

# Welcome to St. Michael's Eye and Laser Institute!

Please bring the enclosed paperwork (completed) to your appointment.

An office member will sign as your "witness" on the agreement page.

### Please also bring:

- o PHOTO ID
- INSURANCE CARDS
- CURRENT LIST of your MEDICATIONS
- Previous MEDICAL RECORDS\* (if applicable)

#### \*MEDICAL RECORDS:

In assisting us with continuing your care, it is helpful to have records of your previous care with you,

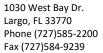
[OR]

If you choose, you may contact your former office and send those records to our

## **FAX NUMBER - (727) 584-9239**

We will then receive them in time for your appointment.

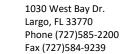
Thank you! We look forward to serving you.





# **Demographics Sheet**

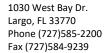
| Patient Information                                |                                |                   |                     |              |               |            |  |
|--|--------------------------------|-------------------|---------------------|--------------|---------------|------------|--|
| Patient Name:                                      | Date of Birth:                 |                   |                     |              |               |            |  |
| Street Address:                                    |                                |                   |                     |              |               |            |  |
|  | Street                         |                   |                     | pt#          |               |            |  |
|  | City                           |                   | Sta                 | ate          | Zip           |            |  |
| SSN:   |                                |                   | Gender: Male Female |              |               |            |  |
| Home Ph:   | ,                              | Work Ph: Cell Ph: |                     |              |               |            |  |
| Emergency Contact:                                 | tact:                          |                   | Ph:                 |              | Relationship: |            |  |
| Email Address:                                     | Employer:                      |                   |                     |              |               |            |  |
| Race: American India                               | an or Alaskan Na               | tive              | Asian Paci          | fic Islander | Africa        | n American |  |
| Caucasian  | Hispan                         | ic                | Other:              |              |               |            |  |
| Insurance Information                              |                                |                   |                     |              |               |            |  |
| Primary Insurance:                                 |                                |                   | ID#:                |              | Group#        | :          |  |
| Subscriber Name ( <i>if other than</i>             | self):                         |                   |                     |              |               |            |  |
| Subscriber SSN:                                    | ·                              |                   | Date of Birth: _    |              | _ Gender:     | ale Female |  |
| Secondary Insurance:                               |                                |                   | ID#:                |              | Group#:       |            |  |
| Subscriber Name (if other than                     | self):                         |                   |                     |              |               |            |  |
| Subscriber SSN:                                    | ·                              |                   | Date of Birth: _    |              | _ Gender:     | ale Female |  |
| Referring Information                              |                                |                   |                     |              |               |            |  |
| How were you referred here:<br>(Please circle one) | Sign Radio                     | TV                | Yellow Pages        | Newspaper    | Mail/ Flyer   | Insurance  |  |
| Referring Doctor Name:                             | Referring Family/ Friend Name: |                   |                     |              |               |            |  |
| Primary Care Doctor:                               |                                | Ph:               |                     |              |               |            |  |





### **HIPAA** Authorization

| We are required to ask anyone requesting information regarding your this form as a person you wish to have access to your health records we the HIPAA agreement is protecting my right to privacy. I wish to allow and/ or St. Michael's Surgery Center to disclose my personal healthcar   | vill be denied their request. I understand that the staff at St. Michael's Eye & Laser Institute  |
|---|---|
| Name  | Relationship  |
| Name  | Relationship  |
| Please read the notice of privacy practices and sign below stating you review it in detail.   | have received a copy and an opportunity to  |
| Consent to Treat  |   |
| During an eye exam, we may dilate your pupils. After dilation, you will need to have someone assist you in driving home. Dilation will also int reading) for 4 to 12 hours, or longer. If at any point additional treatme warranted, an additional consent will be provided outlining the appropriate consent is only revocable in writing and is valid for a lifetime. Plea medication, and previous procedures on the additional Medical Histor will help us make the best decisions regarding your care. I hereby give Michael's Eye & Laser Institute and/or Surgery Center for the treatments. | refere with near vision activities (such as ant outside the scope of general eye care is oriate Risks and Benefits.  The see inform the office of any medical conditions, y forms. Accurate history of your condition my written consent to the clinical staff of St. |
| Patient Signature   | Date  |
| Authorization to Release Information to   | Insurance   |
| I hereby give permission to St. Michael's Eye & Laser Institute (provide company and/or financial institution. I hereby assign payment directly benefits applicable and otherwise payable to me. As a courtesy, St. Mi benefits. However, I understand that I am financially responsible to St. Surgery Center for charges not covered by this assignment or for any a declines to pay.   | to St. Michael's Eye & Laser Institute of all chael's Eye & Laser Institute verifies insurance . Michael's Eye & Laser Institute and/or   |
| Patient Signature   | Date  |





