FLORIDA EYE CLINIC
Ambulatory Surgical Center

160 BOSTON AVENUE, ALTAMONTE SPRINGS, FLORIDA 32701
TELEPHONE (407) 834-7776 • (800) 456-8515

Dear Patient,

We are pleased that you have chosen the Florida Eye Clinic for your eye care. We pledge to provide you with the very finest services available. We look forward to meeting you at your scheduled appointment time.

Please download, print and complete your "Patient Account" and "Medical History" form. We ask that you fill out both sides completely. PLEASE BRING THIS COMPLETED FORM WITH YOU WHEN YOU COME IN FOR YOUR APPOINTMENT. PLEASE DO NOT MAIL IN THIS FORM. This will save you time upon your arrival and ensure that we have all the information needed for insurance and medical purposes.

The cost of your initial eye exam will vary depending on the type of testing performed and your insurance coverage. Please bring your health insurance cards, list of medications and your pharmacy information with you.

Your eyes will be dilated and you should plan to be with us for an hour and a half to two hours. You may wish to bring a driver.

Once again, thank you for choosing the Florida Eye Clinic. We look forward to serving your eye care needs.

Very truly yours,

The Doctors and Staff of the Florida Eye Clinic

Visit our Website at www.floridaeyeclinic.com for additional information, a map to our locations or Optical Coupons.

FLORIDA EYE CLINIC - ACCOUNT INFORMATION (Please Print)

CHART # _____ DATE _____ DR'S NAME _____

PATIENT NAME LAST _____ FIRST _____ MI _____

SEX_____ RACE_____ DOB _____ AGE_____ PATIENT'S SOC. SEC. # _____

HOME PHONE (____)_____ WORK PHONE (____) _____ CELL PHONE (____) _____

ADDRESS STREET _____ CITY _____ STATE _____ ZIP _____

EMPLOYER_____ ADDRESS_____

EMERGENCY CONTACT: (OTHER THAN HOME TELEPHONE NUMBER)

NAME_____ PHONE (_____)_____RELATIONSHIP _____

REFERRED BY: DR. / OTHER_____CITY_____

PRIMARY CARE PHYSICIAN: _____CITY_____

NAME AND ADDRESS OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE_____ **SECONDARY INSURANCE** _____

POLICY HOLDER_____ POLICY HOLDER _____

POLICY HOLDERS'S SOC. SEC. #_____ POLICY HOLDER'S SOC. SEC. # _____

POLICY HOLDER'S DATE OF BIRTH _____ POLICY HOLDER'S DATE OF BIRTH _____

WHAT RELATIONSHIP ARE YOU TO THE POLICY HOLDER?_____

EMAIL:_____

WHO CAN WE SPEAK WITH PERTAINING TO YOUR HEALTH CARE:

NAME	RELATIONSHIP	CONTACT NUMBER

FLORIDA EYE CLINIC HAS PERMISSION TO CONTACT ME ON MY CELLULAR PHONE YES / NO

FLORIDA EYE CLINC HAS PERMISSION TO LEAVE MESSAGE ON MY HOME OR CELLULAR PHONE YES / NO

PHARMACY NAME: _____

ADDRESS: _____

PHONE:_____ DATE: _____

SIGNATURE: _____

PATIENT NAME _____

LIFETIME INSURANCE ASSIGNMENT

A. In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient (including but not limited to private and group health, automobile liability, general liability, personal injury protection, medical payments, and uninsured or underinsured motor vehicle benefits) such benefits or recovery are hereby assigned directly to Florida Eye Clinic "FEC" for application to the patient's bill, and I authorize payment to FEC of such benefits or recovery. It is agreed that FEC may receipt for any such payment. I am responsible for charges not covered by this assignment.

B. I hereby assign the insurance benefits otherwise payable to the undersigned and/or patient to any involved physician(s), and I authorize direct payment to said physicians of such benefits. I am responsible for charges not covered by this assignment.

C. Section 817.234, Florida Statutes, stipulates that "any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement or claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree."

2. ASSIGNMENT OF MEDICARE BENEFITS: PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST. (Medicare Patients Only)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on the patient's 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 to me. I understand that I am responsible for any applicable deductible and co-insurance, and non-covered charges, including personal charges.

3. PATIENT/GUARANTOR AGREEMENT.

A As used in the Agreement, "non-covered charges" mean that are not covered by a third party for any reason, including, but not limited to, denial of coverage, exclusion from coverage, and absence of a responsible third party payor. However, "non-covered charges" do not include the difference between FEC's charges and rates that have been established by contract, if any between FEC and the responsible third party payor(s).

