West Coast Eye Institute

JOHN W. ROWDA, D.O.
Board Certified Ophthalmologist
Cataract and Implant Surgery

KYLE A. PARROW, M.D.
Board Certified Ophthalmologist
Cataract and Implant Surgery
Glaucoma Therapy and Surgery

BEN LAMBRIGHT, M.D.
Fellowship Trained
Refractive Cornea & Cataract Surgery

AMANDA N. COPPEDGE, O.D.
Board Certified Optometric Physician
Contact Lenses

240 N. Lecanto Hwy. • Lecanto, FL 34461 • (352) 746-2246 • 1-800-330-2246

PATIENT INFORMATION

PLEASE PRINT • Please Complete All Information

NAME: _____ SEX: _____

STREET ADDRESS: _____ CITY: _____ ZIP: _____

MAILING ADDRESS (IF DIFFERENT): _____ E-MAIL: _____

HOME PHONE: _____ WORK PHONE: _____

DATE OF BIRTH: _____ SPOUSE'S NAME: _____

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) OTHER

SOC. SEC. #: _____ DRIVER LIC. #: _____

REF'D BY: _____ FAMILY DOCTOR: _____

HOW DID YOU FIND OUT ABOUT US? ( ) YELLOW PAGES ( ) RADIO ( ) NEWSPAPER ( ) PATIENT

( ) OTHER _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

MEDICARE #: _____ PRIMARY ( ) SECONDARY ( )

SECONDARY INSURANCE NAME: _____

OTHER INSURANCE: _____

INSURANCE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____

POLICY HOLDER: ( ) SELF ( ) OTHER DATE OF BIRTH: _____

NAME: _____ SS #: _____

INSURANCE #: _____ GROUP #: _____

EMERGENCY CONTACT: _____ PHONE: _____
(Other than Spouse)

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned for collection and/or suit, the prevailing party shall be entitled to reasonable costs of collection.

••• BE ADVISED THAT THERE WILL BE A $32.00 FEE FOR YOUR REFRACTION. THIS IS A NON-COVERED SERVICE AND WILL BE THE PATIENT'S RESPONSIBILITY.

SIGNATURE: _____ DATE: _____

PATIENT INFORMATION DATE:_____

NAME:_____ Date of Birth: _____

MARITAL STATUS: ☐Single ☐Married ☐Widowed ☐Divorced

Thank you for choosing our office for your eye care. Many diseases of the body and medications used to treat them affect the health of your eyes. To better serve you, please answer the following questions:

Do you wear glasses? ☐Yes ☐No

Do you wear contacts? ☐Yes ☐No

Are you interested in contacts or refractive surgery? ☐Yes ☐No

Are you currently experiencing any eye symptoms? Please check all that apply:

☐ Itching	☐ Sandy, gritty feeling	☐ Veil/curtain
☐ Burning	☐ Double vision	☐ Light sensitivity or glare
☐ Tearing	☐ Blurred vision	☐ Flashes of light
☐ Matter	☐ Decreased vision	☐ Floaters/Cobwebs
☐ Redness	☐ Loss of vision	☐ Pain

If you have noticed a change in your glasses and would like to be checked for new ones, there is a $32.00 fee for this service that your insurance company does not cover.

Would you like to be checked for new glasses? Yes ☐ No ☐

Medication Allergies_____

MEDICAL HISTORY:

☐ AIDS	☐ **Emphysema**	☐ MS
☐ Alzheimers	☐ Enlarged Prostate	☐ Osteo-arthritis/Parosis
☐ Anemia	☐ Epilepsy	☐ Pacemaker
☐ Anorexia	☐ **Heart Disease**	☐ Parkinson's
☐ Arthritis	☐ Hepatitis	☐ Polio
☐ **Asthma**	☐ Hernia	☐ Psychiatric Care
☐ **Bleeding Disorders**	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Bronchitis	☐ High Cholesterol	☐ **Sjogren's**
☐ Bulimia	☐ **HIV Positive**	☐ **Stroke**
☐ Chemical Dependency	☐ Kidney Disease	☐ **Thyroid Problems**
☐ **Diabetes**	☐ Liver Disease	☐ TB
☐ Cancer	☐ Lupus	☐ Ulcers
Type_____	☐ Migraine Headaches	☐ Other

NAME_____ DATE_____

PATIENT REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Constitutional:
- ❑ Fever
- ❑ Weight loss
- ❑ Other

