KAUFMAN
EYE INSTITUTE

See better. Live better.™

·Intra-Sight Cataract Surgery ·Glaucoma ·Retina ·Macula
Founded 1981

Dear New Patient,

The Doctors and staff of Kaufman and Eye Institute would like to take this opportunity to welcome you to our facility. We look forward to caring for you and your family.

We here at the Kaufman Eye Institute, while offering the most technically advanced procedures, take great pride and pleasure in our work, as well as being dedicated to your eye care needs and convenience.

Enclosed you will find all the paperwork that needs to be completed and brought with you to your appointment with our office.

Please note that we offer a full service optical shop for your convenience.

Please bring the following items with you:

- Your Insurance Card(s)
- Drivers license or state issued picture ID
- If possible, any prior medical records that may be pertinent

We are looking forward to both meeting and treating you!

The Doctors and Staff

☐SUN CITY CENTER
4002 Sun City Ctr. Blvd., Unit 103
Sun City Center, FL 33573
(813) 634-9289
(813) 642-8475 Fax

☐ZEPHYRHILLS
6329 Gall Blvd. (Hwy 301)
Zephyrhills, FL 33542
(813) 788-7616
(813) 783-2856 Fax

☐WESLEY CHAPEL
2145 Cypress Ridge Blvd. Ste 201
Wesley Chapel, FL 33544
(813) 973-1133
(813) 973-1144 Fac

☐BUSHNELL
1814 W. C.R. 48
Bushnell, FL 33513
(352) 568-0600
(352) 568-0633 Fax

855-SEE-BEST
WEBSITE: WWW.KAUFMANEYEINSTITUTE.COM

01/18/2012 jsw

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Office Policies

We welcome you to our practice and thank you for choosing our office for medical care. As a valued patient it is important to us that you become familiar with some of our office policies.

1.) We ask that you check in with the receptionist upon arrival at each appointment.

2.) If you have a deductible that is not met we ask you pay in full at the time of service. We will bill your insurance as a courtesy and issue a refund check if necessary.

3.) If your insurance requires you to pay a co-pay it is due at the time of service. We do not bill for co-pays. If you are unable to make your co-pay at the time of service you may be asked to reschedule.

4.) It is your responsibility to verify insurance coverage for certain procedures.

5.) We require 24 hour notice for all cancelled appointments. When a cancellation occurs without 24 hour notice you may be responsible for that days charges. We will not bill insurance on those occasions.

6.) All accounts are to be paid in full each month.

7.) If you were referred by another physician please let us know. We would like to thank them for sending you to Kaufman Eye Institute. Also, we would be happy to provide a copy of your exam findings to the referring physician.

Enclosed in this package are some of the forms that will need to be filled out completely before you arrive at our office. Please be sure to read and sign all forms and bring them with you to your appointment. Please bring these completed forms along with your insurance card so that we can make a copy for your file.

If you have any questions regarding these policies or other concerns please do not hesitate to call the Kaufman Eye Institute and our staff will be more than happy to help you.

Once again, thank you for choosing the Kaufman Eye Institute and we look forward to seeing you at your appointment.

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WEBSITE: WWW.KAUFMANEYEINSTITUTE.COM

Registration : Stuart J Kaufman MD And Associates PA

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home:	How did you hear of us?
	Work:	
Address 2	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Provider **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Are you a seasonal patient?
If yes, what is your second address?
What months are you away?

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Stuart J Kaufman MD And Associates PA , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Stuart J Kaufman MD And Associates PA	
X		6329 Gall Blvd Zephyrhills, FL 33542	Phone: Email:

Please attach all pertinent insurance ID cards for photocopying.

MEDICAL HISTORY QUESTIONNAIRE

Full Legal Name: _____ Sex: ☐ M ☐ F Date of Birth: _____ Date: _____

If this is your first visit, please complete:

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Internet ☐ Other: _____

Date of last eye exam: _____ Where was this done (doctor/clinic)? _____

Primary Care Doctor: _____

Pharmacy: _____

Are you currently taking: ☐ Flomax ☐ Coumadin ☐ Plavix ☐ Aspirin ☐ Rapaflo
☐ Uroxatral ☐ Minipress ☐ Cardura ☐ Hytrin ☐ Avodart

Current Medications (prescription, over the counter, vitamins, homeopathic):

_____

_____

Allergies to medications: _____

Have you ever had any of the following eye procedures: ☐ LASIK ☐ PRK ☐ RK ☐ AK

List **all current & previous** illnesses, injuries, surgeries:

