Ophthalmology Consultants The Center for LASIK
Specialists in cataract and laser surgery
Eye plastics and reconstructive surgery
Corneal and refractive surgery
www.bestvision.com

Randy Burks, M.D., F.A.C.S.
Ray Gailitis, M.D., F.A.C.S.
Tobe L. Rubin, M.D.

NEW PATIENT INFORMATION

Welcome to our office. Please complete this form and return it to the receptionist, who will use the information to prepare your medical record. **PLEASE PRINT**

Date _____

Name _____ Birthdate _____ Age _____ Sex: M F
(First / Middle / Last) (Mo. Day Yr.)

Mailing Address _____ Phone (_____) _____
(Include apt. # or box # / City / State / Zip)

e-mail _____ Cell Phone (_____) _____

Temporary Address _____ Phone (_____) _____
(Include apt. # or box # / City / State / Zip)

Employer _____ Work Phone (_____) _____

Soc. Sec. # _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Spouse's Name _____ Employer _____ Work Phone (_____) _____

Emergency Contact: Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

Who recommended us? _____
(Name)

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Insurance Information

Please identify your health insurance carrier. ☐ I do not have insurance coverage.

☐ Medicare # _____ ☐ Medicaid #

_____

☐ Medicare Supplement (if applicable) _____ Policy #

_____

☐ Blue Cross/Blue Shield #

_____

☐ Workers Compensation (job injury): ☐ Yes ☐ No If yes, to whom is bill to be sent? _____

☐ Other Insurance _____ Policy #

_____

Policy Holder's Name (if other than patient) _____Birthdate_____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other _____
(Please Specify)

Authorization to Release

I request that payment of authorized Medicare / insurance benefits be made on my behalf to Randy Burks, M.D., F.A.C.S.; Ray Gailitis, M.D., F.A.C.S., Tobe Rubin, M.D., or Ophthalmology Consultants for services rendered to me by the same.

I authorize any holder of medical records, or other information about me, to release to my insurance company or the Health Care Financial Administration and its agents any information needed to determine these benefits for related services.

Signature (Patient, or parent if minor) _____

Print Name _____ Date _____

Name: _____ Date of Birth: _____ Age: _____ Date:_____

Language: □ English □ Spanish □ Other _____ Gender □ Male □ Female

Race: **Ethnic Group:** **Marital Status:**

□ White □ Black or African American □ Asian □ Other race □ Declined to specify	□ Hispanic or Latino □ Not Hispanic or Latino □ Declined to specify	□ Married □ Widow □ Single □ Divorced

Is it OK to leave a detailed message? **Who referred you to us: _____**

Home: □ Yes □ No **Cell:** □ Yes □ No **Your Primary Care Dr.: _____**

Preferred Pharmacy: **Your Optometrist: _____**

Local Pharmacy	Address	Phone Number
Mail Order Pharmacy	Address	Fax Number

Select any of the following medical conditions that you currently have:

☐ Anxiety	☐ Colon Cancer	☐ Hearing Loss	☐ Hypothyroidism
☐ Arthritis	☐ COPD	☐ Hepatitis	☐ Blood Disease
☐ Asthma	☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Lung Cancer
☐ Irregular Heartbeat	☐ Depression	☐ HIV/AIDS	☐ Lymphoma
☐ Enlarged Prostate	☐ Diabetes	☐ High Cholesterol	☐ Prostate Cancer
☐ Breast Cancer	☐ Kidney Disease	☐ Hyperthyroidism	☐ Radiation Treatment
☐ GERD	☐ Seizures		
☐ Other: (please list)	_____	_____	_____

List any surgeries you have had: (Non Eye)

_____ _____

_____ _____

Select any of the following eye conditions that you have:

☐ Cataracts	☐ Diabetic Retinopathy	☐ Macular Degeneration	☐ Retinal Tear
☐ Blepharitis	☐ Dry Eyes	☐ Narrow Angles	☐ Crossed Eyes
☐ Contact Lenses	☐ Glasses/Contact Lens	☐ Ocular Hypertension	☐ Lazy Eye
☐ Corneal Dystrophy	☐ Glaucoma	☐ Ophthalmic Migraine	☐ Floaters
☐ Steriod Respondor	☐ Other: (please list)	_____	_____

Select any of the following eye surgeries that you have had:

☐ Blepharoplasty	☐ Eye Muscle Surgery	☐ Ptosis Repair	☐ Laser Capsulotomy after Cataract Surgery
☐ Cataract Surgery Right	☐ Intravitreal Injections	☐ Punctal Plugs	☐ Glaucoma Laser or Surgery
☐ Cataract Surgery Left	☐ LASIK/ PRK/RK	☐ Retinal Laser or Surgery	☐ Corneal Transplant
☐ Other: (please list)	_____	_____	_____

All information you provide is confidential and will not be released to anyone without your consent

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)
If you have a list, please give it to our receptionist to copy in lieu of filling out form:

General Medications	Dosage	Taken how often? PRN= when needed	Route
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection
		___ Times a day OR ☐ PRN	☐ Oral ☐ Topical ☐ Injection

Eye Medications	Dosage	Taken how often? PRN= when needed	Route
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth
		___ Times a day OR ☐ PRN	☐ Right ☐ Left ☐ by mouth

LIST ANY DRUG ALLERGIES:

_____

_____

SOCIAL HISTORY:

Do you use Tobacco? ☐ Never ☐ Every Day Smoker ☐ Some day Smoker ☐ Former Smoker

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

☐ Blood sugar not under control	☐ Unexplained weight loss	☐ Decrease Vision	☐ Fever
☐ Blood pressure not under control	☐ Shortness of Breath	☐ Anxiety	☐ Joint Pain
☐ Headache	☐ Jaw Pain, Difficulty Chewing	☐ Anemia	

