Capital Eye Consultants, P.A.

Demographic Information

Full Name (including Middle Initial):_____

Date Of Birth:_____ Gender (circle one): Male or Female

Mailing Address:_____

Social Security Number: _____-_____-_____ Marital Status: _____

Email Address:_____Home Phone #:(_____)_____-_____

Cellular Phone #: (_____)_____-_____ Work Phone#: (_____)_____-_____

Preferred Method of Contact (Circle one or more): Home Phone , Cell Phone or Work Phone

Emergency Contact Information

Name:_____ Relationship:_____

Best Contact #:_____

Name:_____ Relationship:_____

Best Contact#:_____

Physician Information

Referring Physician:_____

Primary Care Doctor:_____

HIPAA PATIENT CONSENT FORM

In response to the misuse of Personal Health Information, the Department of Health and Human Services has established a **Privacy Rule** to insure that your Personal Health Information is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your Personal Health Information in order to provide health care that is in your best interest.

We support your full access to your medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose your Personal Health Information for purposes of treatment, payment and/or health care operations. These outside entities do not necessarily need to obtain your consent for this communication.

You have the right to refuse to consent to the use of disclosure of your Personal Health Information. This refusal must be made in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your Personal Health Information. If you give consent to disclose your Personal Health Information, by signing this document, you can at some future time request to refuse future disclosures of your Personal Health Information. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our Administrative staff if you have objections to this consent.

Please list below any individual to whom we may discuss your Personal Health Information with. (ie. spouse, family member, friend, etc.)

_____

Patient or Guardian Signature Date

Below, please list the person/persons that may accompany you into the exam room and may make inquiries regarding your care:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

Informed Consent:

COVID-19

I understand that I am consenting to an elective treatment/procedure/surgery that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. After my elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this elective procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the treatment/procedure/surgery listed below.

I have been given the choice to have my treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Patient/Guardian Signature Date

Financial Policy

The following is a statement of our financial policy, which we require that you read, **initial** in the spaces provided, and sign before treatment begins. The responsible party must also provider his/her identification card and insurance cards, if applicable.

_____ **FULL PAYMENT IS DUE WHEN SERVICES ARE RENDERED**: For your convenience, we accept the following forms or payment: cash, personal checks or money orders and all major credit cards. Minor patients must be accompanied by a parent or guardian at all times, the accompanying adult is responsible for full payment at the time of the service. Balances, copays, deductibles, and co-insurance amount must be paid at the time of check-in before future services are rendered.

_____**INSURANCE**: All medical insurance plans must be presented before services are provided. As a service to you our office will verify insurance coverage as well as complete and submit the provided medical claims; however, we can only bill your insurance if you provide us with your correct and complete insurance and demographic information. It is the patient responsibility to make sure that all updated insurance cards, plan information and demographic information is provided to the practice before service are provided. Acceptance of insurance assignment by this office does not absolve the responsible party of full responsibility for the charges in full for treatment rendered. Your insurance policy is a contract between you and your insurance provider. We are not a party to that contract. If your insurance company has not paid your account in full with-in 90 days, the balance will be due and payable by the undersigned. In regards to insurance plans where we are participating providers, all co-pays, deductible and co-insurance amounts are due at the time the service is being rendered. In the event that your insurance coverage changes, is terminated or we are no longer participating providers, please refer to the above. Your payment responsibility may change if your medical insurance coverage varies. This office can make NO GUARANTEE of insurance payment.

_____ **RETURNED CHECKS**: Florida law designates that a $40.00 fee shall become payable on ever returned check. The returned check amount must be paid by cash, money order or credit/debit card within 7 days of return or the account will be turned over to legal prosecution.

_____ **MISSED APPOINTMENT FEE**: Capital Eye Consultants requires that all patients give 24-hour notice of canceling appointments unless there is an emergency or unforeseen circumstance. If you are unable to make your appointment, please contact our office to reschedule or cancel. If someone at our office is unable to be reached, please leave a voicemail notifying of that cancelation. If you fail to cancel or reschedule within 24-hours a fee $45.00 will billed to you.

I, _____ certify that I have read and accept all terms as set forth above and have received a copy of this agreement.

_____ _____

Signature Date

Refractive Fee Notice

DO YOU WANT TO BE CHECKED FOR A NEW EYEGLASS OR CONTACT LENS PRESCRIPTION?

If you do, we must perform a REFRACTION. Refraction is the procedure that a trained ophthalmic professional performs to determine a person's exact eyeglass or contact lens prescription. This is a SEPARATE service performed at the time of your eye examination which is not always covered by insurances. If your insurance does not pay for a refraction, $45.00 will be due at the time of service. If the fee is billed to your insurance carrier and denied as a non-covered service, you will be responsible for the $45.00.

Please indicate if you want to be tested to determine your new eyeglass prescription by initialing next to your desired preference.

_____ Yes, I want to have a new prescription for eyeglasses. By signing below, I understand that I will be charged $45.00 if my insurance does not cover this service.

_____ No, I do not want to have a new prescription for eyeglasses.

_____

Patient or Guardian Signature Date