_____

_____

Please check any of the following conditions that you have **TODAY:**

Constitutional:	☐ fatigue	☐ fever	☐ weight loss	☐ chills	☐ sweats
ENMT:	☐ earache	☐ nasal congestion	☐ nose bleeds	☐ sore throat	☐sinus pain
Cardiovascular:	☐ chest pain	☐ palpitations	☐ leg edema		☐increase heart rate
Respiratory:	☐ wheezing	☐ cough	☐ difficulty breathing		☐COPD
Gastrointestinal:	☐ reflux ☐diarrhea	☐ nausea	☐vomiting	☐indigestion	☐constipation
Genitourinary:	☐ urination	☐ discharge			
Integumentary:	☐ rosacea	☐ rash	☐ change in hair texture		☐ change in nails
Musculoskeletal:	☐ gout	☐ arthritis	☐ joint pain	☐ muscle pain	☐ back pain
Neurological:	☐ slurred speech	☐ memory loss	☐ gait disturbances	☐ loss of coordination	☐ dizziness
Hematologic:	☐ abnormal bleeding		☐ enlarged lymph nodes		☐ swollen glands
Immunologic:	☐ food allergies	☐ seasonal allergies	☐ immune disorder		
Endocrine:	☐ diabetes	☐ hypothyroidism	☐ hypoglycemia		
Psychiatric:	☐ depression	☐ panic disorder	☐ anxiety		

Do any of your blood relatives have the following conditions:

Blindness:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Glaucoma:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Macular Degeneration:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Diabetes:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Retinal Detachment:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent

Social History:

Do you currently drive?	☐ No	☐ Yes	
Do you currently smoke?	☐ No	☐ Yes	If yes, how much?
Have you ever smoked?	☐ No	☐ Yes	When did you quit?
Are you pregnant?	☐ No	☐ Yes	Expected Due Date?
Are you nursing?	☐ No	☐ Yes	
Are you working?	☐ No	☐ Yes	☐ Retired Occupation:
Do you drink?	☐ No	☐ Yes	If yes, how much?

EXTENDED SOCIAL HISTORY

Name: _____ Date:_____

We would like to know how you use your eyes on a daily basis. Along with your eye examination, this information will assist us in recommending the best lens options for your eyes and your personal lifestyle.

In order to better meet your individual visual needs, please check the appropriate activities in which you participate:

	Auto Repair		Movies
	Reading		Football/Basketball
	Golf		Boating/Water sports
	Tennis		Skiing/Snowboarding
	Fishing		Hunting
	Daytime driving		Woodworking/Carpentry
	Nighttime driving		Running/Jogging
	Baseball/Softball		Playing Cards/Dominoes
	Biking		Shooting sports
	Playing a musical instrument		Racquetball
	Sewing/Needlepoint/ Arts/Crafts		Welding
	Skateboard/Scooter		Gardening

Are you? ____Retired ____Homemaker _____ Between jobs ___Student _____ Employed

Occupation_____ Is safety protection a concern?____ Are you outdoors all or part of the time?____
Do you go from indoor to outdoor frequently? Yes/No
Are you interested in or have you worn lenses that darken with sunlight? Yes/No
How much time do you spend on a computer daily? None 0-1 hrs. 1-2 hrs 3-6 hrs. more
I wear: _____ contact lenses _____ glasses _____no vision correction

What are your likes with present glasses:_____
What are your dislikes with present glasses:_____

If you wear glasses or contacts, are you happy with your current glasses or contacts? ___ Yes _____ No

Do you feel your eyeglass lenses are: ____too heavy ____too thick

Do you currently have prescription glasses expressly for any of the following purposes. ____reading ___Sun protection
_____ Computer use _____Playing cards or games _____watching T.V. from bed ____Sports/Safety _____Other

Do you perform tasks above your head regularly? ____
Do you wear Bifocals? _____ Trifocals ? _____Progressive (no line)? ____
What distance do you hold a book for reading?____ 12-14in ____ 14-18in____ +18in.
How far is your computer screen from your eyes____ 14-16in ____17-22in ____ 23-26in
If you wear contacts, do you have :
_____ a current pair of prescription glasses _____ sunglasses (purchases at department/optical store) _____other

Do your eyes seem bothered by glare from any of the following situations;
___ Car headlights ___Haze ___Traffic Lights ___Computer Monitor
___Night Driving ___Sunshine ___Fluorescent Lights ___Other

How would you describe the glare that you encounter daily.
_____Discomfort (causing eye fatigue) ____Disabling (light is scattering on windshields) ____ Blinding (you must close your eyes)

Please tell us how you use your eyes in pursuit of your lifestyle:_____

Thank you for completing this survey & allowing us to serve your visual needs.

