Central Florida Retina

Patient Information Form

Date _____

Patient Information

First Name _____ MI _____ Last Name _____
Street Address _____ P.O. Box (if any) _____
City _____ State _____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____
Email _____ Social Security # _____
Date of Birth _____ Age _____
Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced Sex: ☐ Male ☐ Female

Referring Physician _____ Phone ( ) _____
Family Physician _____ Phone ( ) _____
Endocrinologist _____ Phone ( ) _____
Nephrologist _____ Phone ( ) _____
Cardiologist _____ Phone ( ) _____
Emergency Contact _____ Phone _____ Relation _____
Your Employer _____ Occupation _____
Address, City, Zip _____ Phone ( ) _____

Insurance Information

Do you have insurance? ☐ Yes ☐ No
Do you have Medicare? ☐ Yes ☐ No
Did you provide our office with a copy of your insurance cards today? ☐ Yes ☐ No *Staff Initials* ____
Are you currently employed? ☐ Yes ☐ No
Primary Insurance _____
Policy Holder Name _____ Policy Holder DOB _____
Relationship to Policy Holder _____ ☐ Self ☐ Spouse ☐ Dependant
Secondary Insurance _____
Policy Holder Name _____ Policy Holder DOB _____
Relationship to Policy Holder _____ ☐ Self ☐ Spouse ☐ Dependant

Financial Responsibility

Who will be financially responsible for any balance you may incur? _____ ☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other: _____

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Patient History: Page 1

Name _____ Date _____

Ocular / Medical History

TYPE	PATIENT	FAMILY
Retinal Detachments		
Macular Degeneration		
Diabetes		
Previous Stroke		
Atrial Fibrillation		

Ocular Procedure History

TYPE	Y	N	WHICH EYE	DATE	SURGEON
Retina Surgery or Laser					
Cataract Surgery					
Glaucoma Surgery or Laser					
Most Recent Retina Injection					
Other:					
Other:					

Medical History

Diabetes	Y	N	**Chronic Infections**	Y	N	**Breathing Problems**	Y	N
Diabetes			Hepatitis			COPD		
Approx Diagnosis Date:			Tuberculosis			Asthma		
On Insulin			HIV					
Type I ☐ Type II ☐								
Kidney Problems			**Autoimmune**			**Kidney**		
Current A1C			Autoimmune Disease			Kidney Disease		
Blood Sugar			If yes, what type?			Related to Diabetes		
						On Dialysis		
Cancer			**Cardiovascular Health**			Hx Kidney Transplant		
Cancer			Previous Heart Attack					
If yes, what type?			Bypass Surgery or Stents			**Pneumonia / Flu Shot**		
			If yes, what year?			Flu Shot		
			Previous Stroke			If yes, what mo + year?		
			Atrial Fibrillation			Pneumonia Shot		
			Pacemaker?			COVID-19 Vaccine		

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Patient History: Page 2

Name _____ Date _____

Previous Surgeries

	Y	N		Y	N
Heart Condition / Surgery			**Cancer Diagnosis**		
If yes, what date?			If yes, what date?		
Kidney Condition / Surgery					
If yes, what date?					

Social History

If yes, please explain.

Have you ever used tobacco products? ☐ No ☐ Yes _____

Have you ever used vaping products? ☐ No ☐ Yes _____

Do you drink alcohol? ☐ No ☐ Yes _____

Medications ☐ No medications

	Dosage

Eye Drops ☐ No eye drops

	Dosage	Eye

Allergies ☐ No allergies

Central Florida Retina

Patient Authorization Form

Name _____ Date _____

Authorization to Release Health Information

I **authorize** Central Florida Retina/Ophthalmic Partners of Florida to release personal health information to the following:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____

I **do not** authorize Central Florida Retina/Ophthalmic Partners of Florida to release personal health information to the following:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____

Authorization to Access & Update Medication List

I authorize Central Florida Retina to obtain a list of my medications from my primary pharmacy through electronic data capture. I also give CFR permission to periodically update medications that might be prescribed to me in the future.

Pharmacy _____ Phone _____

Address (Street) _____

Address (City, State, Zip) _____

Patient Signature _____

Central Florida Retina

Financial Policy

800.255.7188. www.centralfloridaretina.com

Please review our financial terms and sign below. Let us know if you have any questions. We want your visit to be as hassle free as possible.

Self-Payment (No insurance coverage)
If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your visit. We require an advance payment plan for professional services.

Payments Due
All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit without a referral or authorization, your insurance plan may deem this as "out-of-network" or "non-covered" treatment and you will be responsible for a larger amount or for all of the charges. By signing below, you acknowledge that it is the patient's responsibility to be aware of what services are covered and agree to pay for any service deemed to be non-covered or not authorized by your plan.

All patient responsible balances that remain delinquent after 90 days with no response to our requests for payment may be referred to Chase Receivables for collection processing.

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

Job-Related Accidents or Injuries
If the reason for your visit is due to an accident or injury while on the job, please know that we will submit the bill directly to your employer or your employer's workers' compensation carrier. The bill will not be covered unless your employer files the claim to the carrier. It will remain your responsibility until a valid claim is filed by your employer.

Authorization & Assignment of Benefits
I hereby authorize the physicians and staff of Ophthalmic Partners of Florida (CFR) to perform such treatments as may be prescribed by my attending physician during all my visits to CFR. I understand that I am financially responsible for all charges arising from services rendered to me by CFR. I hereby authorize CFR to submit any and all insurance claims for any charges that I incur. I request that all payments from any of these insurance carriers be mailed directly to CFR. I authorize any holder of medical information about me to release any information needed to the Health Care Financing Administration and its agents or any insurance company to determine these benefits or the benefits payable for related services.

Patient Agreement

By signing the below, I indicate that I understand and will comply with the above.

Patient/Representative Signature _____ Date _____

Print Name _____ Representative Relation to Patient _____

Central Florida Retina

Patient Consent Form

Name _____ Date _____

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

Submission of Consent

You are entitled to a copy of this consent after you sign it.

I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am authorizing Central Florida Retina to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature _____

If you are signing as a personal representative on behalf of the patient, please complete the following:

Personal Representative _____ Relation _____

Revocation of Consent

I revoke my consent for you to use and disclose my personal health information for treatment, payment activities and health care operations. I understand the revocation of my consent will not affect any action Central Florida Retina took in reliance of my consent before they received this written Notice of Revocation. I also understand CFR may decline to treat or continue to treat me after I have revoked my consent.

Signature _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of this Notice of Privacy Practices.

Signature _____

For Office Use:

- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining the agreement
- ☐ Other: _____