B. Whether I sign as agent/representative or patient, in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay and unconditionally guarantee payment to FEC of patient's co-payments, deductibles and non-covered charges, in accordance with the regular rates and terms of FEC, or such other rates and terms as are applicable to patient's account(s) by contract or regulation. Should any portion of the patient's account(s) be referred to any attorney for collection, I agree to pay all expenses of collection, including reasonable attorney's fees, whether or not suit is filed.

C. I agree to pay FEC at TIME OF SERVICE all co-payments, deductibles, and non-covered charges. I agree that if FEC has been unable to verify patient's coverage, I will pay the entire estimated charges.

D. Our practice imposes a $25 fee for NSF charges for returned checks.

I certify I have read the foregoing. I certify I am the patient, or that I am duly authorized as the patient's agent or representative to execute the above and accepts its items.

Signature _____

Note: The refractive portion of your exam is not reimbursable (paid) by medical insurance. This fee is your responsibility and will be collected at the time of service.

Initials: _____

MONTHLY ATTESTATION STATEMENT

By signing I confirm the insurance & personal information listed on the front of this form is accurate.

DATE	INSURANCE (List all)	SIGNATURE	FEC INITIALS

FLORIDA EYE CLINIC
Ambulatory Surgical Center

FEC Record #_____

FLORIDA EYE CLINIC - MEDICAL/SOCIAL HISTORY

PLEASE BRING THIS FORM WITH YOU THE DAY OF YOUR APPOINTMENT

Date_____ Patient's Name_____

If Child: Mother's Name_____ Father's Name _____

WHAT IS YOUR MARITAL STATUS? ❑ Single ❑ Married ❑ Divorced ❑ Widowed Occupation _____

PLEASE CHECK "YES" OR "NO" FOR THE FOLLOWING

1. Social Drug Use?	❑ YES	❑ NO				
2. Alcohol?	❑ YES	❑ NO	DRINKS/DAY			
3. Tobacco Use	❑ YES	❑ NO	PACKS/DAY _____	❑ NEVER	❑ FORMER	❑ CURRENT
4. Diabetes	❑ YES	❑ NO	HOW LONG?	MEDICATION		
5. High Blood Pressure	❑ YES	❑ NO	HOW LONG?	MEDICATION		
6. Heart Disease	❑ YES	❑ NO	HOW LONG?	MEDICATION		
7. Cancer	❑ YES	❑ NO	HOW LONG?	MEDICATION		
8. Arthritis	❑ YES	❑ NO	HOW LONG?	MEDICATION		
9. Lung Disease	❑ YES	❑ NO	HOW LONG?	MEDICATION		
10. Glaucoma	❑ YES	❑ NO	HOW LONG?	MEDICATION		
			HAVE SURGERY?	WHICH EYE?	WHEN?	
11. Cataracts	❑ YES	❑ NO	HOW LONG?	SURGERY?	WHEN?	
			INTRAOCULAR LENS IMPLANT			
12. Do you wear contacts?	❑ YES	❑ NO	HOW LONG?	HARD	SOFT	EXT. WEAR
13. Have Lazy Eye (Amblyopia)	❑ YES	❑ NO	HOW LONG?	WHICH EYE?		

Is there a family history of any of the above diseases? ❑ YES ❑ NO Which disease? _____

List any other medical conditions you have_____

_____

What other medicines do you take? _____

_____

To what MEDICINES are you ALLERGIC? ❑ Penicillin ❑ Sulfa ❑ Steroids ❑ Aspirin ❑ Codeine

❑ Other (list them)_____

Are you ALLERGIC to any EYE DROPS? ❑ YES ❑ NO IF YES, IDENTIFY_____

Have you ever had an eye examination? ❑ Ophthalmologist ❑ Optometrist

❑ Other Date of last exam:_____ Name/address of examiner _____

Do you use eye drops? ❑ YES ❑ NO Please list_____

When was your last change in eyeglasses? _____

Have you ever been hit in the eye? q YES ❑ NO When? _____ Which Eye? _____

What eye surgery have you had? _____

Are you, or have you ever been cross-eyed? _____

WHAT IS THE MAIN PROBLEM YOU ARE PRESENTLY HAVING WITH YOUR EYES? _____

_____

_____

Are you pregnant? ❑ YES ❑ NO

Are you interested in surgery to reduce your need for glasses? ❑ YES ❑ NO

I understand that many examinations will require dilation of the pupil of the eyes which may make my driving vision blurry and light sensitive and my transportation is my responsibility.

