PATIENT INFORMATION Date________________________________

Patient's Name ____Ethnicity: ______________________

Sex: Male Female Marital Status: _______________ Date of Birth: ____________Age:_______ Race: _________

Social Security #: _______________________ Driver's License #: ____

If minor, Parent's Name & Social Security #:____

Home Address: ____

City: ____________________________________ State: ___________________ Zip: _______________________

Home Phone Number: _____________________________ Cell/Alternate #: ___________________________________

Email Address: ____ May we email you? ________________

How did you hear about us?__________________________Whom may we thank?________________________________

What pharmacy do you use? ____

May we obtain a list of your medications from your pharmacy? ☐ YES ☐ NO

Address: ____ Phone #: __________________________

Person to contact in case of emergency: ____

His/Her Address: ____ Phone #: ______________________

Who is your Referring Doctor? ____

Referring Doctor's Address: ____ Phone #: ______________________

Who is your Primary Care Physician (PCP)?____

PCP's Address: ____ Phone #: ______________________

Who is your Employer (Occupation)? ____

Business Address: ____ Phone #: ______________________

Primary Insurance: ____________________________________Secondary: ____________________________________

Policy #: ____ Policy #: __________________________________

Policy Holder's Name: __________________________________ Policy Holders Name: ___________________________

Policy Holder's Date of Birth: ___________________________ Policy Holders Date of Birth: ______________________

LEGAL GUARDIAN, SPOUSE, PARENT OR POWER OF ATTORNEY INFORMATION

Name: _______________________________________ Relationship to Patient: ______________________________

Address: ____ Home #:____________________________________

SSN: ____ Driver's License #: __________________________________

The patient or responsible party agrees to the Physician's reasonable and customary fee for medical services. The receptionist will accept cash, check, and credit card for routine visits as you leave. If financial problems arise, please make arrangements or be subject to all costs of collections including, but not limited to, attorney fees, court costs and finance charges. I authorize Florida Eye Specialists to release any information acquired in the course of eye exam or treatment to other physicians, etc for health reasons and consent to the use of photographs for the purpose of documentation, publication in medical journals or presentations during medical meetings.

HEALTH QUESTIONNAIRE

Describe in the space below your main symptoms/problems and how long you have had them (including pain) ____

Review of Eye History

Do you have any known eye diseases? ____
____

Have you had eye surgery, laser or other eye procedure? List types, dates and surgeon's name: ____________________
____

What eye drops or medications or supplements do you take for your eyes? ______________________________

Has anyone in your family been diagnosed with any of the following eye diseases? And who was diagnosed?

☐ Glaucoma ________________________ ☐ Blind (unknown)/Other ________________________

☐ Macular Degeneration ________________ ☐ Retinal Detachment ________________________

Review of Medical History

Are you allergic to any medications? ____

Please list all major illnesses, hospitalizations, and surgeries with their approximate dates:

1) ______________________________ 4) ______________________________

2) ______________________________ 5) ______________________________

3) ______________________________ 6) ______________________________

Social History: *Do you smoke?* ☐ Yes – How much? ________ ☐ Quit – How long ago? ______ ☐ Never

Do you drink alcohol? ☐ Never ☐ Rarely ☐ Occasionally ☐ Daily

Review of Overall Health (check all of the following)

☐ Fever ☐ Chills ☐ Loss of weight ☐ Loss of sleep ☐ Headache ☐ Scalp Tenderness

☐ Jaw pain ☐ Difficulty swallowing ☐ Ringing in ears ☐ Loss of hearing ☐ Sinus problems

☐ Chest pain ☐ Shortness of Breath ☐ Irregular heart beat ☐ Poor circulation

☐ High blood pressure ☐ Low blood pressure ☐ COPD ☐ Heart Disease ☐ Asthma

☐ Frequent urination ☐ Poor appetite ☐ Excessive thirst ☐ Diabetes **Type** ____ ☐ Thyroid ☐ Stroke

☐ Pain ☐ Weakness ☐ Numbness **Which area?** ______________

☐ Bruise easily ☐ Scar easily ☐ Itching/rash ☐ Hay fever ☐ Hives

☐ Depression ☐ Dizziness/Fainting ☐ Multiple Sclerosis ☐ Cancer

OUR FINANCIAL POLICY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Florida Eye Specialists (FES) / North Florida Surgeons (NFS). I am responsible for any applicable deductible or copayment prior to the provision of services. FES/NFS will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. Understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. FES/NFS may file a claim for payment with my insurance company as a courtesy to me. If the primary insurance company fails to pay FES/NFS in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to FES/NFS. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL
I understand that it is my responsibility to provide FES/NFS with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). FES/NFS is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify NFS immediately upon any change in my insurance.

INSURANCE WAIVER
I understand that if I do not have a copy of a current insurance card and valid referral, if required, that I can be seen as a "Private Pay" patient. I agree neither FES/NFS nor I will file a claim for the visit. A waiver will be completed for each visit that I am seen as a Private Pay patient and I will be required to pay the total cost of the visit in advance.

Please be aware that when we call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plan's benefits when your healthcare insurance company receives and processes the claim.

DILATION POLICY

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 POLICY

A refraction 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 refractions "vision" services not a "medical" service. Medicare's benefit policy (100.02, Section 90) states: "Routine physical checkups; eyeglasses, contact lenses and eye examinations for the prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and whatever purpose performed; hearing aids; and immunizations are not covered." 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 $50.00 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. Cataract exams must have a refraction unless done by the referring doctor.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to Florida Eye Specialists. I hereby authorize Florida Eye Specialists to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to Florida Eye Specialists. I hereby authorize Florida Eye Specialists to release medical information necessary to obtain payment. I understand I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of Florida Eye Specialists privacy notice. I understand that I am responsible to read this notice and notify Florida Eye Specialists, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. Florida Eye Specialists has the right to revise this notice at anytime and will post a copy of the current notice in the office in a visible location at all times. Florida Eye Specialists will provide me with a copy of its most recent notice upon my request.

Patient Signature:____**Date:**_______________________

Witness Signature:____

ARBITRATION: THIS ARBITRATION AGREEMENT is made between **North Florida Surgeons, P.A.,** their subsidiaries, affiliated professional associations, physicians, agents, employees, servants, or any of the foregoing, referred to hereinafter as “Doctor” and _________________________,referred to hereinafter as the “Patient”. It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but also their heirs, personal representatives, guardians and any persons deriving claims through or on behalf of the patient.

It is understood by the Patient that he or she is not required to use North Florida Surgeons, P.A. or any Doctor and that there are numerous other physicians located near Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. Other than what may be in conflict with this Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and the Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only. Prior to commencing any action under this Arbitration Agreement, Patient must comply with the pre-suit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by the filing of an application for arbitration within the applicable statute of limitations for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following Florida counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Duval County, Florida. In the event that either party to this Arbitration Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrators shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

Except for legal reporting requirements, all arbitration proceedings and outcomes under this Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Duval County, Florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: “The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay.” The Patient understands and acknowledges that signing this Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, the sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patient has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had this Arbitration Agreement translated for him or her by _________________. The Patient has had an opportunity to ask questions about this Arbitration Agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with an attorney before signing this Arbitration Agreement.

BY SIGNING THIS ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: ____**Date:**________________________________

Parent, Guardian or Legal Representative Signature: ____

Witness Signature:___________________________________ **Physician Signature:**___________________________________