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

BENJAM N LAMBRIGHT, M.D.
Board Certified Ophthalmologist
Refractive Cornea & Cataract Surgery
Fellowship Trained

REBECCA LESSNER, D.O.
Board Trained Ophthalmologist
Glaucoma Therapy and Surgery
Refractive Cornea and Cataract Surgery

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

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 $50.00 FEE FOR YOUR REFRACTION. THIS IS A NON-COVERED SERVICE AND WILL BE THE PATIENT'S RESPONSIBILITY.

SIGNATURE: _____ DATE: _____

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 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 OF MY CLAIMS.

_____ _____ _____

PATIENTS 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'S 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 PRIOR 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'S SIGNATURE WITNESS SIGNATURE DATE

West Coast Eye Institute - Lecanto

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). 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 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 _____

Signature of patient or legal guardian _____

Date: _____

DATE: _____

NAME: _____ DOB: _____

MARITAL STATUS: ❑Single ❑Married ❑Widowed ❑Divorced

To better serve you, please answer the following questions:

Primary Care Physician: _____ **Preferred Pharmacy:** _____

Medication Allergies: _____

Past Ocular History:

- ❑ Amblyopia
- ❑ Astigmatism
- ❑ Cataract
- ❑ Corneal Disorder
- ❑ Diabetic Retinopathy
- ❑ Dry Eye Syndrome
- ❑ Glaucoma
- ❑ Hyperopia
- ❑ Iritis/Uveitis
- ❑ Macular Degeneration
- ❑ Myopia
- ❑ Presbyopia
- ❑ Retinal Detachment

Past Ocular Surgeries:

- ❑ Cataract
- ❑ Cornea Transplant
- ❑ DCR
- ❑ Glaucoma Surgery
- ❑ Globe
- ❑ Injections of _____
- ❑ Lid procedure of _____
- ❑ NLD Probing
- ❑ Nystagmus Surgery
- ❑ Ptosis Repair
- ❑ Retinal Procedure of
- ❑ Strabismus Surgery
- ❑ Thyroid Decompression
- ❑ Vision correction w/_____
- ❑ YAG Laser
- ❑ Other: _____

Do you currently wear glasses? ❑Yes ❑No

If yes, check all that apply:

❑Far ❑Near ❑Monofocal ❑Bifocal ❑Progressive

Do you currently wear contacts? ❑Yes ❑No

If yes, check all that apply:

❑Monofocal ❑Multifocal ❑RGP ❑Scleral Lens **Brand**: _____

If you have noticed a change in your glasses and would like to be checked for new ones, there is a $50.00 fee for this service that your insurance company does not cover.

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

PAST MEDICAL HISTORY

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

❑ Pneumonia Vaccine ❑ Influenza Immunization

Within the last year have you fallen 2 or more times or had an injury from a fall? ❑Yes ❑No

CONTINUED ON BACK

PATIENT REVIEW OF SYSTEMS **Name:** _____ **Date:** _____

Eyes
- ❑ Previous Surgery
- ❑ Contact Lens
- ❑ Pain
- ❑ Double Vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular Degeneration
- ❑ Dry Eyes
- ❑ Flashes
- ❑ Floaters

Ear, Nose & Throat
- ❑ Hard of Hearing
- ❑ Ringing in Ears
- ❑ Vertigo

Cardiovascular
- ❑ Chest Pain
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Shortness of Breath
- ❑ Irregular Heart Beat
- ❑Difficulty Lying Flat

Constitutional
- ❑ Fatigue/Weakness
- ❑ Fever
- ❑ Weight Gain/Loss

Respiratory
- ❑ Cough
- ❑ Congestion
- ❑ Wheezing
- ❑ Asthma

Gastrointestinal
- ❑ Heartburn
- ❑ Nausea/Vomiting
- ❑ Jaundice/Hepatitis

Genito-Urinary
- ❑ Pain/Difficulty
- ❑ Blood in Urine
- ❑ History of Kidney Stones
- ❑ History of STD's

Nervous Conditions
- ❑ Anxiety/Depression
- ❑ Mood Swings
- ❑ Difficulty Sleeping