Signature_____

INFORMED CONSENT FOR THE ADMINISTRATION OF MEDICATION TO CHILDREN

I give permission for eye medication to be administered to my son/daughter. I understand that these medications are for the purpose of his/her diagnosis and treatment.

I realize that in the course of this diagnosis and treatment, my child may need to be restrained by being held during the administration of drops or examination. In that event, I understand that I'm responsible for the restraint and holding of my child.

Signature_____

Patient's Name _____ Chart # _____

SPECIAL PROCEDURE / SURGERY / PROBLEM LIST

OFFICE USE ONLY			
DATE	**DOCTOR**	**SURGERY / PROCEDURE / DIAGNOSIS**	**POST OPERATIVE PERIOD**

SUMMARY OF PRIVACY PRACTICE

This summary of our privacy practices contains a condensed version of our 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.

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 that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- To run our Practice more efficiently and ensure all our patients receive quality care
- For appointments and patient recall reminders
- For research
- To avert a serious threat to health or safety
- 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 see the detailed Notice of Privacy Practices.

Signed by: _____ Relationship (*if other than patient)* _____

Printed Name of Patient or Representative _____ Date: _____

OFFICE USE ONLY			
MEDICAL INFORMATION DISCLOSURE LOG			
DATE	**RECORDS REQUESTED**	**SENT TO**	**FEC STAFF SIGNATURE**

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Florida Eye Clinic Presents
A New Look on Life with Advanced Technology Intraocular Lenses

A Breakthrough in Cataract Surgery Providing Freedom from Glasses

The vast majority of patients who undergo cataract surgery today receive monofocal lenses which typically require them to use reading glasses or bifocals for near vision following surgery. Until now, conventional (standard) intraocular lenses used in cataract procedure provided good functional distance vision, but offered little benefit for a full range of vision, making most patients dependant on glasses even after surgery.

FINALLY…AN OPTION…FREEDOM FROM GLASSES

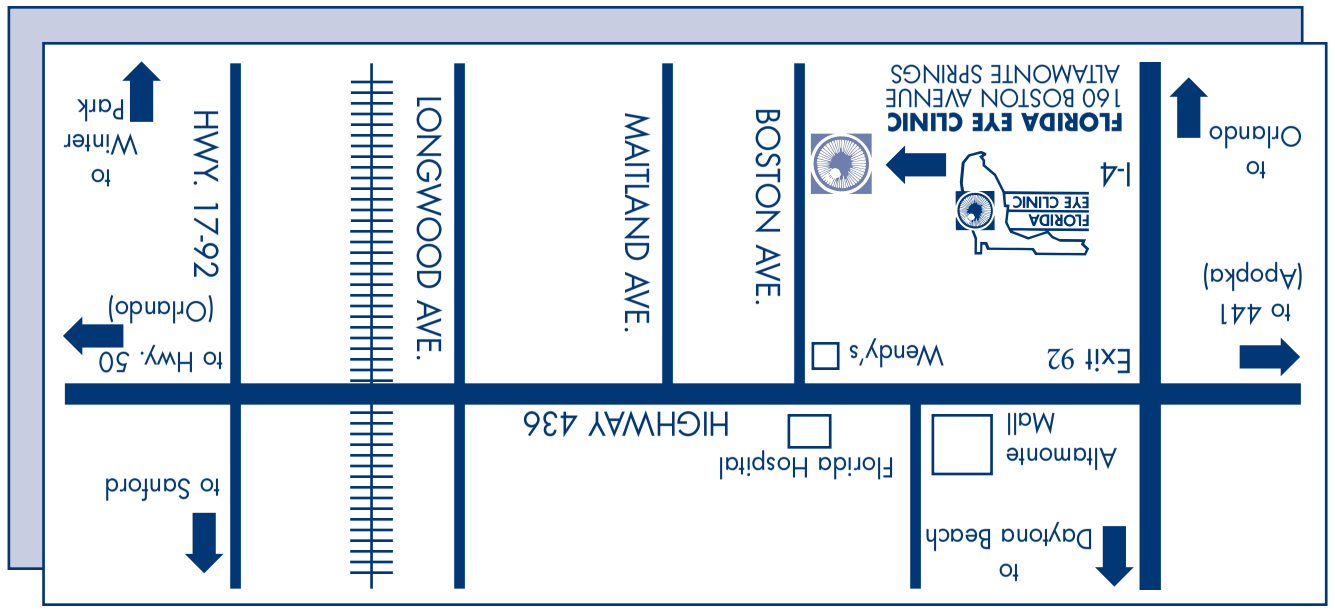
Advanced technology lenses are a breakthrough lens that uses patented technology, giving patients a full range of vision, near through distance, and greatly reduces the reliance on reading glasses or bifocals.

