

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

Email Address: \_\_\_\_\_ Name by which you prefer to be called \_\_\_\_\_

Date of Birth \_\_\_\_\_ Race \_\_\_\_\_ Sex  Male  Female

Home Phone (\_\_\_\_\_) \_\_\_\_\_  Married  Single  Widowed  Divorced

Cellular Phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Person Responsible for account \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Date of your last eye examination \_\_\_\_\_ Have you ever worn glasses?  Yes  No

Do you wear glasses now?  Yes  No If yes:  for distance  for near  wear full time  for computer

Do you wear contact lenses?  Yes  No If yes:  Soft  Hard  Continuous Wear  Multifocal

**This is your opportunity to tell us about all areas in which your vision is not serving you well.**

**What is your main reason for coming here today?** \_\_\_\_\_

**List any activities you would enjoy doing, but must restrict because of your vision:** \_\_\_\_\_

**Are you interested in:**

Laser Vision Correction  Contact Lenses  Ortho-K (Non-Surgical) vision correction  Cosmetic Surgery

**HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.**

- |                       |                               |                                 |                    |                               |                                 |
|-----------------------|-------------------------------|---------------------------------|--------------------|-------------------------------|---------------------------------|
| Allergies             | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Color "blind"      | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Respiratory disease   | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Light sensitive    | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Cancer                | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Lazy eye           | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Diabetes              | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Dry eyes           | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Drug allergies        | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Floaters/spots     | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Elevated cholesterol  | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Flashing lights    | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heart problem         | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Retinal detachment | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| High blood pressure   | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Blindness          | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Thyroid condition     | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Cataracts          | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Migraine or headaches | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Glaucoma           | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Turned eye            | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Eye Injury         | <input type="checkbox"/> Self |                                 |
| Head trauma           | <input type="checkbox"/> Self |                                 | Eye Surgery        | <input type="checkbox"/> Self |                                 |
| Smoke Tobacco         | <input type="checkbox"/> Self |                                 | HIV / AIDS         | <input type="checkbox"/> Self |                                 |

Do you drink alcohol?  No  Socially  Daily

What is the name of your general physician? \_\_\_\_\_

Date of last physical \_\_\_\_\_ How is your general health?  Excellent  Good  Fair  Poor

Please list all medications you are now taking. (Include vitamins, food supplements and birth control pills):

Medication	For What Condition?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Please complete BOTH SIDES of this form**

# Brevard Eye Center

## HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from Brevard Eye Center, please complete this form.

I authorize the persons listed below to have access to any and all of my health information, including eyeglass prescription, contact lens prescription, diagnosis and treatment, HIV, drug and alcohol abuse and psychiatric records. Brevard Eye Center is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons or organization authorized to receive my medical information (full name and phone number):

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You may notify me or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows:

\_\_\_\_\_ Message on answering machine (Phone number \_\_\_\_\_ )  
\_\_\_\_\_ Message on work voicemail (Phone number \_\_\_\_\_ )  
\_\_\_\_\_ Message on pager (Phone number \_\_\_\_\_ )  
\_\_\_\_\_ Message on cell phone (Phone number \_\_\_\_\_ )  
\_\_\_\_\_ Other \_\_\_\_\_ )

**MY RIGHTS:**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization *in writing*. If I did, it would not affect any actions already taken by Paul J. Befanis, M.D., P.A. and or Brevard Eye Center Associates, Optometric Physicians based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the Clinical Administrator, OR
- Write a letter to the Clinical Administrator

Once health care information is disclosed, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient – Print Name

\_\_\_\_\_  
Witness – Print Name

\_\_\_\_\_  
Patient – Signature

\_\_\_\_\_  
Witness – Signature

\_\_\_\_\_  
Patient – Date of Birth

Date \_\_\_\_\_

**Brevard Eye Center** complies with all HIPAA and other federal privacy regulations. I acknowledge that I have been made aware of my rights to review or obtain a copy of the policies. \_\_\_\_\_ initials

**Please complete BOTH SIDES of this form**

**OCCUPATION:** What kind of work do you do? \_\_\_\_\_

**What activities do you do at work:**  driving  typing  data entry  computers  program  inspecting  
 accounting  writing/editing  using spread-sheets  loading  deliveries  sales  monitor instruments.

Other activities: \_\_\_\_\_

**COMPUTER USAGE:**

Do you use a computer on your job? . . . .  Yes  No . . . . . # hours daily \_\_\_\_\_  
Do you use a computer at home? . . . . .  Yes  No . . . . . # hours daily \_\_\_\_\_

**RECREATION AND LEISURE:**

Please list your hobbies and sports in which you participate: \_\_\_\_\_

Do you wear any special or protective eyewear for your sport?  Yes  No  
Does your vision, or do your lenses, interfere with any activity?  Yes  No  
Does television viewing ever become visually uncomfortable?  Yes  No

**VERY IMPORTANT! WHOM MAY WE THANK FOR RECOMMENDING OUR OFFICE TO YOU?**

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?  Yellow Pages  Sign/Building  Insurance List  Other \_\_\_\_\_

**INSURANCE: (please show your insurance cards to the receptionist)**

**Vision Insurance Co:** \_\_\_\_\_ Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's SS

No. \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Subscriber's address if different from Patient: \_\_\_\_\_

**Primary Health Insurance Co:** \_\_\_\_\_ Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's SS

No. \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber's

Employer: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Subscriber's address if different from Patient: \_\_\_\_\_

**Secondary Health Insurance Co:** \_\_\_\_\_ Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's SS

No. \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

Subscriber's address if different from Patient: \_\_\_\_\_

**PAYMENT TERMS:** As participating Medicare Providers, we agree to charge no more than the Medicare Allowable. Medicare pays only 80% of this amount after the annual deductible has been met. Office policy calls for payment of the deductible and the remaining 20% at the time of service. Payment in full is required on all eyewear and contact lenses orders. Cancellation of eyeglass orders after fabrication begins will result in a 25% restocking fee on the lenses. We accept cash, personal checks, Visa, Mastercard and American Express. A Refraction is the process

of determining the eye's refractive error and the need for corrective lenses. It is an essential part of an eye exam, but Medicare and most health insurance companies **do NOT cover it**. The fee for this service will be collected today in addition to all insurance co-payments. I also understand that I could be responsible for additional collection fees should my account become delinquent.

**CANCELLATION POLICY:** A 24 hour notice must be given to cancel appointment or a \$25.00 fee will be assessed.

*I have read and agree to all the provisions of the office financial policy. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I hereby authorize Brevard Eye Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance forms.*

Guarantor Signature: \_\_\_\_\_ Date \_\_\_\_\_

## **PRIVACY NOTICE**

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within Brevard Eye Center for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of Brevard Eye Center receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by Brevard Eye Center to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to restrict the use of your confidential healthcare information. However, Brevard Eye Center may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.

- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Brevard Eye Center is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- Brevard Eye Center will abide by the terms of this notice. Brevard Eye Center reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to Brevard Eye Center if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to Brevard Eye Center

Brevard Eye Center  
 Att: Gary R. Hardey  
 665 Apollo Blvd.  
 Melbourne, FL 32901

- All complaints will be investigated. No personal issue will be raised for filing a complaint with Brevard Eye Center
- For further information about this Privacy Notice, please contact:

Gary R. Hardey  
 Privacy Compliance Officer  
 (321) 984-3200

- This notice is effective as of April 16, 2003. This date must not be earlier than the date on which the notice is printed or published.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_