not always the case with some patients that receive our services.

Do I Need to Sign the Credit Card On File Policy? Yes. Your signature ensures understanding of our financial policy.

How Will I Know How Much You Are Going to Charge Me? When we receive payment from your insurance company, you will also receive an EOB (Explanation of Benefits). The EOB will have a column named "Owed by Patient." This is the deductible/co-insurance/copay amount that you owe. We will charge the credit card on file the remaining patient responsibility amount, if any, as per the EOB. Once charged, we will email you an itemized receipt of payment.

But Wait, I'm Nervous About Leaving You My Credit/Debit Card. We do not store your sensitive credit/debit card information in our office. Your information is stored on Practice's credit card processing platform, which uses PCI-Validated Point-to-Point Encryption (P2PE)—the most secure technology available—and includes support for EMV chip-card transactions, reducing credit card processing security risks for our patients.

When Do I Give You My Credit/Debit Card Info? Your credit card information must be given to front office staff before you are seen by a provider.

My Health Plan Has a Health Savings Account (HSA) Card. Can I Keep My HSA Card On-File? Yes, you can keep your HSA card on file, however, we may require an additional card to be kept on file should the funds in your HSA account become insufficient.

What If I Need to Dispute My Bill? We will always work with you and your insurance company to ensure accurate billing. If a billing error has occurred with your insurance company, we will refund any money owed to you once dispute/error is settled.

CREDIT CARD ON FILE POLICY

Keeping your credit or debit card on file is a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are responsible. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account. An itemized statement will be mailed to you specifying insurance payments and the patient responsibility amount charged to your card.

I authorize Island Eye Specialists, APC. to charge the portion of my bill that is my financial responsibility to my credit or debit card which is securely stored on their practice management system.

I, the undersigned, authorize and request Island Eye Specialists, APC to charge my credit/debit card, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me. This authorization will remain in effect until I cancel this authorization in writing. To cancel, I must give a 30-day notification and my account must be in good standing.

Patient Name (Print): _____

Date: _____ / _____ / _____

Patient Signature:_____

NOTICE OF NONCOVERED REFRACTION SERVICES TO PATIENTS

Definition of REFRACTION: The refraction test is an eye examination that measures a person's ability to see an object at a specific distance.

Medicare and most commercial insurance plans do not cover refractions. If it is determined that you need to have this test and your insurance does not pay for it, you will be held responsible for paying that portion of the exam fees (currently $60.00, subject to change) at the time of service along with your co-pay and deductible if not met yet.

By signing, I understand that the refraction may not be a covered service under my insurance plan. If I want a glasses prescription update/renewal or other eye services performed today, I agree to pay any fees related to this non-covered service along with my co pay and deductible.

Patient Signature: _____ Date: _____/_____/_____