Witness Signature

## Patient Financial Agreement

| Patient Name:   | DOB:                                      | Date:  |
|---|---|--|
| St. Michael's Eye & Laser Institute along with St. Michael's Surgery Cer information as needed to assess the financial aspect of their eye care i   | needs.                                    |  |
| Please remember that insurance is considered a method of reimburse for payment. Some carriers pay fixed allowances for certain procedure  | es, and others pay                        | a percentage of the charges.   |
| t is your responsibility to pay any deductible, co-insurance, co-payme  | nt, and any other                         | balance not paid for by your insurance.  |
| In addition, you are responsible for obtaining any authorization requirenct obtained, the insurance company will deny payment and you will be be being that our charges for the office visits be paid upor our office will send your bill to our collections department and you will fees incurred for the collection of your delinquent account. | be responsible for<br>n arrival of your v | r payment. In order to control the cost isit. If payment is not received timely, |
| Medical Records: St. Michael's Eye & Laser may provide you with your of \$1.00 per page up to 25 pages, then \$.025 for each additional page.   |   | if desired. You may be billed at a rate  |
| <ol> <li>I request payment of authorized Medicare and/or insurance be<br/>and/ or St. Michael's Surgery Center for services furnished to r</li> </ol>   |   | to St. Michael's Eye and Laser Institute   |
| <ol><li>I authorize St. Michael's Eye and Laser Institute and/ or St. Micregarding myself to the Center for Medicare and Medicaid Ser</li></ol>   |   |  |
| <ol><li>This assignment will remain in effect until revoked by me in wi<br/>as valid as the original.</li></ol>   | riting. A photocop                        | by of this assignment is to be considered  |
| <ol> <li>I understand that I am financially responsible for all charges w<br/>said assignees to release all information necessary to secure p</li> </ol>  | •   | d by said insurance. I hereby authorize  |
| 5. I agree to pay all collections, attorney, and court fees that may  | / be incurred for t                       | the collection of delinquent accounts.   |
|   |   |  |
| Patient Signature   | Date                                      |  |
|   |   |  |

Date



#### What Is A "Refraction"?

During your visit today, the technician or doctor may request a refraction test to be done.

The refraction test could be performed in a Phoropter or an Auto refractor. (See below)



This necessary test tells your doctor a few important things about your vision.

- 1. Whether your vision complaints are caused by a medical disorder.
- 2. Your visual improvements following a surgical procedure.
- 3. Whether glasses or contact lenses would benefit your current visual state.

#### Medicare and most other insurance plans do not cover this test.

The cost of a refraction is \$45.00 and will be collected at the time of service. If you have any questions regarding this policy, please see one of our front office staff members.

By signing this form, you are acknowledging that you have read and understand the above policy.

This <u>does not</u> mean you are having a refraction today, it means that you understand the charge will apply should a refraction test be performed at any time.

Thank you for choosing St. Michael's Eye & Laser Institute for your eye care needs.

We look forward to caring for you.

| Patient or Pernancible Party |      |
|------------------------------|------|
| Patient or Responsible Party | Date |