Eye Care Specialists of SWFL, PLLC

Consent for Purpose of Treatment, Payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Eye care Specialists of SWFL (ECS) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ECS.

I understand that diagnosis or treatment of me by ECS may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. ECS is not required to agree to the restrictions that I may request. However, if ECS agrees to a restriction that I request, the restriction is binding on the practice.

I have the right to revoke this Consent, in writing, at any time, except to the extent that ECS has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ECS's Notice of Privacy Practices prior to signing this document.

ECS's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for ECS describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations.

A summary of the Notice of Privacy Practices for ECS is also available in the waiting room.

This Notice of Privacy Practices also describes my rights and the duties of ECS with respect to my protected health information.

ECS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by contacting ECS located at 3455 Pine Ridge Road, Naples, FL 34109 or by calling (239) 597-5700.

_____

Name of Patient (please print)

_____ _____

Signature of Patient or Representative **Date**

FINANCIAL POLICY

Medicare Part B

Eye Care Specialists of SWFL, PLLC is a Medicare Part B provider. We will accept assignment on all Medicare Part B claims. By accepting assignment, she agrees to adjust your charges to reflect the Medicare approved amount. However, Medicare only pays 80% of the approved amount, and the remaining 20% is your responsibility. If you have supplemental insurance, we will bill your supplement insurance for the 20% balance. **If there is any remaining balance after Medicare and the supplement insurance payment, it is the patient's responsibility**.

Private Health Insurance

As a courtesy to you, we will file claims with your insurance company. Please understand, however, that your insurance reflects a contract between you and the insurance company, not ECS of SWFL.. You, as the patient, are ultimately responsible for your bill. **Patients without health insurance will be expected to pay at the time of service or to make payment arrangements with the billing office. We may also collect at the time of service, any fee that will be paid directly to you from your insurance company, as well as any co-pay or deductible amounts.**

Managed Care Networks

Your doctor is a participating provider with BCBS/FL and Community Health Partners. We will file claims to insurers contracted with these organizations. Co-pays, co-insurance and/or deductibles will be due at the time of service. Your doctor also participates with a number of other managed care organizations. If you have any questions regarding participation, please ask at the front desk.

Usual, Reasonable and Customary

Some insurance carriers have established "usual" and "reasonable and customary" maximum amounts that they will pay for specific procedures. These amounts may vary with each insurance company. Any amount considered in excess of the "usual" and "reasonable and customary" amount that is not paid by the insurance company, becomes the patient's responsibility.

Non-Covered Services

Not all services are covered by all insurance health plans. Some services may not be covered by your specific or individual policy. **Services not covered or considered payable by the insurance company becomes the patient's responsibility. Refraction services are not covered by Medicare and most insurance plans. You will be required to pay for refraction at the time of service.**

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to liquidate the account.

I request that payment of authorized Medicare benefits be made on my behalf to Eye Care Specialists of SWFL, PLLC for any services furnished me by my provider.

I hereby assign and transfer any insurance benefit due me for the professional services that I have received, to Eye Care Specialists of SWFL, PLLC.

I authorize the release of any medical information necessary to process insurance claims.

_____ _____

Signature of Patient **Date**

Eye Care specialists of SWFL, PLLC
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.

WHO WILL FOLLOW THIS NOTICE:

This notice describes information about privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION:

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest or benefit to you.

Health-Related Products or Services: We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (see office address at end of Notice) that you do not wish to receive such communications, we will use every effort to not use or disclose your information for these purposes. You may revoke your ***Consent*** at any time by giving us a written notice. Your revocation will be effective when we receive it, but it will not apply to any uses or disclosures which occurred prior to that time. If you do revoke your ***Consent***, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operation, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS:

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Military, Veterans, National Security, and Intelligence: If you were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.
Worker's Compensation: We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
Health Oversight Activities: We may disclose health information about you to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
Law Enforcement: We may release health information about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while your treatment is being discussed.
In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any other purpose other than those identified in the previous sections without your specific, written ***Authorization.*** We must obtain your ***Authorization*** separate from any ***Consent*** we may have obtained from you. If you give us ***Authorization*** to use or disclose health information about you, you may revoke that ***Authorization*** in writing at any time. If you revoke your ***Authorization,*** we will no longer use or disclose information about you for the reasons covered by your written ***Authorization***, but we cannot take back any uses or disclosures already made with your permission.
If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different from the ***Authorization*** and ***Consent*** mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed ***Consent*** and a special written ***Authorization*** that complies with the law governing HIV or substance abuse.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you:
Right To Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the practice Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we

may charge a fee for the costs of copying, mailing and other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health care information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right To Amend: If you believe that health information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the practice Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect or copy
- Is accurate and complete

Right to an Accounting of Disclosures: You have the right to request "an accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the practice Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information w disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. As example, you may ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will make all reasonable efforts to accommodate this request. For example, you may not wish us to contact you at work.

