Perez EYE CENTER

4506 WISHART PLACE, TAMPA, FLORIDA 33603 • • TEL. 813-875-6588 • • FAX. 813-873-3688

PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Today's Date _____

PATIENT'S NAME (First, Middle, Last)		PATIENT'S DATE OF BIRTH		PATIENT'S AGE
PATIENT'S COMPLETE MAILING ADDRESS	CITY	STATE	ZIP CODE	PATIENT'S SEX
PATIENT'S HOME PHONE NUMBER / CELL PHONE	PATIENT'S SOCIAL SECURITY NUMBER			
E-MAIL ADDRESS	HOW DID YOU HEAR ABOUT US? ☐ Walk-In ☐ Radio ☐ Website ☐ Patient Referral _____			
NAME AND RELATIONSHIP OF FAMILY MEMBERS SEEN HERE	☐ Primary Doctor Name & Phone Number _____ ☐ Other: _____			
PATIENT'S EMPLOYER	SPOUSE'S NAME			
PATIENT'S WORK PH. (Area Code, Number, Ext.) / FAX NUMBER	SPOUSE'S SOCIAL SECURITY NUMBER			
1ST INSURANCE - POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER	SS #	DOB	
2ND INSURANCE - POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER	SS #	DOB	
EMERGENCY CONTACT (Name & Phone Number)				
PREFER SPANISH OR ENGLISH				

FOR MINORS:

MOTHER'S NAME (or Legal Guardian)		FATHER'S NAME	
MOTHER'S EMPLOYER		FATHER'S EMPLOYER	
WORK PHONE (Area Code, Number, Ext.)	FAX NUMBER	WORK PHONE (Area Code, Number, Ext.)	FAX NUMBER
MOTHER'S SOCIAL SECURITY NUMBER	DOB	FATHER'S SOCIAL SECURITY NUMBER	DOB
NAME(S) OF PATIENT'S SIBLINGS (Name & Age, Name & Age, Name & Age, Name & Age) *CHILDREN ONLY			

PAYMENT AUTHORIZATION

I understand that payment of all medical care is due and payable at the time of service, and that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any cost incurred in the collection of patient's account in case of default, including reasonable attorney's fees, court cost, and hereby waive presentment for payment, protection, and notice of protection, and non-payment of outstanding account. I understand it is my responsibility to provide current and accurate insurance information to file claims.

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to the undersigned physician or supplier.

PRINT	SIGN	DATE	RELATION

AUTHORIZATION TO ADMINISTER DIAGNOSTIC OPHTHALMIC DROPS

I consent to the administration of diagnostic ophthalmic drops by the medical personnel of the Perez Eye Center during the course of the examination. I understand that these dilating drops are an essential part of the ophthalmic examination and may produce sensitivity to light and slightly blurred vision lasting from four (4) to twenty-four (24) hours.

PRINT	SIGN	DATE	RELATION

POS® Reorder # 1314717

Perez EYE CENTER
Medical & Health History Form

Date _____

Patient Name _____ DOB _____ Age _____ Sex: M or F

Certain illnesses, and drugs may make it necessary to alter our treatment in our effort to provide the best possible health care to you (or your child), it is necessary to have the following information.

Current Medications		Ocular Medications	Allergies
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate answer regarding your ***MEDICAL HISTORY*** of the following:

☐ Have you ever sued or been involved in a lawsuit against a doctor or hospital?

- ☐ Alzheimer's disease
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma, emphysema, lung problems
- ☐ Atherosclerosis
- ☐ Bleeding or clotting disorders
- ☐ Bone loss
- ☐ Brittle hair or nails
- ☐ Cancer
- ☐ Cataracts
- ☐ Chronic fever
- ☐ Coronary artery disease
- ☐ Degenerative joint disease
- ☐ Dementia
- ☐ Depression, mild
- ☐ Diabetes
- ☐ Dysmenorrhea
- ☐ Environmental allergies (hay fever, cats, dogs, etc.)
- ☐ Epilepsy, other nervous disorders
- ☐ Fatigue
- ☐ Fluid retention
- ☐ General health / wellness
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heartburn, abdominal pain, ulcer
- ☐ Heart Disease
- ☐ Hepatitis or other communicable diseases
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV or AIDS
- ☐ Hot flashes
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Insomnia
- ☐ Joint pain / stiffness
- ☐ Kidney stones, kidney or bladder infections
- ☐ Low energy levels
- ☐ Macular degeneration (eye sight)
- ☐ Memory loss
- ☐ Menopause
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peripheral vascular disease
- ☐ PMS
- ☐ Pregnancy
- ☐ Rashes, hives, excessive dryness
- ☐ Sinusitis, or other sinus problems
- ☐ Stress
- ☐ Thyroid problems
- ☐ Unexpected weight loss or gain

Please indicate answer regarding your ***FAMILY HISTORY*** of the following:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Glaucoma
- ☐ Macular degeneration (eye sight)
- ☐ Blindness
- Other retinal problems
- ☐ "Lazy eye" or amblyopia
- ☐ Crossed eye or eye drift
- ☐ Other not listed _____

Please indicate answer regarding your ***SOCIAL HISTORY*** of the following:

