Orlando Eye Associates
7682 Dr. Phillips Blvd., Suite A
Orlando, FL 32819
Phone (407)351-3880
Fax (407)351-4846

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name				**Salutation**	
Date of Birth		**Age**			
Sex					
Address					
Address Type	Home ☐ Business ☐				

Communication					
Preference	☐ Home ☐ Work ☐ Cell ☐ Email				
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Email**			

Information			
Primary Language		**Ethnicity**	
Race		**Employer**	
Marital Status		**Occupation**	
Referred by			

Account Responsible					
Responsible				**Salutation**	
Relationship					
Address					
Home Phone #		**Work Phone #**		**Extension**	

Vision Insurance			
Name		**Date of Birth**	
ID #			

Medical Insurance - 1			
Name		**Group Name**	
ID #		**Group #**	
Insured		**Date of Birth**	

MEDICAL HISTORY

Name: Date:
Current Physician Name/Number: _____ (___) ___-____
Current Pharmacy Name/Number: _____ (___) ___-____

Height:		Weight:	
Occupation:			

CURRENT MEDICATIONS

Name	Dose	Frequency	Starting	Ending	Physician	Purpose

SURGICAL PROCEDURES

Date	Procedure	Physician	Hospital	notes

Tobacco Use: Check only those which apply to you	☐Never Used ☐Discontinued use ☐Chewing Tobacco ☐Cigarettes, 1 Pack/Day ☐Cigarettes, 1-3 Packs/Day ☐Cigarettes, <1 Pack/Day ☐Cigarettes ☐Cigars, 3 Or More/ Week ☐Cigars, Occasional ☐Pipe	**Do you drink alcohol?**	☐Never ☐Social ☐Beer, 3 Or Less Per Week ☐Beer, 4 Or More Per Week ☐Liquor, 3 Or Less Per Week ☐Liquor, 4 Or More Per Week ☐Wine, 3 Or Less Per Week ☐Wine, 3 Or More Per Week
Recreational Drug Use: Check only those which apply to you	☐N/A ☐Cocaine ☐Crack ☐Heroin ☐Marijuana ☐Methamphetamine ☐Speed	**Hobbies**	☐Fishing ☐Piano ☐Pilot ☐Sewing ☐Sports ☐Other:

Date	

Name			
Date of birth		Age	
General health			

Medication Allergies: Yes or No (if yes, please list below)

Personal Medical History:

Yes	No	Condition	
		Anxiety	
		Arthritis	
		Asthma	
		Atrial fibrillation	
		Cardiac arrest	
		Carotid artery occlusion	
		Chest pain	
		Chronic obstructive lung disease	
		Congestive heart failure	
		Dementia	
		Diabetes type 1	
		Diabetes type 2	
		Disorder of endocrine system	
		Eczema	
		Hypercholesterolemia	
		Hypertensive disorder, systemic arterial	
		No current problems or disability	
		Primary malignant neoplasm (cancer)	
		Are you currently pregnant or nursing?	If so please list due date:

Family Medical History

Yes	No	Condition	Which Family Member
		Hypertension	
		Amblyopia (lazy eye)	
		Blindness	
		Cataract	
		Diabetes	
		Arthritis	
		Cancer	
		Endocrine disease	
		Hashimotos	
		Hypercholesterolemia (High cholesterol)	
		Glaucoma	
		Retinal disorder	
		Strabismus	

Signature _____

Orlando Eye Associates

Dr. Carl Gaterbaum

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OFFICE PROCEDURE AGREEMENT

PATIENT LATE CANCELLATION AND NO SHOW FEES:

Patients are required to give our office a minimum 24-hour notice for all cancelled appointments. Appointments cancelled less than 24-hours in advance, or patients who do not show for a scheduled appointment will be charged a "no-show fee" of $25.

PRESCRIPTIONS:

Prescription refills will be processed within 24 hours of the request.

CELL PHONE USAGE:

Cell phones must be placed on silent or vibrate mode upon entering the office.

INSURANCE AND BILLING:

Current insurance cards must be presented at each visit. Orlando Eye Associates will submit insurance claims to participating insurance companies on behalf of the insured patient. This service is being provided as a courtesy, and the patient will be financially responsible for all services that are not paid in full within 90 days of service.

PAYMENT OF SERVICES:

Co-pays, and unpaid balances must be paid in full at the time of visit. All self-pay, and non-participating insurance patients must pay in full at time of service. We will gladly provide a receipt so that patients can file for reimbursement from their insurance company.

NSF:

All returned checks will be charged a fee of $30. Once an NSF occurs, only credit cards or cash will be accepted.

We thank you for your patience and understanding.

I have read and agree to abide by the office policies as stated above.

Signature of Patient or Responsible Party Date

Orlando Eye Associates
7682 Dr. Phillips Blvd, Ste A
Orlando, FL 32819
Ph(407)351-3880 Fax (407)351-4846 Email: info@orlandoeyeassociates.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice). We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

hen a state or federal law mandates that certain health information be reported for a specific purpose;
r public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
sclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
es and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
sclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
sclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
sclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
es or disclosures for health related research;
es and disclosures to prevent a serious threat to health or safety;
es or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
sclosures of de-identified information;
sclosures relating to worker's compensation programs;
sclosures of a "limited data set" for research, public health, or health care operations;
cidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
sclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
her uses specified by state law

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:
Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.
Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.
Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose. We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law. We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).
Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:
To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law. **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information was not created by us, unless the person that created the information is no longer available to make the amendment is not part of the health information kept by or for us, is not part of the information you would be permitted to inspect or copy, or is accurate and complete.
To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.
Contact Person: Our contact person for all questions, requests or for further information related to the privacy of your health information is:Carl Gaterbaum, OD
Complaints: If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice: We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.
Notice Revised and Effective: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Orlando Eye Associates' Notice of Privacy Practices on: Date: _____

Patient Name: _____Signature: _____

Authorization for Release of Information to Family Members

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Orlando Eye Associates to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____
5. _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient's Signature: _____ Date: _____

Guardian's Signature (For Minors): _____ Date: _____