ORLANDO EYE INSTITUTE
Your Eyes are in Good Hands

PARBHU OCULOFACIAL PLASTIC SURGERY

Patient Name: _____

Refraction is the process of determining your best possible vision. It is necessary to determine if any medical, optical, or surgical treatment is needed. Because Dr. Parbhu and Dr. Raja are medical providers, we participate with medical insurance plans. Medical insurances do not cover refractions for a new glasses prescription. If you would like a refraction today, you may elect for one, however there will be a $40 charge. Refractions cannot be sent in for reimbursement to your medical insurance.

It may be necessary for you to have a refraction today. If it is decided that a refraction is necessary, you will still be required to pay the $40 charge.

By placing your signature below, you are indicating that you understand our refraction policy. If you have any questions, you may ask the technician when they call you back to see the physician.

Signature: _____ Date: _____

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REGISTRATION FORM

Preferred Language:
Ethnicity (circle): Hispanic / Non-Hispanic / Unknown
Race (circle):White / Black or African American / Hispanic / Asian / Pacific Islander / American Indian /Other

Date:	**Email Address:**		
Last Name:	**First Name:**	**Middle:**	**Nickname:**
Address:	**City:**	**State:**	**Zip Code:**
Marital Status: ☐S ☐M ☐D ☐W ☐Sep ☐Other	**Birth Date:**	**Age:**	**Sex:** ☐M ☐F / **Social Security #:**
Home Phone:	**Work Phone:**	**Cell Phone:**	
Employment Status: ☐FT ☐PT ☐Temp ☐Student ☐Retired	**Employer/School Name:**	**Occupation:**	
Billing Address, If Different From Above Address:			
Primary Insurance Name:	**Policy Holder DOB:**		
Primary Insurance Policy Number:	**Group Number:**		
Secondary Insurance Name:			
Secondary Insurance Policy Number:	**Group Number:**		
☐**Spouse's Name or** ☐**Parent's Name**	**Spouse/Parent Phone #:**	**Spouse/Parent Social Security #:**	
Referring Doctor (First & Last Name):	**Clinic or Location:**	**Phone:**	
Family/Primary Care Physician:	**Clinic or Location:**	**Phone:**	
Eye Doctor (First & Last Name):	**Clinic or Location:**	**Phone:**	
Pharmacy Name:	**Location (Zip Code):**	**Phone:**	

I heard about this clinic from:

Patient:_____ ☐ ED ☐ Internet ☐ Newspaper ☐ Magazine ☐ Other _____

NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE & OTHER THAN YOUR ADDRESS)

Name:	**Relationship:**	**Phone Number:**
Address:		
City:	**State:**	**Zip Code:**

Signature on File, Assignment of Benefits, Financial Agreement

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1. **MEDICARE:** I request that payment of the authorized Medicare benefits be made on my behalf to Orlando Eye Institute for services furnished me by Orlando Eye Institute. I authorize any holder of medical information about me to re Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the be related services. I understand my signature requests that payment be made and authorizes release of medical informatio the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim fo authorizes releasing the information to the insurer or agency shown. Orlando Eye Institute accepts the charge determina Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. C deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Orlando Eye Institute, if possible or otherwise to me.

3. **HIPAA PRIVACY STATEMENT:** By signing I acknowledge that Orlando Eye Institute made available to me their Privacy Policy Statement and that I had the choice to accept or deny the brochure and read it and that it is also available for download on their website.

4. **INSURANCE COVERAGE:** Orlando Eye Institute contracts with most of the major health plan payers; however, I acknowledge that is my responsibility to confirm specific health plan coverage and benefit levels. Our business office is available for assistance at 407-704-3937. I understand that I am responsible to pay for any health care services for which my health plan denies coverage.

5. **NON-COVERED SERVICES:** I understand that Orlando Eye Institute contracts with health care plans that identify items and services which are "covered services." Accordingly, the undersigned accepts full financial responsibility for all items or services, which are ultimately determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Orlando Eye Institute to obtain necessary health care service plan authorizations. Payment for non-covered services is expected at time of service.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Orlando Eye Institute, I will pay my account at the time service is rendered or will make financial agreements satisfactory to Orlando Eye Institute for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Orlando Eye Institute. If copayments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Orlando Eye Institute. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

_____ _____

Patient//Responsible Party Signature Date

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Review of Symptoms (circle if it applies to you)

EYES

Previous Surgery
Contact Lens
Pain
Asthma
Glaucoma
Cataracts
Macular Degeneration
Dry Eyes

EAR, NOSE, and THROAT

Hard of Hearing
Ringing in the Ears
Vertigo

CARDIOVASCULAR

Chest Pain
Dizziness
Fainting Spells
Shortness of Breath
Irregular Heartbeat
Difficulty Lying Flat
Hypertension