Patients Signature:_____ Tech Initials:_____ Dr. Initials_____
5/2014

Optical Recommendations:
Prog - AR - Trans - HiIndex
Computer - Eye Fatigue -
SunProtection
Other:_____
Optician Initials:

Will my eye exam today be covered by my vision insurance or my medical insurance?

The insurance industry's rules with regard to which insurance should be billed for eye services can be confusing. We would like to help you to understand the differences in your vision insurance and medical insurance coverages.

Vision insurance companies offer coverage for a refractive diagnosis only. This includes such problems as nearsightedness, farsightedness and astigmatism. The exam includes a prescription for glasses and an evaluation of the eyes to ensure the eyes are healthy. Vision insurance never covers diagnosis and treatment of eye disease.

Medical insurance companies offer coverage for any medical problems of the eye or for monitoring of systemic problems known to affect the eyes. Some common reasons for a medical eye exam include diseases such as diabetes, glaucoma or suspicion of glaucoma, dry eyes, cataracts, macular degeneration or any condition that causes redness, discomfort or has any potential for vision loss.

It is important that you understand the difference between your vision insurance coverage and your health insurance coverage because we must bill the insurance that is appropriate for the services we provide you today. If you have any questions please ask any member of our team.

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Refraction Coverage

What is a refraction?

A refraction is a test to determine what is your best correctable vision of your eyes.

Why do you need a refraction?

The doctor needs a refraction to determine if the cause of your blurry vision is from a medical issue (cataracts, macular degeneration, dry eyes…) or from a change in your glasses prescription.

Can a refraction be used to prescribe a pair of glasses or contact lens?

Yes. If the doctor determines that a change in glasses would improve your prescription, he will prescribe you a glasses prescription from the refraction.

Is the refraction covered by insurance?

Most insurance companies do not cover the refraction. Expect to pay $59.00 for the test.

Initials _____

10/9/14 JSP

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because.

☐ Individual refused to sign.

☐ Communications barriers prohibited obtaining the acknowledgment.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (please specify) _____

_____

_____

Employee Signature: _____

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CONSENT OF CONFIRMATION AND REFERRAL AWARNESS FORM

I, _____, authorize the physicians and staff of Kaufman Eye Institute to contact me at the numbers provided by me or by a representative of me and to leave messages either on an answering machine or with persons whom answer the phone regarding appointments, insurance, referrals, and financials unless otherwise SPECIFIED by me below**.

I am aware that if I am currently enrolled with an insurance company that requires authorization, or should I in the future enroll with an insurance company that requires referrals, I am aware that referral's, are the patient's responsibility, as provided in my INSURANCE CONTRACT, and not the responsibility of the physicians or staff of Kaufman Eye Institute.

If at any time I choose to change insurance coverage I will notify Kaufman Eye Institute, prior to any upcoming appointments.

Upon signing this form I agree to the above to the above consent and I am aware of the Insurance/Referral patient responsibility.

_____
Patient's Printed Name

_____
Patient's Signature Date

PATIENT'S RIGHT TO LIMITED MEDICAL INFORMATION:
**I DO NOT WANT ANY MESSAGES LEFT ON MY ANSWERING MACHINE OR WITH ANYONE OTHER THAN MYSELF.

_____
Patient's Signature

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☐ ZEPHYRHILLS
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Zephyrhills, FL 33541
(813) 788-7616
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Wesley Chapel, FL 33544
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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.

Original Effective Date: April 14, 2003

A federal regulation, known as the "HIPAA Privacy Rule," requires that we provide detailed notice in writing of our privacy practices. This Notice is long. The HIPAA Privacy Rule requires us to provide you with the information on many things.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information about you and that can be used to identify you. This information is called "protected health information" or "PHI". In addition to the protections under HIPAA, the Florida Law and other Federal laws may provide additional protections of health information about you in some circumstances. This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI under HIPAA and other applicable laws.

We are required by law to:

- Maintain the privacy pf PHI about you;
- Give you this Notice of our legal duties and privacy practices with respect to PHI; and
- Comply with the terms of the Notice of Privacy Practices that is currently in effect.

As permitted by the HIPAA Privacy Rule, we reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location or you may obtain a copy on our website at www.kaufmaneyeinstitute.com. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Official.

You will be asked to sign a form that you received this Notice. Even if you do not sign this form, we will still provide you treatment.

