Treasure Coast Eye Specialists
514 SW Prima Vista Blvd.
Port Saint Lucie, FL 34983
Phone: (772) 878-3437
Fax: (772) 878-1298

TREASURE COAST
EYE SPECIALISTS

Dear

Welcome to our practice. We are very pleased that you have selected us for your eye care needs. We look forward to meeting you and providing you with personal and quality care. We pride ourselves on trying to make your eye care and treatment a pleasant experience.

Please fill out the enclosed forms, checking that all sections are completed, and bring them with you to your visit. Please make sure to bring your current glasses and contact lenses with you to your appointment, as well as all of your eye medications, in a bag.

If you have any questions, please do not hesitate to contact us at (772)878-3437 so that we may assist you.

Thank you for choosing Treasure Coast Eye Specialists(P) to take care of your ocular health.

We look forward to seeing you.

Sincerely,

Directions To the Port St. Lucie Office

Our office is located between Bayshore Blvd and Airoso Blvd, on the south side of Prima Vista Blvd

From the SOUTH (traveling NORTH on US1): Make a LEFT onto Prima Vista Blvd, approximately 4 miles. You must make a U-Turn at Friar Street and come back east ¼ mile to the opening of the parking lot.

From the NORTH (traveling SOUTH on US1): Make a RIGHT onto Prima Vista Blvd, approximately 4 miles. You must make a U-Turn at Friar Street and come back east ¼ mile to the opening of the parking lot.

FROM I-95: *(St. Lucie West Blvd becomes Prima Vista Blvd and you cross Bayshore Blvd)* Take EXIT 121, which is St. Lucie West Blvd. Head EAST 3 miles (you will cross over the turnpike). After you pass the Bayshore/ Prima Vista intersection, you will travel .6 of a mile and the parking lot entrance will be on the RIGHT.

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Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name				**Salutation**	
Date of Birth		**Age**			
Gender				**SS #**	
Address					

****Do you have a secondary address? □ YES or □ NO**
If yes, please write it on the back of this paper.

Communication					
Preference					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Email**			
Please Check: **I give permission to leave voicemail on:**	[ ] Home Phone [ ] Cell Phone [ ] Work Phone **OR** [ ] No Voicemail	**Please Check:**	[ ] I give permission to communicate with me via email and/or text message using the information I have provided. [ ] I understand that email and text message is not a secured medium for transmitting personal health information.		

Information			
Primary Language (Please circle)	English Spanish French Italian Other:	**Marital Status (Please circle)**	Single Married Widowed Divorced Other:
Race- (Please circle)	American Indian Asian African American Native Hawaiian other Pacific Islander White Other Race	**Ethnicity (Please circle)**	Non-Hispanic or Latino Hispanic or Latino
Primary Care Physician:		**Who were you referred by?**	

Account Responsible					
Responsible				**Salutation**	
Relationship				**SS #**	
Address					
Home Phone		**Work Phone #**		**Extension**	
Email					

Primary Insurance			
Name		**Group Name**	
ID #		**Group #**	
Address			

Primary Insurance			
Insured		**Date of Birth**	
Secondary Insurance			
Name		**Group Name**	
ID #		**Group #**	
Address			
Insured		**Date of Birth**	

Emergency Contact							
Sal	**First**	**M**	**Last**	**Relation**	**Home#**	**Cell#**	**Permission to release personal health information**
							[ ] Yes [ ] No

Other Contacts							
Sal	**First**	**M**	**Last**	**Relation**	**Home#**	**Cell#**	**Permission to release personal health information:**
							[ ] Yes [ ] No

Patient Health History

Please review, make necessary changes and supply any missing information.

Review Of Systems	
Please CIRCLE any symptoms that you are experiencing	
General	Appetite Changes, Chills, Fatigue, Fever, Light Headedness, Weakness, Weight Gain, Weight Loss
Cardiovascular	Tightness, Chest Pain, Palpitations, Shortness of Breath, Swelling Hands/ Feet, Sudden Awakening From Sleep with Shortness of Breath
Ears, Nose, Mouth, Throat	Ear Drainage, Hay Fever, Hoarseness, Sore Tongue, Thrush, Non-Healing Sores, Dentures, Dizziness, Earaches, Hearing Loss, Nose Bleeds, Sinus Pain, Sore Throat, Stuffy Nose
Respiratory / Lungs	Cough, Shortness of Breath, Sputum, Wheezing, Coughing up Blood, Painful Breathing
Stomach / Intestines	Change in Appetite, Constipation, Diarrhea, Difficulty Swallowing, Change in Bowel Movements, Heartburn, Jaundice, Nausea
Urinary / Reproductive	Burning or Pain, Blood in Urine, Change in Urinary Strength, Change in Color of Urine, Frequent Urination, Incontinence
Bones / Joints / Muscles	Stiffness, Swelling of Joints, Trauma, Back Pain, Joint Pain, Muscle Pain, Neck Pain
Skin / Hair / Nails	Changes in Color/ Pigmentation, Changes in Nail/ Hair, Dryness, Itching, Lumps, Skin Rashes
Neurological	Headaches, Head Injury, Numbness, Tingling, Tremor, Weakness, Dizziness
Psychiatric	Memory Loss, Anxiety, Depression, Nervousness