CONSTITUTIONAL

Fatigue/Weakness
Fever
Weight Gain/Loss

RESPIRATORY

Cough
Congestion
Wheezing
Heavy Aspirin Use
COPD

GASTROINTESTINAL

Heartburn
Nausea/Vomiting
Jaundice/Hepatitis

GENITO-URINARY

Pain/Difficulty
Blood in Urine
History of Kidney Stones
History of STD's

PSYCHIATRIC

Anxiety/Depression
Mood Swings
Difficult Sleeping

ENDOCRINE

Increased Thirst
Increased Hunger
Increased Urination
Increased Sweating
Fingernail Changes

BLOOD/LYMPH NODES

Easy Bruising
Gums Bleed Easily
Prolonged Bleeding
Double Vision
HIV Positive/Hep C
Other_____

MUSCULOSKELETAL

Stiffness
Arthritis
Joint Pain/Swelling

SKIN

Rash/Sores
Lesions
Hives/Eczema

NEUROLOGICAL

Seizures
Weakness/Paralysis
Numbness
Tremors

IMMUNOLOGIC

Hives
Itching
Runny Nose
Sinus Pressure

Have you received a Flu shot this year? Yes____ No___
Has the patient fallen in the last 2 years? Yes____ No____
Have you received the pneumonia vaccine this year? Yes____No_____
Smoking status: Never____Former____Current everyday_____
Alcohol? Yes_____ No_____ If yes, how much?_____
Drugs? Yes____No____ If answered yes, which ones?_____How much?_____ How long?_____
When did you quit?_____
This information is accurate to the best of my knowledge.

Guardian/Patient Signature:_____Date:_____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH/MEDICAL INFORMATION PURSUANT TO HIPAA (Health Insurance Portability and Accountability Act of 1996)

I authorize the release of my Protected Health Information to the following person(s) or organization who can call on my behalf. I authorize disclosing of all my medical records received or created by the Practice. All images/photography of my eye(s), and Billing/Account Information to (please complete):

Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
_____.

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may re-disclose it.

Expiration of this Authorization:

This Authorization will automatically expire if I send in a written request. And I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to Orlando Eye Institute, to our physical address or email address. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____

Patient Signature **Date**

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Notice to Health Insurance Marketplace Participants

Those individuals who obtained health insurance coverage through the health insurance marketplace will need to provide proof of premium payment for the current month before receiving services from Orlando Eye Institute and its physicians. If proof of premium payment cannot be provided the balance for the services rendered will be collected from the patient at the time of service and held for 180 days. After payment has been provided to Orlando Eye Institute by the insurance company for the service date and held for 180 days a refund check will be issued for the balance of funds.

_____ _____

Patient/Responsible Party Signature Date

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Dry Eye Questionnaire

Speed Score:_____

Tech Initials:_____

Patient Name:_____ DOB:_____Date:_____

Dry Eye Disease is the most frequent reason that patients visit eye doctors. Most patients are not aware they even have dry eyes. Please take a few moments and complete the questionnaire below as it will help us determine whether or not you do have dry eyes and guide us as to appropriate testing.

1. Report the **FREQUENCY** of your symptoms using the rating list below:

0= Never
1 = Sometimes
2 = Often
3 = Constant

Dryness/Grittiness/Scratchiness	0	1	2	3
Soreness or Irritation	0	1	2	3
Burning or Watering	0	1	2	3
Eye Fatigue	0	1	2	3

2. Report the **SEVERITY** of your symptoms using the rating system below:

0 = No Problems
1 = Tolerable/Not Perfect
2 = Uncomfortable but does not affect my day
3= Bothersome, affects my day
4 = Intolerable

Dryness/Grittiness/Scratchiness	0	1	2	3	4
Soreness or Irritation	0	1	2	3	4
Burning or Watering	0	1	2	3	4
Eye Fatigue	0	1	2	3	4

Allergy Symptoms:

)	Itchy Eyes
)	Watery Eyes
)	Red Eyes
)	Swollen Eyes
)	Runny Nose
)	Itchy Skin
)	Flaky/ Red Skin
)	Asthma
)	Dark Circles
)	Congestion

Sjogren's Symptoms:

)	Dry Mouth
)	Fatigue/ Body Aches
)	GI Distress
)	Muscle Weakness or numbness in your arms and legs
)	Inability to Concentrate

Have you or a family member ever been diagnosed with an autoimmune disease such as Lupus, Rheumatoid Arthritis, Sjogren's or other associated autoimmune disease:
) Yes No

What would you like to see improve with your dry eyes?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____