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no	Mother Father Sibling Child/Children	Diabetes	yes	no	Mother Father Sibling Child/Children
Macular Degeneration	yes	no	Mother Father Sibling Child/Children	Hypertension	yes	no	Mother Father Sibling Child/Children
Blindness	yes	no	Mother Father Sibling Child/Children	Stroke	yes	no	Mother Father Sibling Child/Children
Retinal Disorders	yes	no	Mother Father Sibling Child/Children	Thyroid Disease	yes	no	Mother Father Sibling Child/Children
Cancer	yes	no	Mother Father Sibling Child/Children	Arthritis	yes	no	Mother Father Sibling Child/Children
Glaucoma	yes	no	Mother Father Sibling Child/Children		yes	no	Mother Father Sibling Child/Children

All information you provide is confidential and will not be released to anyone without your consent

FINANCIAL POLICY

The fees charged in our office are directly related to the complexity of your problem and the resources devoted to your diagnosis and treatment. Our doctors are participating providers with Medicare and many commercial insurance carriers. Medicare assignment is accepted for all covered services. Due to the many changes in insurance policies, we cannot be responsible for interpreting each & every policy. We will verify that you have a current & active insurance policy only. Therefore, we urge you to please check with your insurance company regarding the specifics of your individual coverage, including co-insurance, copays, and deductibles, as well as who is an authorized provider for your plan. We request payment of the 20% Medicare co-insurance and any deductibles or co-pays at the time of your visit.

Refractive surgery and cosmetic procedures are usually not covered by Medicare and most insurance companies. Please ask our financial counselors about payment options for these procedures.

Referrals & Non-Participating Provider Policy
If you need a referral from your insurance company or from your primary care physician to be seen in our office, we must have the referral at the time of your visit. You are responsible for obtaining the referral. If you do not have a referral you will need to reschedule your visit. If we are not providers for your insurance company, we will need to collect the fee for the visit at the time of service.

Medicare
We accept assignment but you must understand that you are still responsible for the yearly deductible as well as the 20% co-insurance. There are also a number of non-covered Medicare services (i.e. refractions) that you will be responsible for. Make sure you understand your insurance and Medicare coverage limits.

PPO/POS
Your co-pay must be paid at the time of service.

We accept Cash, Checks, MasterCard, Visa, American Express and Discover.

A fee of $50.00 will be charged for any returned check.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

I have read the Financial Policy & I agree to it.

Patient Signature_____ Date_____

Printed Name_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS

_____ DOB: _____ SS#:_____
Name of Patient

I understand that Ophthalmology Consultants/ The Center for LASIK from time-to-time may be requested to disclose my protected health information (PHI) with members of my family or a close friend. Therefore, I authorize Ophthalmology Consultants/ The Center for LASIK to disclose my PHI for the following purposes:

- ☐ Make an appointment for me
- ☐ Cancel an appointment for me
- ☐ Obtain test or lab results on my behalf
- ☐ Discuss my current health condition or symptoms
- ☐ Pick-up written prescriptions or pharmaceutical samples on my behalf
- ☐ Other: _____

with the following individuals:

Person's Name	**Contact Phone #**	**Relationship to Patient**

I understand that if information is requested via telephone, the caller will be asked to identify me by providing (a) my social security number and my date of birth as shown on Ophthalmology Consultants/ The Center for LASIK's records, and (b) the caller's full name shown above. If the request is made in person, the individual will be required to provide proper identification, including a picture ID.

I understand that in order to add or delete designated people from this list, I must notify Ophthalmology Consultants/ The Center for LASIK in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to Ophthalmology Consultants/ The Center for LASIK.

_____ _____
Print Name of Patient / (Personal Representative) Signature of Patient / (Personal Representative)

_____ _____
Personal Representative Relation to Patient Date signed

PRIVACY NOTICE CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity
  to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.
- The Practice Utilizes a number of methods to contact or communicate with our patients. We use the telephone, posted mail, e-mail, facsimile transmission (fax), TTY relay operators and translators. If you do not want the Practice to communicate with you by any of the methods listed above, you must so state.

  □ Any of the above communication methods are acceptable
  □ Please do not use the following methods to contact me:
  _____

This Consent was signed by: _____
Sign and print name

Relationship to Patient (if other than patient):_____

Date:__/__/__

In front of _____
Sign and print name

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. You may request the detailed Notice from our office staff.

Date of Last Revision: Feb 25, 2016
Effective Date: Immediately

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices document):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please request the detailed Notice of Privacy Practices document from our office staff.

24 HOUR CANCELLATION & "NO SHOW" OFFICE FEE POLICY

Every time a patient misses a scheduled appointment without providing proper notice to the office, another patient is prevented from receiving the care they require. Therefore the physicians at Ophthalmology Consultants reserve the right to charge a fee of $50.00 for all missed Appointments/No Shows etc which are not cancelled with the courtesy of a 24-hour notification.

Thank you for your understanding and full cooperation as we strive to best serve the needs of all our of patients.

By signing below you acknowledge that you have received this notice & understand this policy.

_____ _____

Printed Name **Date**

Signature

ABOUT YOUR REFRACTION

The refraction is an important part of your medical eye exam because it helps determine if eye diseases, such as cataracts or macular degeneration, are affecting your vision. The refraction portion of your eye exam also determines if eyeglasses or a change in your present lenses are needed to optimize your vision.

The charge for your refraction is $65.00. Most medical insurances consider the refraction a non-covered service and therefore, will not pay for it. You will be responsible for this payment plus any co-payments and deductibles on the day of your exam.

If you have questions regarding refractions, their importance to your exam, or insurance policy concerning coverage of refractive services, please ask our office staff or call your carrier at the toll free number listed on your insurance card.

Ophthalmology Consultants