Ear/Nose/Mouth/Throat:
- ❑ Bleeding gums
- ❑ Chronic Cough
- ❑ Difficulty Swallowing
- ❑ Ear Ache
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Nose Bleeds
- ❑ Post Nasal Drip
- ❑ Ringing In Ears
- ❑ Runny Nose
- ❑ Sinus Problems

Cardiovascular:
- ❑ Chest Pain
- ❑ Irregular Heart Beat
- ❑ Palpitations
- ❑ Poor Circulation
- ❑ Swelling of Ankles

Respiratory:
- ❑ Chronic Bronchitis
- ❑ Coughing
- ❑ Shortness of Breath
- ❑ Wheezing

Gento-Urinary:
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Lack of Bladder Control
- ❑ Painful Urination

Gastro-intestinal:
- ❑ Appetite Poor
- ❑ Bloating
- ❑ Bowel Changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas
- ❑ Indigestion
- ❑ Nausea
- ❑ Reflux
- ❑ Stomach Pain
- ❑ Vomiting

Skin:
- ❑ Bruise Easily
- ❑ Hives
- ❑ Itching
- ❑ Changes in Moles
- ❑ Rash
- ❑ Scars
- ❑ Sores That Won't Heal

MusculoSkeletal:

Pain, Weakness, Numbness In:
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Other

Allergic/Immunologic:
- ❑ Head Allergy Symptoms
- ❑ Seasonal Allergies
- ❑ Hay Fever Symptoms

Nervous Conditions:
- ❑ Anxiety
- ❑ Depression
- ❑ Nervousness

Hematologic/Lymphatic:
- ❑ Blood Irregularities
- ❑ Lymph Node Irregularities

Neurological:
- ❑ Dizziness
- ❑ Headaches
- ❑ Memory Loss
- ❑ Seizures
- ❑ Weakness
- ❑ Tremor
- ❑ Shakes

Endocrine:
- ❑ Increased Urination
- ❑ Increased Thirst
- ❑ Sweats / Clamminess
- ❑ Lethargy
- ❑ Decreased Energy

NAME_____ DATE_____

FAMILY MEDICAL HISTORY: (Blood Relatives)

	Relationship to patient:
❑ Blindness	_____
❑ Cataract	_____
❑ Glaucoma	_____
❑ Macular Degeneration	_____
❑ Arthritis	_____
❑ Cancer	_____
❑ Depression	_____
❑ Diabetes	_____
❑ Heart Disease	_____
❑ High Blood Pressure	_____
❑ Kidney Disease	_____
❑ Liver Disease	_____
❑ Lupus	_____
❑ Sjogrens Syndrome	_____
❑ Stroke	_____
❑ Thyroid Disease	_____
❑ TB	_____
❑ Other	_____

EYE HISTORY (PATIENTS)

- ❑ Blindness
- ❑ Cataract
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Diabetes
- ❑ Eye Surgery
- ❑ Lazy Eye
- ❑ Trauma

WHO IS YOUR FAMILY DOCTOR?_____

Do you smoke? ☐Yes ☐ Never If yes, how much per day?_____
☐ Quit How long ago? _____

Do you drink alcohol? ☐ Socially How much per day?_____
☐ Occasionally How much per week?_____
☐ Never

Do you drive? ☐ Yes ☐ No ☐ Daytime only

PAST MAJOR SURGERIES AND MAJOR ILLNESSES:

_____

_____

_____

_____

NAME____ **DATE**_________________

OFFICE USE ONLY

REVIEWED PAGES 1-3 WITH THE PATIENT. (PFSH) CHANGES NOTED.

INITIAL EXAM:

ALL OTHERS NEGATIVE

TECH INITIALS: __________ DATE:____________ DR: __________________

JOHN ROWDA DO / KYLE PARROW MD / AMANDA COPPEDGE OD / BEN LAMBRIGHT MD

SUBSEQUENT EXAMS:

CHANGES NOTED:

TECH INITIALS:__________ **DATE:**____________ **DR:** __________________________

JOHN ROWDA DO / KYLE PARROW MD / AMANDA COPPEDGE OD / BEN LAMBRIGHT MD

TECH INITIALS:__________ **DATE:**____________ **DR:** __________________________

JOHN ROWDA DO / KYLE PARROW MD / AMANDA COPPEDGE OD / BEN LAMBRIGHT MD

TECH INITIALS:__________ **DATE:**____________ **DR:** __________________________

JOHN ROWDA DO / KYLE PARROW MD / AMANDA COPPEDGE OD / BEN LAMBRIGHT MD

TECH INITIALS:__________ **DATE:**____________ **DR:** __________________________

JOHN ROWDA DO / KYLE PARROW MD / AMANDA COPPEDGE OD / BEN LAMBRIGHT MD

TECH INITIALS:__________ **DATE:**____________ **DR:** __________________________

JOHN ROWDA DO / KYLE PARROW MD / AMANDA COPPEDGE OD / BEN LAMBRIGHT MD

West Coast Eye Institute - Lecanto

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand the following is not required; however, it is for my convenience if I wish to give West Coast Eye Institute- Lecanto permission to discuss my medical condition with anyone I may designate such as a spouse, children, or caregiver. I understand I must notify West Coast Eye Institute – Lecanto in writing if I wish to add or delete names.

I, _____, give permission for the staff and physicians to discuss my medical condition with the following:

Please give full name, including first and last name.

/_/ Spouse _____

/_/ Children _____

/_/ Caregiver _____

/_/ Other _____

Patient Name : _____

Signature of patient or legal guardian:_____

Date: _____

West Coast Eye Institute - Lecanto
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise. Our practice may use and disclose your PHI to contact you by telephone, with our automated computerized appointment reminder system, or in writing. Unless you tell us otherwise, we will leave a message on your home answering machine or with someone who answers your phone if you are not home about your upcoming appointments.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you (if available) or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

PATIENT NAME: _____

MEDICARE CERTIFICATION

PATIENT'S MEDICARE NUMBER: _____

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE THE RELEASE OF MEDICAL OR OTHER INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS NECESSARY FOR MEDICARE CLAIMS. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE IN MY BEHALF. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO WEST COAST EYE INSTITUTE, WHO IS ACCEPTING ASSIGNMENT IN BEHALF ON ALL MY CLAIMS.

_____ _____ _____

PATIENT SIGNATURE WITNESS SIGNATURE DATE

SUPPLEMENTAL/COMMERCIAL INSURANCE RELEASE AND ASSIGNMENT

PATIENT'S ID NUMBER: _____

I HEREBY AUTHORIZE THE WEST COAST EYE INSTITUTE TO RELEASE ANY INFORMATION CONTAINED IN MY FILES TO _____ RELATIVE TO CLAIMS MADE IN MY BEHALF. I FURTHER AUTHORIZE PAYMENT OF ALL CLAIMS DIRECTLY TO THE WEST COAST EYE INSTITUTE. THIS AUTHORIZATION REMAINS VALID FOR A LIFETIME OR UNTIL OTHERWISE REVOKED BY MYSELF.

_____ _____ _____

PATIENT SIGNATURE WITNESS SIGNATURE DATE

HMO RELEASE/ASSIGNMENT

PATIENT'S ID NUMBER: _____

I CERTIFY THAT MY PRIMARY INSURANCE COMPANY IS _____(HMO) AND I AM AWARE THAT APPOINTMENTS REQUIRE PRIOR AUTHORIZATION FROM MY PRIMARY CARE PHYSICIAN. I UNDERSTAND IT IS MY RESPONSIBILITY TO CONTACT MY PRIMARY CARE PHYSICIAN AND OBTAIN PRIOR AUTHORIZATION AND TO PROVIDE WEST COAST EYE INSTITUTE WITH THIS AUTHORIZATION. I UNDERSTAND MY HMO MAY PAY FOR ROUTINE YEARLY EYE EXAMS WITHOUT PROIR AUTHORIZATION ONLY IF I AM ELIGIBLE UNDER MY PARTICULAR PLAN. IF I AM NOT ELIGIBLE, I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT.

I AUTHORIZE WEST COAST EYE INSTITUTE TO RELEASE ANY INFORMATION CONTAINED IN MY FILES RELATIVE TO CLAIMS MADE IN MY BEHALF. I FURTHER AUTHORIZE PAYMENT OF ALL CLAIMS DIRECTLY TO WEST COAST EYE INSTITUTE. THIS AUTHORIZATION REMAINS VALID FOR LIFETIME OR UNTIL OTHERWISE REVOKED BY MYSELF.

_____ _____ _____

PATIENT SIGNATURE WITNESS SIGNATURE DATE