MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

JOSE A. VAZQUEZ, M.D.
Board Certified Ophthalmologist

EYE CLINIC & LASER INSTITUTE

SINCE 1980

CONTACT RECORD

Patient's Name _____ Date of Birth _____/_____/_____

Pharmacy Name _____ Pharmacy # (_____) _____-_____

Eye Clinic & Laser Institute will leave confidential messages on your answering machine, with a family member or other individual answering the phone when you are not at home unless you indicate otherwise. We will safeguard your privacy by limiting the amount of information disclosed. For example, when calling your home we will only leave our name and number and other information necessary to confirm an appointment, or ask you to call back.

Please contact me as follows:

* Home Telephone (_____) _____-_____ Cell (____) _____-_____

E-MAIL ADDRESS_____

- □ OK to leave a message with healthcare information.
- □ Leave message with call back number only.
- □ Do NOT leave messages.
- □ E-MAIL ONLY

- Work Telephone (_____) _____-_____
  - □ OK to leave messages with healthcare information.
  - □ Leave a message with call back number only.
  - □ Do Not leave messages.
  - □ Retired or not working.

* List the names of individuals you authorize us to speak with regarding your healthcare.

□ None.

□ Spouse _____

□ Child _____

□ Other _____

If we are unable to reach you by any other means, we will send information through the U.S. Postal Service to your home address.

_____ _____

Signature of Patient Date

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Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment or health information.
- The Practice has a Notice of Privacy and that I have received this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.
- I may revoke this Consent in writing at any time and all future disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent.

This consent was signed by: _____
Signature of Patient or Representative Date

Relationship to Patient (if other than patient): _____

Witnessed by: _____
Signature of Witness Date

AUTHORIZATION TO BILL INSURANCE AND UNDERSTANDING NON-COVERED SERVICES

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The fee for a medical eye exam varies depending on the level of service provided by the physician. Any additional test and or procedures will be charged and billed as allowed by Medicare. The patient is always responsible for the Medicare deductible each calendar year. Medicare pays 80% of their allowed charge. The remaining 20% is the patient's responsibility.

When assignment is accepted on a claim, physicians may bill beneficiaries for services that are denied as non-covered services. While the assignment agreement prohibits physicians from collecting more than the Medicare allowed charge for services, it does not prohibit collecting non-covered services. Collection for non-covered services applies to services that are not normally covered by Medicare, such as annual or routine exams, as well as services deemed not medically necessary.

The following are examples of non-covered services, collected the day of services:

1. Eye Refraction 92015
2. Contact lens / fitting
3. Medications
4. Cosmetic Procedures

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of Medical or Other information about me to release to the Social Security Administration or its intermediaries of carries any information needed for Insurance related claims. I request that the payment of authorized benefits be made on my behalf to the physicians and /or organization. I accept financial responsibility for any denied services or uncovered services as stated above.

IMPORTANT INFORMATION ABOUT YOUR EYE EXAMINATION

If you choose to be checked for an eye glass prescription (refraction) there will be a $35.00 charge. This charge is totally independent of whether the prescription changed. _____ Initial

Payment is required for **any charges not covered** by your Insurance Company at the time of service. **NO EXCEPTIONS!** _____ Initial

Any co-payment of the eye examination charges is due on the day of service. _____ Initial

If you have not met your insurance's annual deductible for the year, payment **of services is due on the same day of your examination.** _____ Initial

It is your responsibility to get an authorization for your visits, should your insurance require it. Should you fail to do so and the insurance does not pay, it will be your responsibility to pay the amount due. _____ Initial

_____ _____ ____/___ /_____

Patient Signature Printed Name Date

PATIENT REGISTRATION

Merritt Island
1045 N Courtenay Pkwy
Merritt Island, Fl 32953
(321) 453-EYES (3937)

Port St. John
6725 N. Highway US1
Cocoa, FL 32927
(321) 383-EYES (3937)

Melbourne
232 S Wickham Rd.
Melbourne FL 32940
(321) 953-EYES (3937)

Suntree
6599 N Wickham Rd Unit C101
Melbourne, FL 32940
(321) 723-EYES (3937)

