

Personal Information Sheet

Name _____ Date of Birth _____ Account Number _____

Sex M / F Marital Status S / M / W / D Who may we thank for referring you? _____

Primary Address _____

Secondary Address (if applicable) _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ Driver's License _____

Social Security Number _____ Primary Care Physician _____

Employer _____ Address _____

If under 18 years of age Parent / Guardian _____

Insurance Information

Primary Insurance _____ Policy Number _____

Policy Holder _____ Date of Birth _____

Secondary Insurance _____ Policy Number _____

Policy Holder _____ Date of Birth _____

Emergency Contact

Person to notify in case of emergency _____ Phone _____

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Financial Agreement

1. I request that payment of the authorized Medicare and/or Insurance benefit be on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents for any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid for by said insurance. I hereby authorize and assign to release all information needed to secure the payment.

Patient signature _____ Date _____

Patient History Record

Name _____ Date of Birth _____ Primary Care Physician _____

Occupation _____ Referred by _____

Pharmacy _____ Pharmacy Phone _____

Medical History: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes (Insulin dependent?) Y/N When were you diagnosed? _____ | |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Other _____ | |

Eye History: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Amblyopia "lazy eye" | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Eye surgery? _____ | |

Family History: Diabetes Glaucoma Macular degeneration Other None

Review of Systems:

Do you have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic fever, unexpected weight loss/gain, fatigue? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear / nose/ throat problems (ex: hearing loss, sinus problems, sore throat)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart problems (ex: chest pain, irregular heart beat)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory problems? (ex: shortness of breath, wheezing, coughing)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastrointestinal problems (ex: heartburn, abdominal pain, diarrhea, vomiting)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary problems (ex: pain or discomfort, blood in urine)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin problems (ex: rashes, excessive dryness)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Musculoskeletal problems (ex: muscle aches, joint pain, swollen joints)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological problems (ex; numbness, weakness, headaches, paralysis)? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric problems (ex: depression, anxiety)? _____ |

Medications / Vitamins / Supplements:

Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____	Name _____	Dose _____	Frequency _____

Allergies:

Medication / Food _____ Reaction _____

Medication / Food _____ Reaction _____

Social History: Yes No Smoke If Yes how much? _____ Yes No Drink alcohol If Yes how much? _____

Patient Signature: _____ Date: _____

Technician Updates:

Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____
Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____
Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____
Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____

Sarasota Ophthalmology

Financial Practices Disclosure

Welcome to the office of Sarasota Ophthalmology. We would like to explain to you our financial procedures.

HMO/POS Policies: Patients must have and obtain a prior authorization from their primary care physician before they can be seen for their scheduled appointment. If your authorization is not here prior to your arrival, you will be asked to reschedule or sign a waiver that you accept full financial responsibility for all services rendered.

HMO/PPO/POS Policies: Patients must pay their co-payment at the time of service as requested by their individual policy, unless prior arrangements have been made with the practice management. If your deductible has not been met you will be financially responsible and billed for this amount once we have been notified by your insurance carrier.

Self Pay Policy: Patients with no insurance will be expected to pay for all services rendered in full on the day of the visit, unless prior arrangements have been made with the practice management.

Medicare: We accept assignment on all Medicare claims. As participating providers, we are required by law to file all Medicare claims. As a courtesy we will file a claim to your supplemental insurance company. However, any claim not paid within 60 days will be billed to you and you will be expected to follow-up with your insurance carrier.

Auto Insurance Policy: We will file your insurance as a courtesy to you upon verification of all claim information with your insurance carrier. If we cannot verify this information you will be considered self pay. (see policy)

Worker's Compensation Policy: Patient must have prior approval before being seen at our practice.

Medicaid: We don't accept.

We accept: Cash, personal checks, Visa, Master card, Discover and American Express.

I have read and accept the financial policies and procedures outlined above. I hereby acknowledge this notice and accept financial liability for the professional services being provided by the physicians of Sarasota Ophthalmology Associates. If payment is denied by my insurance carrier as a "non covered" service, I accept full financial responsibility.