Review Of Systems	
Please CIRCLE any symptoms that you are experiencing	
Endocrine / Hormonal	Sweating, Frequent Urination, Thirst, Change in Appetite
Blood / Circulation	Easy Bleeding, Easy Bruising
Allergic / Immunologic	Seasonal Allergies
Other	
OR:	***NOT EXPERIENCEING ANY SYMPTOMS AT THIS TIME***

	PAST MEDICAL HISTORY
PLEASE CIRCLE ANY PREVIOUSLY DIAGNOSED CONDITIONS:	Alzheimer's Disease, Anemia, Aneurysms, Anxiety Disorder, Arthritis, Asthma, Atrial Fibrillation, Bell's Palsy, Bipolar Disorder, Cancer/ Hx of Cancer, Cerebral Palsy, Chronic Heart Failure, COPD, Dementia, Depression, Eczema, Emphysema, Epilepsy, Fibromyalgia, Giant Cell Arteritis, Heart Disease, Hepatitis A B C, Herpes Zoster, High Cholesterol, HIV/ AIDS, Hypertension, Hyperthyroid, Hypothyroid, Kidney Disease, Migraines, Multiple Sclerosis, Muscular Dystrophy, Osteoporosis, Pacemaker/ Defibrillator, Parkinson's Disease, Pneumonia, Polymyalgia Pneumatica, Prediabetes, Rheumatoid Arthritis, Seizure Disorder, Sinusitis, Sjoren's Syndrome, Stroke/ TIA-Previous, Tuberculosis, Ulcers, Vertigo, OTHER: **<u>DIABETES (please circle one below):</u>** **TYPE II-** **INSULIN DEPENDENT** **NON-INSULIN DEPENDENT** **TYPE I-** **INSULIN DEPENDENT** **NON INSULIN DEPENDENT** ***OR PLEASE SELECT:*** **( ) No previously diagnosed conditions**

Diabetic Information		
Type of Test		
SMBS: Self Monitoring Blood Sugar test	**Date of Last Recorded Test**	
	Value	
	Location / Timing	
HgbA1c: Hemoglobin A1c test	**Date of Last Recorded Test**	
	Value	
	Location / Timing	

Surgical Information- Please list all past surgeries				
Date	**Eye**	**Procedure**	**Surgeon**	**Complications**

Medications			
Please cross out any medications that you are no longer taking **Please list all prescriptions, over the counter and herbal medications** ****If you are not currently taking any medications, please indicate NONE below:**			
Date	**Name**	**Strength**	**Directions**

Past / Present Ocular History		
Please CIRCLE all that apply and FILL IN any missing information		**Date/ Duration**
Last Eye Exam:	Date:	
Cataracts	YES or NO If Yes, have you ever had any surgery? YES or NO When?	
Glaucoma	YES or NO If yes, have you ever had any surgery? YES or NO When?	
Vision	Vision Loss/ Changes: How long? Blurry/ Double Vision: How long?	
Retinal Disease	YES or NO If yes, have you ever had any surgery? YES or NO When?	
Glasses/ Contacts	YES or NO If yes, how long have you been wearing?	
Pain	YES or NO If yes, how long?	
Redness	YES or NO If yes, how long?	
Flashing Lights	YES or NO If yes, how long?	
Floaters/ Specks	YES or NO If yes, how long?	
Dry Eyes	YES or NO If yes, how long?	
Other:		

Do you work on a computer?		**Hours per day**	

Social History	
What type of recreational drugs do you use?	
What type of alcohol do you drink, how much and how often?	
Are you a smoker, former smoker or never smoked? Do you smoke everyday or some days?	

Family History	
Please list any family members with these conditions MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)	
Glaucoma	
Cataracts	

PATIENT REGISTRATION FORM

Financial Agreement and Assignment of Benefits

We are delighted that you have chosen treasure. Your understanding of our financial policies is important to our relationship. If you have questions or concerns about any of the information below please discuss this with our team hearing that we consider it an honor and privilege to provide repair.