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LAST NAME_____FIRST NAME _____ M.I. _____
ADDRESS_____CITY_____ST_____ZIP_____
HOME PHONE (_____) _____-____ CELL PHONE (_____) _____-_____ WORK (____)_____-_____
E-MAIL _____
PRIMARY CARE PHYSICIAN _____
REFERRING
PHYSICIAN_____
DATE OF BIRTH____/_____/_____SEX_____ MARITAL
STATUS_____
SOCIAL SECURITY NUMBER_____-_____-_____ETHNICITY_____RACE_____
LOCAL PHARMACY_____LOCATION _____
EMPLOYER NAME_____
EMPLOYER ADDRESS_____
PRIMARY INSURANCE_____MEMBER/GROUP#_____
SECONDARY INSURANCE_____ MEMBER/GROUP#_____

FOR INSURANCE PURPOSES, PLEASE LIST THE RESPONSIBLE PARTY'S (SUBSCRIBER'S):

LAST NAME_____FIRST NAME _____ M.I. _____
ADDRESS_____CITY_____ST_____ZIP_____
HOME PHONE (_____) _____-_____CELL PHONE (_____)_____-_____ WORK (____)____-_____
E-MAIL_____
RELATIONSHIP TO PATIENT_____RESPONSIBLE PARTIES D.O.B____/_____/_____
SOCIAL SECURITY NUMBER_____-_____-_____LANGUAGE OF CHOICE_____

EMERGENCY CONTACT INFORMATION

NAME _____PHONE (____)_____-_____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

PATIENT SIGNATURE (OR PARENT IF A MINOR) _____DATE_____/_____/_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTED TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES.

PATIENT SIGNATURE (OR PARENT IF A MINOR)_____DATE_____/_____/_____

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MEDICAL HISTORY

Name: _____ Sex: M / F DOB: ____/_____/_____Ht: _____ Wt _____

Are you presently under the care of a physician? Yes / No If so,

Physician's name: _____

List ALL medications you are currently taking

_____

List ALL of your allergies

_____

PLEASE CHECK ALL OF THE EYE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

__ Redness __ Light sensitivity __ Dry eye feeling __ Eye Pain/Soreness __ Mucous discharge __ Sties/Chalazion __ Chronic infection of eye or lids __ Sandy or gritty feeling

__"Tired" eyes __Itching/Burning __ Fluctuating visual acuity

__ Other

_____

Do you use lubricating eye drops? Yes / No What brand name? _____

Do you wear contact lenses? Yes / No How long? _____

Are they comfortable? Yes / No Have you tried wearing them before and discontinued use? Yes/No

Do you wear glasses? Yes / No How long? _____

Have you ever had an eye injury? Yes / No

Describe: _____

OVERALL MEDICAL HISTORY

Please indicate if you or a blood relative have or have had any of the following conditions:

Macular degeneration [_] No [_] Self [_] Family Relationship:
_____

Diabetes [_] No [_] Self [_] Family Relationship:
_____

Heart disease [_] No [_] Self [_] Family Relationship:
_____

High blood pressure [_] No [_] Self [_] Family Relationship:
_____

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Cancer Type: _____	[_] No [_] Self	[_] Family	Relationship:
Asthma/Respiratory	[_] No [_] Self	[_] Family	Relationship:
Arthritis	[_] No [_] Self	[_] Family	Relationship:
Epilepsy	[_] No [_] Self	[_] Family	Relationship:
Stroke	[_] No [_] Self	[_] Family	Relationship:
Headaches/Migraines	[_] No [_] Self	[_] Family	Relationship:
Glaucoma	[_] No [_] Self	[_] Family	Relationship:
Allergies	[_] No [_] Self	[_] Family	Relationship:
Gastrointestinal/Liver	[_] No [_] Self	[_] Family	Relationship:
Blood disorder Type: _____	[_] No [_] Self	[_] Family	Relationship:
Kidney stones	[_] No [_] Self	[_] Family	Relationship:
Kidney failure	[_] No [_] Self	[_] Family	Relationship:

SOCIAL HISTORY

Do you smoke? Yes / No Number of packs per day: _____

Do you drink alcohol? Yes / No Number of drinks per day: _____

Do you use Illegal drugs? (Cocaine, marijuana, etc.) Yes / No

Patient signature _____ Date _____/_____/_____

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How Did You Hear About Us

PATIENT NAME _____

☐ PHYSICIAN REFERRAL NAME

_____

☐ TV

☐ CNN ☐ ESPN2 ☐ OXYGEN ☐ GOLF CHANNEL ☐ NEWS 13 CHANNEL

☐ FLORIDA TODAY NEWSPAPER

☐ MAILER / POSTCARD

☐ Website

☐ Friend or Colleague

☐ Other

_____

_____

_____

_____

_____