Eye Care Specialists of SWFL

3455 Pine Ridge Rd.
Naples, FL 34109
Ph: (239) 597-5700, Fax: (239) 597-3500

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.

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.

Acknowledgement of Receipt or Offer of Notice of Privacy Practices

I have received and/or have been offered the Consent for Purpose of Treatment, Payment or Health Care Operations, Financial Agreement and the Notice of Privacy Practices from EYE CARE SPECIALISTS OF SWFL.

Release of Information and Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to any of my insurance companies. I also authorize release of information to my referring physician and or primary care physician. I allow a copy of this to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement in disputed claims. I assign any rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Name of Patient (please print): _____

Patient(Guarantor) Signature/Date: _____

Patient Demographics

Referring/Primary Care 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: _____

Status: Single: __ Married: __ Widowed: __ Divorced: __

Methods of Contact: Voice Text Email Don't Contact Prefer Phone: Home or Mobile for app reminders

Preferred Language: _____ Race: _____ Ethnicity: _____

Preferred Pharmacy/ Address: _____Phone:_____

Primary Ins: _____Secondary Ins: _____

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

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

_____ _____ _____
Name Phone Relationship

_____ _____ _____
Name Phone Relationship

_____ _____ _____
Name Phone Relationship

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

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	☐	☐

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:_____