Oviedo Eye Care
171 S Central Ave
Oviedo, FL 32765

Port St John Eye Care
3720 Curtis Blvd #106
Port St John, FL 32927

PATIENT INFORMATION FORM

Patient's Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____Work Phone: _____

Home Phone: _____Cell Phone: _____ Email Address: _____

Best time and place to contact you? _____

Date of Birth: _____ Social Security #: _____

Spouse's Name: _____ Spouse's Phone Number: _____

Parent/Guardian (if minor): _____

Person responsible for payment:_____

Insurance Company: _____ ID #: _____

Insurance Primary: _____ Primary's Date of Birth: _____

Primary's Social Security #: _____ Primary's Zip Code: _____

Who may we thank for referring you? _____

MEDICAL HISTORY

Do you have problems with any of the following areas?

Cardiovascular	**SELF**	**FAMILY (Parents or Siblings)**
-Heart Disease	_____	_____
-High Blood Pressure	_____	_____
-Lung Disease	_____	_____
Endocrine		
-Diabetes type I	_____	_____
type II	_____	_____
-Thyroid Disorder	_____	_____
Urinary		
-Kidney Disease	_____	_____
-Bladder Disease	_____	_____
Musculo-skeletal		
-Arthritis	_____	_____
-Other	_____	_____

Gastro-Intestinal

-Crohn's Disease _____ _____

MEDICAL HISTORY (Cont.)

	SELF	FAMILY
-Ulcerative Colitis	_____	_____
Immune Disease		
-Cancer	_____	_____
-other	_____	_____
Blood Disorders	_____	_____
Ear, Nose, Throat	_____	_____
Neurological/Psychiatric		
-Stroke	_____	_____
-Epilepsy	_____	_____

Current Medications (including eye drops): _____

_____

Do you have any allergies? **Y/N** If yes, to what? _____

Do you use cigarettes/tobacco? **Y/N** If yes, amount per day? _____

Do you use alcohol? **Y/N** If yes, drinks per day? _____

Do you use social drugs? **Y/N**

OCULAR HISTORY

	SELF	FAMILY
Glaucoma	_____	_____
Cataracts	_____	_____
Macular Degeneration	_____	_____
Retinal Detachment	_____	_____
Eye Surgeries	_____	_____
Eyestrain/Headaches	_____	_____

When was your last eye exam? _____

Do you wear glasses? ☐ **Yes** ☐ **No** If so, how long? _____

Do you wear contact lenses? ☐ **Yes** ☐ **No** If so, hard/soft and how long? _____

Are you interested in trying contact lenses? ☐ **Yes** ☐ **No**

Name of Primary Care Physician? _____

Robert S. Webster, O.D.
Oviedo Eye Care
(407) 365 – 7475

Stephen J. Thomas, O.D.
Port St. John Eye Care
(321) 639 – 0910

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

I authorize Dr. Webster, Dr. Thomas and their staff to share my personal information, such as appointments, pick up and/or drop off of glasses or contacts, and any other details in relation to my eye care, with the following person(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization **IN WRITING** at any time. Unless revoked, this authorization will not expire.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Robert S. Webster, O.D.
Oviedo Eye Care
(407) 365 – 7475

Stephen J. Thomas, O.D.
Port St. John Eye Care
(321) 639 – 0910

Oviedo and Port St. John Eye Care
Financial Statement and Authorizations

Please Print Name: _____

I understand that I am fully responsible for all professional fees and expenses incurred. If my health insurance carrier does not pay a portion of my bill, I agree to immediately pay the entire remaining balance.

Initial: _____

It is the policy of this practice that full payment (including co-pays, deductibles and patient percentages) is due at the time services are rendered. We are happy to accept your payment by cash, check, Visa, MasterCard, Discover, American Express and Debit Card. We will submit claims to those insurance companies with which we have a contract, however it is the sole responsibility of the insured to know the type of insurance and coverage. All patients will be given receipts that will be sufficient to submit to an insurance company for reimbursement. Any balances that are over 90 days past due will have the credit reporting agencies notified and be turned over to a collections agency unless previous arrangements have been made.

Initial: _____

Insurance Authorization: I authorize payment of medical benefits to the attending optometrist for services.

Initial: _____

To all Medicare Patients: We are happy to continue to participate as Medicare providers. We will bill Medicare, as well as your secondary insurance. If payment is not received from your secondary (or is denied for any reason) within 45 days, you will be notified and will be required to pay our office the balance due. You must file for reimbursement through your secondary insurance to receive payment for the balance you paid our office.

Initial: _____

As a Final Note:

- Please understand that our office is not the cause of insurance delays and denials. We file to the insurance companies on a timely basis.

Remember, you and/or your employer pay the insurance premiums. Your insurance company is accountable to you, not us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claim.

Thank you for your cooperation and understanding.

Signature: _____

Date: _____

Robert S. Webster, OD
171 S Central Ave, Oviedo FL 32765

Stephen J. Thomas, OD
3720 Curtis Blvd #106, Port St. John FL 32927

Effective Date of Notice: April 14, 2003

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 respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose 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 have to do 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.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

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

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For 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;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses 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;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures 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;
- Disclosure 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;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses 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;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. They must be brought to the office and given to an office contact person to be included in your file.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have on 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it in our web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Robert S. Webster, O.D., Notice of Privacy Practices

Patient Name: _____ Date: _____

Signature: _____

Oviedo & Port St. John Eye Care

Dr. Robert S. Webster
Dr. Stephen J. Thomas

We are committed to providing quality eyecare to our patients by using the most advanced equipment and techniques. As part of this commitment, we have a Visual Field Analyzer on site that can provide visual field screenings for our patients as an addition to their comprehensive eye exam. This instrument is a highly-sophisticated computerized machine that checks for areas of reduced vision in the central (straight-ahead) and peripheral (side vision) areas. Visual Field testing is important in the early detection of:

Glaucoma
Retinal Detachment
Brain Tumors
Optic Nerve Disease
Macular Degeneration
Diabetes

As medical professionals, we strongly recommend that all of our patients aged 13 and over take this evaluation once a year, especially those that have family histories of those conditions or a personal history of unusual headaches or vision problems. Unfortunately, an individual does not notice most visual field defects until the very late stages. Early detection significantly increases the chances of either curing the disorder before permanent damage occurs or, at least, minimizing its effects.

The Visual Field Screening Analysis takes an additional five minutes and there is a nominal fee of $15. **This test is not covered by routine vision insurance. It is an optional screening.**

Would you like the Visual Field Screening? Yes ☐ No ☐

Name (please print): _____

Signature: _____ Date: _____

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We strongly urge our patients to take advantage of our online services. Using the online features will keep your office visits to a minimum and allow you the opportunity to complete forms and order supplies from the comfort of your own home. Please read and agree to the online signature agreement to submit your forms online.

ONLINE SIGNATURE AGREEMENT

By checking this box I agree to use an electronic signature in lieu of paper-based signatures on all of my patient registration documents. I understand that electronic signatures, just like signatures on paper documents, are legally binding in the United States. I certify that I have read, understood and agree with everything presented in this document. I further agree that I have provided all information requested in this document and that it is up-to-date and accurate. I understand that it is my responsibility to notify Oviedo/Port St. John Eye Care as soon as possible if the information presented in this document changes. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction and I will not hold my optometrist, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand that more information may be requested by employees of Oviedo/Port St. John Eye Care in order for them to work with your insurance company, dependent on the individual insurance company's regulations.

☐ I agree to these terms and conditions

Name:

Date:

Submit by Email To Our Oviedo Office

Submit by Email to our Port St. John Office

Print Forms