Patient/ legal guardian signature: _____

Date _____

Doctor: Dr. Halvey / Dr. Campbell

Patient # _____

Sarasota Ophthalmology

Assignment of Medicare Benefits

I request that payment of authorized Medicare benefits be made on my behalf to:

Sarasota Ophthalmology

For any services furnished to me by a physician of this practice, I hereby authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for services rendered. This provider agrees to accept the assigned charge determined by Medicare.

My signature below verifies that ***I understand that I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, as well as any non-covered services.*** I also verify that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished. This assignment shall remain in effect until revoked by me in writing. I give my permission to fax any medical records needed with the understanding that there is a possibility of it being misdirected.

Medicare # _____

Name as it appears on ID card: (Print) _____

Signature: _____ Date _____

*Refraction is the optical determination of your best possible vision. It is needed to determine if any optical, medical and/or surgical treatment is necessary. It is an essential part of an eye exam. However, it IS NOT covered by Medicare or most secondary insurances. Our office charge for the refraction is \$35.00. My initials below signify that I understand that a refraction is not a covered service and that this fee will be collected at the time of service in addition to any deductible or co-payment Medicare and/or my supplemental insurance requires. Initials: _____

Secondary Insurance

I request that payment of authorized benefits be made on my behalf to:

Sarasota Ophthalmology

For any services furnished to me by a physician of this practice, I hereby authorize any holder of medical or other information about me to release it to my insurance company, billing agent, and/or the Centers For Medicare & Medicaid Services to determine these benefits payable for services rendered.

My signature below verifies that ***I understand that I am responsible for any or all co-payments, deductibles or non-covered services rendered by this practice.*** I give my permission to fax any medical records with the understanding that there is a possibility of it being misdirected.

Insurance Company: _____

Member I.D. : _____

Signature : _____ Date _____

Sarasota Ophthalmology

HIPAA

(Health Insurance Portability and Accountability Act)

Notice of Privacy Practices Acknowledgement

By signing below I acknowledge that I have received a copy of Sarasota Ophthalmology's notice of privacy practices.

I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact the organization at any time to obtain a current copy of the privacy notice.

Signature : _____ Date: _____

Printed Name: _____

If patient is a minor or unable to sign form:

Signature of legal parent/guardian: _____ Date: _____

Printed Name of legal parent/guardian: _____ Date: _____

Sarasota Ophthalmology is authorized to disclose appointment, billing, medical information with the following:

Name: _____ Relationship: _____

Phone number _____

Name: _____ Relationship: _____

Phone number _____

Name: _____ Relationship: _____

Phone number _____

Patient Signature _____ Date: _____

Official Use Only

I attempted to obtain the patient signature. On this acknowledgement, I was unable to do so for the following reason: _____



Sarasota Ophthalmology **Notice of Privacy Practices**

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. If you have any questions about this notice, please contact our Privacy Officer.

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, which may identify you and relates to your past, present or future physical or mental health condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at anytime. 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.

1. Uses and Disclosures of Protected Health Information.

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician or health care provider (e.g. specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for surgery may require that your relevant protected health information be disclosed to the health plan to obtain approval for the surgery.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical staff, licensing, etc. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g. billing, transcription services: for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization: Other uses and disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent. Authorization or Opportunity to Object: We may use or disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of your protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use your protected health information to treat you.

Communication Barriers: We may use or disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

Other Permitted and Required Uses and Disclosures That May be Made Without Your Consent, Authorization or Opportunity to Object.

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaboration with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuses, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products, to enable product recalls, to make repair or replacement, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to an order of a court

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include 1) legal processes and otherwise required by law, 2) limited information requests for identification and location purposes, 3) pertaining to victims of a crime, 4) suspicion that death has occurred as a result of criminal conduct, 5) in the event that a crime occurs on the premises of the practice, and 6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel 1) for activities deemed necessary by appropriate military command authorities, 2) for the purposes of a determination by the Department of Veterans Affairs of your eligibility for benefits, or 3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected services to the President or to others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

2. Your Rights

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physicians not required to agree with a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction we may not use the disclosure of your protected health information of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you may wish to request with your physician. You may request a restriction by notifying our Privacy Officer in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate all reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specifications of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosure we have made to you, to family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by contacting our Privacy Officer at 941-955-6363. You will not be penalized for filing a complaint.

This notice was published and becomes effective on March 10, 2003.