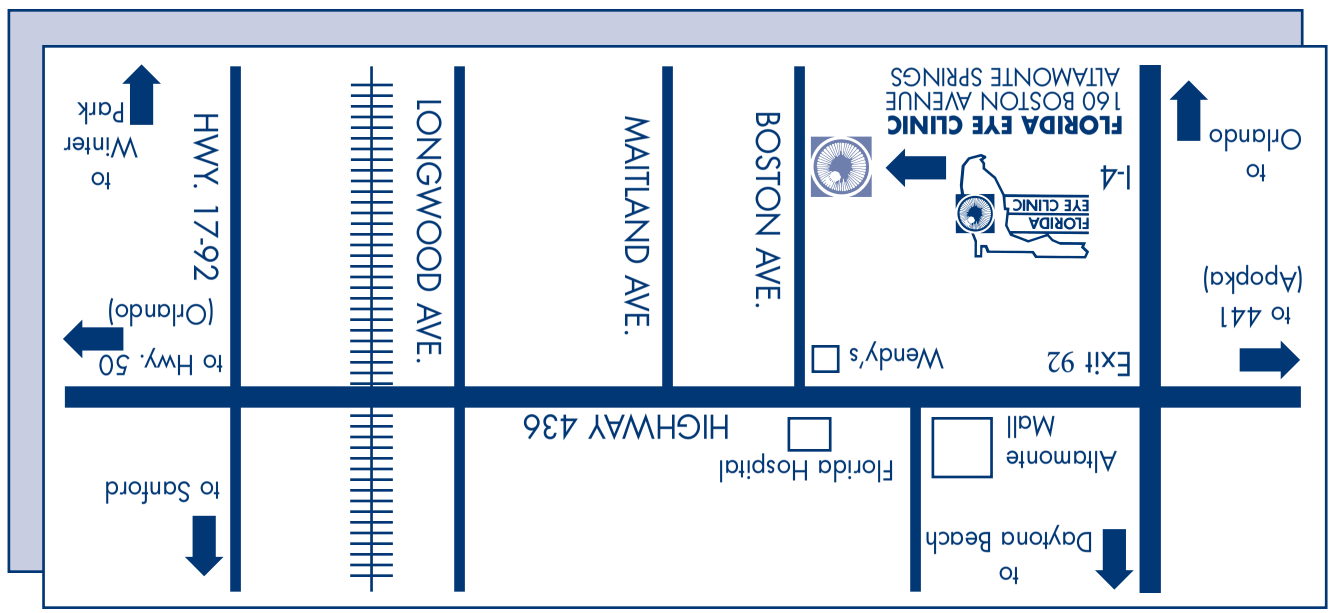
What does this mean for you?

It means a better quality of life, through visual freedom. With the Advanced Technology lenses, it may be possible to read the print on items such as magazines and newspapers, while also having the ability to drive or go on sightseeing tours, all without using glasses. In fact, the FDA clinical studies have demonstrated that 80 percent of patient never needed to wear glasses or bifocals again.

Who is a candidate?

Not everyone is a candidate for the Advanced Technology Lenses. Please speak to one of our surgeons at Florida Eye Clinic to see if you could benefit from this Advanced Technology!





FLORIDA EYE CLINIC

REMINDERS

PLEASE BRING WITH YOU:

- YOUR PRESCRIPTION.
- DARK SUNGLASSES.
- INSURANCE REFERRALS & CARDS.
- THE PATIENT'S SOCIAL SECURITY & MEDICARE NUMBERS.
- A LIST OF ALL MEDICATIONS & DOSES.

IF YOU DO NOT HAVE DARK SUNGLASSES, DISPOSABLE DARK GLASSES ARE AVAILABLE.

MOST EXAMINATIONS INCLUDE DILATION OF THE PUPILS OF YOUR EYES. YOUR DRIVING VISION MAY BE AFFECTED AND YOU MAY PREFER TO HAVE SOMEONE DRIVE YOU HOME.

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