Endocrine
- ❑ Increased Thirst
- ❑ Increased Hunger
- ❑ Increased Urination
- ❑ Increased Sweating
- ❑ Fingernail Changes

Blood/Lymph nodes
- ❑ Easy Bruising
- ❑ Gums Bleed Easily
- ❑ Prolonged Bleeding
- ❑ Heavy Aspirin Use

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

PAST SURGERIES

_____

_____

FAMILY HISTORY

❑ None ❑ Unknown

	Relationship		Relationship
❑ Blindness	_____	❑ Diabetes	_____
❑ Cataract	_____	❑ Heart Disease	_____
❑ Lazy Eye	_____	❑ High Blood Pressure	_____
❑ Macular Degeneration	_____	❑ Kidney/Liver Disease	_____
❑ Retinal Disease	_____	❑ Lupus	_____
❑ Glaucoma	_____	❑ Sjogren's syndrome	_____
❑ Arthritis	_____	❑ Stroke	_____
❑ Cancer	_____	❑ Thyroid Disease	_____
❑ Depression	_____	❑ TB	_____

Have you ever had any problems with anesthesia?
If yes, please explain: _____

_____

Have you EVER taken any medication for frequent urination or prostate problems?
❑ Yes ❑ No
If yes, name of medication: _____

SOCIAL HISTORY

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

Do you drink?
- ❑ Socially How much per day? ____
- ❑ Occasionally How much per week? ___
- ❑ Never

Name: _____ Date: _____

MEDICATIONS

BLOOD PRESSURE

MEDICATION	STRENGTH	INSTRUCTIONS
METOPROLOL		
AMLODIPINE		
LISINOPRIL		
ATENOLOL		
LOSARTAN		
PROPRANOLOL		
FUROSEMIDE		
DILTIAZEM		
LASIX		
HCTZ		

DIABETES

MEDICATION	STRENGTH	INSTRUCTIONS
METFORMIN		
GLIMEPIRIDE		
GLIPIZIDE		
HUMALOG		
NOVOLOG		
INSULIN		

BLOOD THINNERS

MEDICATION	STRENGTH	INSTRUCTIONS
COUMADIN		
XARELTO		
PRADAXA		
ELIQUIS		
HEPARIN		
PLAVIX		

DIGESTION

MEDICATION	STRENGTH	INSTRUCTIONS
NEXIUM		
PRILOSEC		
OMEPRAZOLE		

THYROID

MEDICATION	STRENGTH	INSTRUCTIONS
SYNTHROID		
LEVOTHYROXINE		
ARMOUR		

ARTHRITIS

MEDICATION	STRENGTH	INSTRUCTIONS
MELOXICAM		
PLAQUENIL		

CHOLESTEROL

MEDICATION	STRENGTH	INSTRUCTIONS
SIMVASTATIN		
LIPITOR		
CRESTOR		
PRAVASTATIN		
LOVASTATIN		
ATORVASTATIN		
ZOCOR		

NERVOUS CONDITIONS

MEDICATION	STRENGTH	INSTRUCTIONS
PROZAC		
CYMBALTA		
LEXAPRO		
CELEXA		
ZOLOFT		
PAXIL		
ABILIFY		
CLONAZEPAM		

PULMONARY

MEDICATION	STRENGTH	INSTRUCTIONS
ADVAIR		
SYMBICORT		
ALBUTEROL		
FLOVENT		
SINGULAIR		

NEUROLOGICAL

MEDICATION	STRENGTH	INSTRUCTIONS
LYRICA		
GABAPENTIN		
TOPAMAX		
TEGRETOL		

OTHER MEDICATIONS & SUPPLEMENTS

MEDICATION	STRENGTH	INSTRUCTIONS

DO YOU PREFER A 30 OR 90 DAY SUPPLY OF MEDS? _____

West Coast Eye Institute – Lecanto Office
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.
- 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 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.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency

where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer

Phone number: (352) 746-2246 X119

Fax number: (352) 746-2807

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 9/23/2013.