Right to a Paper Copy of This Notice: You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To receive a copy of this notice, contact the practice Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

We will post a summary of the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the practice Privacy Officer. You will not be penalized for filing a complaint.

Thank you for taking the time to read this information,

Eye Care Specialists of SWFL, PLLC
3455 Pine Ridge Road
Naples, FL 34109

Past Ocular/Medical History

Name:_____ **DOB:**_____

Allergies: _____

Past Ocular History

_____
_____
_____
_____

Past Ocular Surgeries

_____
_____
_____
_____

Current Eye Medications

_____
_____
_____
_____

Past Medical History

_____
_____
_____
_____

Past Surgeries

_____
_____
_____
_____

Current Systemic Medications

_____
_____
_____
_____

Family History: **P = Parent** **S = Sibling** **G = Grandparent**

Cataract	**P**	**S**	**GP**	High Blood Pressure	**P**	**S**	**GP**	Stroke	**P**	**S**	**GP**
Glaucoma	**P**	**S**	**GP**	Heart Disease	**P**	**S**	**GP**	Other: _____			
Macular Degeneration	**P**	**S**	**GP**	Cancer	**P**	**S**	**GP**				

Social History:

Smoking Status ☐ YES ☐ NO ☐Quit How long:_____
Alcohol ☐ YES ☐ NO If Yes: How much?_____
Drugs ☐ YES ☐ NO Drugs Used:_____

Review Of Symptoms

NAME:_____ **DOB:** _____

EYES	**YES**	**NO**
Previous Surgery	☐	☐
Contact Lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐

Ear, Nose, and Throat	**YES**	**NO**
Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐

Cardiovascular	**YES**	**NO**
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heart Beat	☐	☐
Difficulty Lying Flat	☐	☐

Constitutional	**YES**	**NO**
Fatigue/Weakness	☐	☐
Fever	☐	☐
Weight Gain/ Loss	☐	☐

Respiratory	**YES**	**NO**
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐

Gastrointestinal	**YES**	**NO**
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hepatitis	☐	☐

Genito-Urinary	**YES**	**NO**
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
History of Kidney Stones	☐	☐
History of STD'S	☐	☐

Psychiatric	**YES**	**NO**
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐

Endocrine	**YES**	**NO**
Increased Thirst	☐	☐
Increased Hunger	☐	☐
Increased Urination	☐	☐
Increased Sweating	☐	☐
Fingernail Changes	☐	☐

Blood/Lymphnodes	**YES**	**NO**
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolonged Bleeding	☐	☐
Heavy Aspirin Use	☐	☐

MusculoSkeletal	**YES**	**NO**
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swelling	☐	☐

Skin	**YES**	**NO**
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐

Neurological	**YES**	**NO**
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐

Immunologic	**YES**	**NO**
Hives	☐	☐
Itching	☐	☐
Runny Nose	☐	☐
Sinus Pressure	☐	☐

Patient Demographics

Referring Physician: _____OR

How did you hear about our office? _____

Patient Name: _____, _____, _____
Last First MI

Date of Birth: _____ Sex: M_____ F _____

SS#: _____

Address: _____

City, State, Zip: _____

Phones: Home _____Mobile: _____Work: _____

Fax: _____ E-Mail: _____

Primary Ins: _____

Secondary Ins: _____

Status: Single: __ Married: __ Widowed: __ Divorced: __ Preferred Contact: Home or Mobile

Preferred Language: _____ Race: _____ Ethnicity: _____

Guardian Name: _____, _____, _____ _____
Last First MI Date of Birth

Names of authorized Relatives or Doctors to receive your medical information:

_____ _____ _____
Name Phone Relation

_____ _____ _____
Name Phone Relation

_____ _____ _____
Name Phone Relation

******_____ _____**
Patient Signature Date