- ☐ Currently smoke _____ packs per day
- ☐ Quit smoking/How long ago? _____
- ☐ Currently drink alcohol/ How many drinks and how often? _____ drinks each (circle one) day / week / month

Patient Signature _____ **Date** _____

Tech Signature _____ **Date** _____

Updated _____ Tech Initial _____	Updated _____ Tech Initial _____	Updated _____ Tech Initial _____
Updated _____ Tech Initial _____	Updated _____ Tech Initial _____	Updated _____ Tech Initial _____
Updated _____ Tech Initial _____	Updated _____ Tech Initial _____	Updated _____ Tech Initial _____

PLEASE READ CAREFULLY

DOCTOR-PATIENT ARBITRATION AGREEMENT

This agreement is made between Perez Eye Center, Don J. Perez, M.D., Bernard R. Perez, M.D., their agents, employees or any of the foregoing, referred to herein as "Doctor" and _____ referred to hereinafter as the "patient". It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, children, spouses or any person deriving their claims through or on behalf of the patient.

It is understood by the patient that he or she is not required to use Dr. Don J. Perez, M.D., Bernard R. Perez, M.D., nor any of the foregoing referred to as "doctor" for ophthalmic surgery and that there are numerous other physicians in the Tampa Bay area who are qualified to perform ophthalmic surgery.

For in consideration of the mutual benefits flowing one to the other, it is understood and agreed that in the event of any controversy, dispute, or claim which might arise between the doctor and the patient, regardless of whether the dispute concerns medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided in the Florida Arbitration Code, Chapter 682, Laws of Florida. IT IS UNDERSTOOD THAT THIS ARBITRATION SHALL BE IN LIEU OF AND INSTEAD OF ANY TRIAL BY JUDGE OR JURY. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The arbitrators shall be licensed physicians certified by the American Board of Ophthalmology and actively engaged in the practice of ophthalmology in the State of Florida. The panel of arbitrators shall hear and decide the controversy, dispute or claim, and the decision shall be binding on all parties.

It is further understood and agreed by the parties hereto that the arbitration of any controversy, dispute or claim pursuant to this agreement shall be commenced within the time prescribed by the applicable Florida Statute of Limitations. An action pursuant to this agreement shall be deemed to commence upon receipt of a written claim notifying the Doctor or Patient, whichever the case may be, of the nature of the controversy, dispute, claim, and demanding that the parties proceed with arbitration in accordance with the terms of this agreement. The maximum recoverable damages under this agreement are limited to $250,000.00

In witness thereof, I (We) have set our hands this _____ day of _____ 20 _____.

"Doctor" "Patient"

by: _____ by: _____
Authorized agent Patient

Witness: _____
Witness: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 included a series of "administrative simplification" provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. By ensuring consistency throughout the industry, these national standards will make it easier for health plans, doctors, hospitals and other health care providers to process claims and other transactions electronically. The law also requires the adoption of security and privacy standards in order to protect personal health information. HHS is issuing the following major regulations:

- Electronic health care transactions;
- Health information privacy;
- Security requirements;
- Unique identifier for providers;
- Unique identifier for health plans; and
- Enforcement procedures.

Although the HIPAA law also called for a unique health identifier for individuals, HHS and Congress have indefinitely postponed any effort to develop such a standard.

Today, health plans, hospitals, pharmacies, doctors and other health care entities use a wide array of systems to process and track health care bills and other information. Hospitals and doctor's offices treat patients with many different types of health insurance and must spend time and money ensuring that each claim contains the format, codes and other details required by each insurer. Similarly, health plans spend time and money to ensure their systems can handle transactions from various health care providers.

HIPAA includes a wide array of provisions designed to make health insurance more affordable and accessible. With support from health plans, hospitals and other health care businesses, Congress included provisions in HIPAA to require HHS to adopt national standards for certain electronic health care transactions, codes, identifiers and security. HIPAA also set a three-year deadline for Congress to enact comprehensive privacy legislation to protect medical records and other personal health information. When Congress did not enact such legislation by August 1999, HIPAA required HHS to issue health privacy regulations.

Security and privacy standards can promote higher quality care by assuring consumers that their personal health information will be protected from inappropriate uses and disclosures.

In addition, uniform nationals standards will save billions of dollars each year for health care businesses by lowering the costs of developing and maintaining software and reducing the time and expense needed to handle health care transactions.

By signing this authorization form you agree to have your protected health information used and possibly shared with your other doctors for your treatment and reimbursement from my health insurance.

Print Name

Signature Date

ADVANCE BENEFICIARY NOTICE

We expect that your insurance will not pay for the item(s) or service(s) that are described below. Your insurance does not pay for all of your health care cost. Your insurance only pays for covered items and services when your insurance rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommened it. Right now, in your case, **your insurance will not pay for -**

Items or Services:

Determination of refractive state - this procedure is not included in the general ophthalmological service. Determination of refractive state includes specification of lens type, lens power, axis, prism, absorptive factor, impact resistance, and other factors. **The cost for this service is $45.00.**

☐ **YES.** I want to receive these items or services.
(Payment due when services rendered)

☐ **NO.** I have decided not to receive these items or services.

DATE _____ Signature of patient or person acting on patient's behalf _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office.