Insurance

Treasure Coast Eye Specialists participates with Medicare and most major medical insurance companies. As a courtesy to you, we will submit all medically necessary services to your insurance company. Because of the complexity and number of plans available in South Florida, we highly recommend that our patients determine what their plan covers. If we do not participate in your network, you will be responsible for a larger portion, or possibly the entire bill.

Although we can estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility and benefits. You will be responsible for any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance company pays you directly, you are responsible for payment.

Co-Pays, Co-Insurance and Deductibles

We expect our patients to present a current insurance card at each visit. All copayments and previous balances are due when you check in for your appointment. We accept cash, check, Visa, MasterCard, Discover, and we also have financing options available. Co-insurance and deductibles will be collected at the time services are rendered.

Referrals and Pre-Authorizations

If your insurance company requires a referral and/ or preauthorization, we will do our best to obtain it for you. You are responsible for making sure that the referral and/or preauthorization is obtained. Failure to obtain it may result in significantly lower payment from the insurance company, and the remaining balance will be your responsibility.

Self-Pay Accounts

Self-pay accounts refer to:

- Patients without insurance coverage
- Patients covered by insurance plans in which Treasure Coast Eye Specialists does not participate
- Patient without an insurance card on file with us.

It is our responsibility to know if our office participates in your plan. We require self pay patients to pay for services rendered at the time of the appointment please let us know if you have questions period we are here to help you!

Non-covered Fees

Even though your plan may cover medical eye exam and services related to your condition, you may still have out of pocket expenses, such as specialized testing or advanced Cadillac technology. We will provide our best recommendation for your care for non-covered services in advance. Payment for non-covered services is due at the time they are provided.

Refraction Fee

As part of your comprehensive eye examination, refraction will be performed. A refraction is a test done to determine the best corrected vision. It is a critical part of the eye exam that allows your provider to determine your current visual status, and whether decreased vision is caused by eye disease (cataract, macular degeneration, etc) or some other problem period after surgery, the refraction helps your provider to determine how your eye is progressing and to assess visual improvement. Unfortunately, Medicare, Medicaid and most commercial insurance plans do not cover the cost of refraction under their medical coverage, so this amount is charged separately and is the responsibility of the patient.

The reservation fee is $50.00 and is due at the time of service. My signature below indicates that I have read and understand and agree to the Financial Policy above.

_____

Patient/Legal Guardian Signature

_____ _____

Patient/Legal Guardian Printed Name **Date**

Assignment of benefits and Lifetime Authorization

I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Treasure Coast Eye Specialists. I request the payment of authorized Medicare benefits be made on my behalf to Treasure Coast Eye Specialists for services provided to me by Treasure Coast Eye Specialists. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agreed to accept the charge determination of the Medicare contractor.

I also request that the payment of any authorized Medigap benefits, or other secondary insurance made on my behalf to Treasure Coast Eye Specialists or any physician of that group, for services provided to me. I authorize any holder of medical information about me to release to my medigap insurer or other commercial payer (where applicable) and any information needed to determine these benefits payable for related services.

I understand I am responsible for any deductible, copay, coinsurance and or any non-covered procedures. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Health Insurance Portability and Accountability Act (HIPAA)

Treasure Coast Eye Specialists is committed to being responsible stewards of our patients protected health information. By signing this form, I acknowledge that I have read and understand Treasure Coast Eye Specialists' notice of policy practices and a copy has been provided to me. I consent to the use or disclosure of my protected health information by Treasure Coast Eye Specialists for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of Treasure Coast Eye. I give permission for Treasure Coast Eye Specialists to discuss and release protected health information with my HIPAA approved contacts, listed below. A copy of this authorization may used in place of the original.

Please list the authorized individuals you get permission to have access to and discuss your protected health information. Changes may be made to the list at any time in person or in a written request.

Name	Phone	Relation to Patient
Name	Phone	Relation to Patient
Name	Phone	Relation to Patient

I hereby authorize the providers of Treasure Coast eye specialist and its employees, agents, and assignees to contact me via e-mail, text messages and to my cellular device.

My signature below indicates that I have read, understand and agree to the information above.

_____

Patient/Legal Guardian Signature

_____ _____

Patient/Legal Guardian Printed Name **Date**

Information Regarding Dilating Drops

Dilating eye drops are used to enlarge the pupils of the eyes to allow your doctor to examine the inside of your eye. Dilating drops may cause blurred vision and make bright lights bothersome. It's not possible to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, we recommend that you arrange for transportation, and not drive yourself home from your appointment.

In rare instances, dilating drops may cause acute angle closure glaucoma. This is treatable with immediate medical attention.

By signing below, I hereby authorize the physicians and/ or assistants as designated by the providers, to administer dilating drops when deemed necessary to examine my eyes.

_____

Patient/Legal Guardian Signature

_____ _____

Patient/Legal Guardian Printed Name Date