PATIENT HISTORY AND INFORMATION

NAME: ____
FIRST MIDDLE LAST

DATE OF BIRTH: ______________ SOCIAL SECURITY # ______________

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

GENDER: ☐MALE ☐FEMALE NAME OF SPOUSE:______________________________

ADDRESS:____
STREET CITY STATE ZIP CODE

NORTHERN ADDRESS:____
STREET CITY STATE ZIP CODE

PHONE: HOME: (_____) _______-_______ CELL: (_____) _______-_______

WORK: (_____) _______-_______ NORTHERN PHONE: (_____) _______-_______

E-MAIL ADDRESS:______________________________

LANGUAGE: ☐ENGLISH ☐SPANISH ☐FRENCH/CREOLE ☐GERMAN ☐OTHER

ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC

RACE: ☐ AMERICAN INDIAN ☐ASIAN ☐BLACK ☐HAWAIIAN ☐UNKNOWN ☐WHITE

OCCUPATION/PLACE OF EMPLOYMENT:_______________________________

BUSINESS ADDRESS:____

PRIMARY CARE PHYSICIAN:_______________________________________
NAME ADDRESS PHONE

LAST EYE DOCTOR SEEN:____
NAME ADDRESS PHONE

DATE OF LAST EYE EXAM:__________________ WERE GLASSES PRESCRIBED:_______

PHARMACY:____
NAME ADDRESS PHONE

PRIMARY INSURANCE:____
NAME POLICY NUMBER

SECONDARY INSURANCE:____
NAME POLICY NUMBER

HOW DID YOU HEAR ABOUT US?_____________________________________

661 Goodlette Road, North, #105
Naples, FL 34102

NOTICE OF PRIVACY PRACTICES

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As required by the Health and Insurance Portability & Accountability Act of 1996 ("HIPAA"), this Notice gives an explanation of how we maintain the privacy of your personal health information(PHI) and how we may disclose your personal information. We may use and disclose your medical record information only for the following purposes:

- To conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be directly or indirectly involved in treatment.

- To obtain payment from third party payers.

- To conduct normal healthcare operations such as quality assessments, auditing functions and data analysis.

In accordance with HIPAA omnibus rule, January 25, 2013, Naples Eye Physicians, P.A. will not disclose your personal health information for the purpose of marketing or fund-raising and will never sell your information.

You may have the following rights with respect to their PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends or any other person identified by the patient.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

You know also have the right to restrict certain disclosures of PHI to a health plan where you have paid out of pocket in full for the healthcare item or service.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date on the bottom left of the page indicates the date of the most current revision in effect.

You may receive a copy of our most current Notice in effect in its entirety, please ask at our front desk and we will provide you with a copy.

If you have any questions or concerns about the Notice or your medical information, please contact our privacy Office at (239) 262-6288.

Acknowledgment of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Naples Eye Physicians and NaplesEye Physicians Optical shop's Notice of Privacy Practices.

____

NAME

____

SIGNATURE

____

DATE

IMPORTANT NOTICE TO OUR PATIENTS

- This will serve as notice that you have been duly advised that your vision may be temporarily impaired following your eye examination today or during subsequent visits to our office. Dilating drops may be used during the course of your examination to aid in the diagnosis and treatment of various pathologic processes affecting the eyes. The use of these drops as well as other methods of examination and treatment may render your vision blurred for a period of time, thus interfering with your ability to safely operate a vehicle or other mechanical equipment. Whenever possible, you should come to the office with a driver. If your vision is blurred, please do not attempt to drive. You should wait in our office until your vision returns to normal.

- I do hereby consent to interview, examination and treatment that may be required for the eyes. I also consent to photographs, which may be necessary in treating my eye condition. I further agree to release past records from physicians and/or hospitals, which would aid in treating my eye condition.

- I realize that most insurance companies will not pay for the refraction fee. A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses. It is an essential part of the eye exam and is necessary to write a prescription for glasses. A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a medical service.

- The refraction fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

_______________________________________ _______________

Patient's Name (printed) Date

____

Patient Signature (Legally responsible/relationship to patient)

IMPORTANT NOTICE REGARDING INSURANCE PAYMENT

I request that insurance payment of authorized medical benefits be made on my behalf to Naples Eye Physicians. I authorize Naples Eye Physicians to share my health care information to any insurance provider as needed to determine eligibility for benefits.

_______________________________________ _______________

Patient Signature Date

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

May we leave messages/detailed medical information on voice mail at either of these phone numbers?

Home Phone: ☐ Yes ☐ No
Cell Phone: ☐ Yes ☐ No

May we contact you at your place of employment? ☐ Yes ☐ No
If so, may we leave a message? ☐ Yes ☐ No

If yes: Work number:________________________________ Extension:_______________

Person(s) authorized to release medical information to. By signing below you authorize the following person(s) to receive information regarding your treatment of care.

Spouse:_________________________________

Parent:__________________________________

Other:___________________________________

Print Name:_______________________________

Signature:________________________________

Date:____________________________________