Signature Authorization

Release of Information

1. I hereby authorize Kaufman Eye Institute to release to any 3rd party pay or, such as an insurance company or government agency (I.e.; Medicare) any medical information and records concerning diagnosis and treatment when requested by such 3rd party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

2. I hereby authorize Kaufman Eye Institute to release to any 3rd party pay or any medical information and records needed to obtain pre-authorization and payable benefits for determination of medical necessity and pre-certification.

3. I hereby also authorize any physician examining and/or treating me to release any and all medical information and records concerning diagnosis and treatment to Kaufman Eye Institute.

Understanding of Patient Responsibility

1. I certify that the information given by me on the Patient Information sheet is correct and complete and that I have fully disclosed there all information concerning all insurance coverage, which I now have.

2. I understand that all services rendered will be billed to my insurance company. I understand and agree that if the amount of my insurance benefits is insufficient to cover the amount due, I am responsible for payment of the balance. I also understand that should my insurance determine the service to be non covered, I will be responsible for the entire amount. I also understand that I am responsible for any insurance deductibles and co-payments as determined by my insurance.

3. In the event that it is necessary for the physician to retain the services of any attorney in order to collect any amount due from me, I agree to pay all costs of collections incurred by the physician including reasonable attorney's fees and court costs.

Assignment of Benefits

1. I hereby authorize payment for all medical and surgical benefits to Kaufman Eye Institute for all medical and surgical services rendered to me.

2. I agree that a copy hereof may be used in place of the original, which shall remain on file in the physician's office.

_____ _____

Patient's Name Date

_____

Patient's Signature

Medicare Part B Lifetime Signature Authorization

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 or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim to Medicare for payment for me.

_____ _____

Patient Name Date

_____ Medicare # _____

Patient Signature

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FINANCIAL POLICY

Dr. Kaufman, Associates and Staff would like to welcome you to our practice. We strive to provide you with excellent care, and our goal is to make your visits as convenient as possible.

By Signing below you confirm that you have read this policy and understand it.

- It is your responsibility to inform our office of any address or telephone changes.
- Your account is to be kept current-accordingly, all self-pay or insurance co-payments, co-insurance & deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, and Discover.
- If you do not have your payment(s), your appointment may be rescheduled.
- A returned check will result in a $25.00 service charge and in some cases future payments being required in the form of cash or credit.
- You will only be sent a statement if your balance is $5.00 or more and you will only receive a refund if the credit amount is over $5.00. Refunds will be issued 2-4 weeks from the date requested, if there are no pending insurance claims.
- There is a $25.00 charge for the completion of paperwork i.e. disability, etc.
- Any unpaid balance older than 30 days may be subject to a 1.5% interest fee per month.
- If your account is turned over to a collection agency you will be responsible for any cost incurred in the collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court cost and attorney fees.

IF YOU HAVE MEDICAL / VISION BENEFITS:

We will submit your claims, however, ***we must emphasize that as medical providers, our relationship is with you <u>not</u> your insurance company***. Although we attempt to verify your coverage/benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.

By signing below you confirm that you understand.

- It is your responsibility to inform us of any changes to your medical/vision policy prior to your appointment.
- Not all services are a covered benefit with all policies.
- It is your responsibility to be aware of what service(s) are being provided to you and if it is a covered benefit under your policy.
- You are responsible for any non-covered charges not payable by your plan.
- Although filling your claims is a courtesy extended to you, all charges are your responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

I have read and understand the above financial policy and agree to meet all financial obligations.

_____	_____	_____
Patient Name (Please print)	*Patient Signature*	*Date*
_____	_____	_____
Responsible Party (Please print)	*Responsible Party Signature*	*Date*

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RECORDS RELEASE AUTHORIZATION TO KAUFMAN EYE INSTITUTE

I _____ hereby authorize and request you to release my medical records.

From: Dr._____

Practice Name _____

Address _____

Phone ( )_____ Fax ( )_____

I request that you forward the complete history of records in your possession concerning my illness or treatment to:

KAUFMAN EYE INSTITUE

4002 Sun City Center Blvd Unit 103	**6329 Gall Blvd (301)**	**2145 Cypress Ridge Blvd Ste 201**	**1814 W. C.R. 48**
Sun City Center, FL 33573	**Zephyrhills, FL 33542**	**Wesley Chapel, FL 33544**	**Bushnell, FL 33513**
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813-634-9289	**813-788-7616**	**813-973-1133**	**352-568-0600**

Print Name_____DOB_____
(Patient)

Address_____

City_____ State_____ Zip_____

Signature_____ Date_____

Witness_____ Date_____