REGISTRATION INFORMATION

Thank you for assisting us in updating your personal information

Date: _____
Patient's Name: _____ Sex: [ ] M [ ] F Age_____ Date of Birth _____
Responsible Party (if a minor):_____ Relationship to Patient: _____
Social Security #:_____ [ ] SINGLE [ ] MARRIED [ ] WIDOWED [ ] SEPERATED [ ] DIVORCED
Address: _____ Home Phone: _____
City: _____ State: _____ Zip:_____

Employed by: (Responsible party if patient is a minor): _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insured's Name: _____ Date of Birth _____ Social Security # _____
Employed By: _____ Occupation: _____
Business Address: _____ Business Phone: _____
How will you be paying for today's visit: [ ] Check [ ] Cash [ ] Credit Card [ ] Insurance
Do you have Medical insurance? [ ] Yes [ ] No If yes, complete below. [ ] Medicare [ ] Medicaid [ ] Workman's Comp.
Primary Insurance Carrier Name: _____Insured's DOB:_____
Contract # _____ Group # _____ Subscriber # _____
Secondary Insurance Carrier Name: _____Insured's DOB:_____
Contract # _____ Group # _____ Subscriber # _____
Do you have a vision plan? [ ] yes [ ] no Name of Plan _____ ID# _____
In case of emergency, who should be notified? _____
Phone # _____ Relationship to Patient: _____
Your Drugstore Name: _____ Phone: _____
How did you learn of our practice? ___Newspaper ___ Friend/Family
___ Radio ___ T.V.
___ Employee ___ Yellow Pages
___ OTHER _____
PURPOSE OF VISIT: _____ Date last eye exam: _____
Do you have a backup pair of glasses? [ ] YES [ ] NO Date last glasses changed: _____
Do you have prescription sunglasses? [ ] YES [ ] NO Do you wear contact lenses? [ ] Yes [ ] No

MEDICAL HISTORY

Do you have the following?

Heart Disease	( ) YES ( ) NO	Arthritis	( ) YES ( ) NO	Allergies:_____
High Blood Pressure	( ) YES ( ) NO	Thyroid Problems	( ) YES ( ) NO	_____
Diabetes	( ) YES ( ) NO	Cancer	( ) YES ( ) NO	_____
Kidney Disease	( ) YES ( ) NO	Sinus Problems	( ) YES ( ) NO	Are you taking Medications?
Lung disease	( ) YES ( ) NO	Do you smoke?	( ) YES ( ) NO	IF YES, PLEASE LIST: _____
AIDS/HIV	( ) YES ( ) NO	Do you drink?	( ) YES ( ) NO	_____
				_____
Do you have, or have you had?				_____
Glaucoma	( ) YES ( ) NO	Double Vision	( ) YES ( ) NO	_____
Cataracts	( ) YES ( ) NO	Blurred Vision	( ) YES ( ) NO	_____
Concussion	( ) YES ( ) NO	Eye Injury	( ) YES ( ) NO	If yes, explain: _____
Head Injury	( ) YES ( ) NO			_____
Amblyopia (lazy eye)	( ) YES ( ) NO			_____
Retinal disease	( ) YES ( ) NO			_____
Tired when reading	( ) YES ( ) NO	Eye Surgery	( ) YES ( ) NO	If yes, explain: _____
Spots in vision	( ) YES ( ) NO			_____
Flashes of light	( ) YES ( ) NO			_____

Other eye or vision problems? ( ) YES ( ) NO If yes, list: _____
Are there any eye diseases or blindness in your family? [ ] Yes [ ] No If yes, explain: _____

DILATION POLICY

We usually include papillary dilation as part of your examination. We may want to dilate your eyes depending on your age and the date of your last examination. Papillary dilation gives the doctor a much better view of the interior of your eyes. There are many eye diseases that cannot be discovered without viewing the eye through enlarging or dilated pupils.

The eye drops we use for this procedure may make your eyes sensitive to sunlight. We provide disposable sunglasses for your comfort and safety. This will make your drive home more comfortable. However, some patients experience blurred vision, which may last for several hours, depending on your individual eye color.

If you feel unable to drive home after dilation, you may want to phone someone to do the driving for you.

Please check one of the following:

____ I agree to have my eyes dilated today.
____ I would like to reschedule my dilation for another day.
____ I would like to discuss this procedure with the doctor before deciding.
____ I do not want my eyes dilated under any circumstances.

Signed _____ Date_____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature for each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ herby authorizes _____
to pay and hereby assign directly to The Eye Center of North Florida all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I further acknowledge that any insurance benefits, when received by and paid to The Eye Center of North Florida, will be credited to my account in accordance with the above said assignment. **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.**

Signed _____ Date _____

FOR MEDICARE PATIENTS ONLY

Please be aware that the fee for refraction (the test of an eyeglass prescription) is not covered by Medicare or Medicare Supplements.

I request that payment of authorized MEDIGAP benefits be made on my behalf to the doctors of The Eye Center of North Florida for any services furnished to me by the doctors of The Eye Center of North Florida. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

Signed _____ Date _____

LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Signed _____ Date _____

THE Eye CENTER of North Florida

2500 MLK Jr. Blvd.
Panama City, FL 32405
(850) 784-3937

10900 Hutchison
Panama City Beach, FL 32407
(850) 234-1829

528-B Fifth Street
Port St. Joe, FL 32456
(850) 227-7266

1400 Main Street
Chipley, FL 32428
(850) 638-7333

To our Patients

NOTICE OF PRIVACY PRACTICES

This Notice is effective As of April 14, 2003.

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

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

How We May Use and Disclose your Medical Information.

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contacting or arranging for other business activities..

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders.

We may contact you to provide appointment reminders.

Treatment Information.

We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services.

We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Notification.

Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

Disaster Relief.

We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Health Oversight Activities.

We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect.

We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings.

We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement.

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners and Funeral Directors.

We may disclose your medical information to a coroner, medical examiner or a funeral director.

Organ Donation.

If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research.

We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent s information.

Public Safety.

We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Workers Compensation.

We may disclose your medical information as authorized by laws relating to workers compensation or similar programs.

Business Associates.

We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

Authorizations.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact our Privacy Officer at the address and phone number on the back of this brochure.

Your Rights Regarding Your Medical Information

You have the following rights with respect to your medical information:

You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the disclosures of your medical information made by our practice during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.

You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact our Privacy Officer at the address and phone number on the back of this brochure.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact our Privacy Officer at the address and phone number on the back of this brochure.

Revision Of Notice Of Privacy Practices

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Date: _____

_____

Patient or Patient's Representative

Print Patient's Name _____

If Signed by Representative, state name of Representative: _____

Relationship to Patient: _____

THE Eye CENTER of North Florida

Medical Information Release Form
(HIPAA Release Form)

Name:_____
Date of Birth: _____/_____/_____

RELEASE OF INFORMATION:

___ I authorize the release of information including the diagnosis, records; examination rendered to me & claims information. This information may be released to:

_____ Spouse:_____
_____Child(ren):_____
_____Other:_____

___ Information is Not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call ____my home ____my work ____my cell

If unable to reach me:
____you may leave a detailed message
____please leave a message asking me to return your call

Signed:_____date:_____
Witness:_____date:_____