Eye Center
of St. Augustine

New Patient Registration Form

Last Name: _____ **First Name:** _____ **MI:** ____

Nickname: _____ **SSN:** _____

Birth Date: _____ **Sex:** ☐ Male ☐ Female **Employer:** _____

Home Address: _____
STREET CITY / STATE / ZIP

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Preferred Phone:** ☐ Home ☐ Work ☐ Cell

E-Mail: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Spouse's Name:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Referring Doctor: _____ **Primary Care Doctor:** _____

How did you hear about Eye Center of St. Augustine?

☐ Referring Doctor
☐ Television / Radio
☐ Mailing
☐ Event / Exhibit
☐ Other: _____
☐ Friend / Family
☐ Internet
☐ Magazine / Newspaper
☐ Insurance

Cultural Background Information

Federal healthcare programs require that we collect and report patient race and ethnicity data in an effort to identify and improve healthcare disparities among various racial / ethnic groups. This information is confidential and will not impact your care at Eye Center of St. Augustine. Your response is voluntary, and you select "Decline to Specify".

Race

☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other
☐ Decline to Specify

Ethnicity

☐ Not Hispanic or Latino
☐ Hispanic or Latino
☐ Decline to Specify

Preferred Language: _____ **Interpreter Needed?** ☐ Yes ☐ No

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Patient Portal

The patient portal is a convenient and secure way to access your health information. If you are not yet enrolled, we will complete your enrollment at the time of your appointment. You will receive instructions to complete registration to participate in the patient portal when enrollment has been completed. Participation is encouraged but not required.

Pharmacy Name: _____ Phone: _____

Location / Address: _____

Do we have permission to obtain a list of your prescriptions directly from your pharmacy? ☐ Yes ☐ No

Is your visit today related to a work-related or auto injury? ☐ Yes ☐ No

If so, what was the date of your injury? _____

Primary Medical Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____

Secondary Medical Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____

Routine Vision Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____ ID# _____

Subscriber Information (if different from patient)

Address: _____ Phone: _____

Guardian / Medical Power of Attorney

Do you have legal representation, or does someone make medical decisions for you? ☐ Yes ☐ No

Name: _____ Phone: _____

Hospice Care

Are you currently under inpatient or outpatient hospice care? ☐ Yes ☐ No

Hospice Care Service: _____ Phone: _____

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Medical History Questionnaire

Name: _____ **Birth Date**: _____

Vision Correction – Do you wear glasses? ☐ No ☐ Yes Do you wear contact lenses? ☐ No ☐ Yes

Reason(s) for Visit – In your own words, please describe the reason for your visit today:

_____

_____

Is this a work-related injury? ☐ No ☐ Yes **Is this related to an auto injury?** ☐ No ☐ Yes

If so, what date did the injury occur? _____

Allergies – Please list all known medication (including intravenous contrast dye and anesthetics) and environmental (including seasonal, food and latex) allergies or indicate ☐ NO KNOWN ALLERGIES.

Allergy	Reaction	Allergy	Reaction

Current Medications – Please list all current prescribed medications (including eye drops and medical cannabis), over-the-counter medications, vitamins and supplements or indicate ☐ **NO MEDICATIONS.**
**If not enough space is provided, please supply on a separate sheet of paper.

Name	Dosage	Frequency	Name	Dosage	Frequency

Past Surgical History – Please list any surgeries you have had: (tonsillectomy, appendectomy, cataract, LASIK, etc.)

Procedure	Year	Doctor	Procedure	Year	Doctor

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Personal and Family Medical History – Please check if you or a family member have / have had any of the following or indicate ☐NO RELEVANT PERSONAL HISTORY ☐NO RELEVANT FAMILY HISTORY.

Condition	Self	Mother	Father	Sister	Brother	Grandmother	Grandfather
Congestive Heart Failure							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Atrial Fibrillation							
COPD							
Asthma							
Emphysema							
Cancer (Type: _____)							
Diabetes							
HIV / AIDS							
Hepatitis							
MRSA							
Thyroid Disease							
Psychiatric Disorder							
Lupus							
Anemia							
Stroke							
Rheumatoid Arthritis							
Sjogren's Disease							
Macular Degeneration							
Glaucoma							
Fever Blisters / Cold Sores							
Other:							
Other:							
Other:							

Females: Are you currently pregnant? ☐No ☐Yes Are you currently breastfeeding? ☐No ☐Yes

Social History

Have you ever smoked? ☐ Current ☐ Former ☐ Never

Do you drink alcohol? ☐ No ☐ less than 1 a day ☐ 1-2 a day ☐ 3 or more a day ☐ 5 or more a day

Occupation: _____ Status: ☐ Full Time ☐ Part Time ☐ Retired / Other

Have you had the pneumonia vaccination? ☐No ☐ Yes Do you have a living will? ☐ No ☐ Yes

Do you have a health care proxy? ☐ No ☐ Yes If yes, please list their name and phone number below:

Name: _____ Phone: _____

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Authorizations

- I hereby authorize and request the medical treatment necessary for the care of the above patient.

- I authorize Eye Center of St. Augustine to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to the referring and family physicians and to my insurance company. If necessary, I allow the fax transmittal of my medical records.

- I acknowledge full financial responsibility for services rendered at Eye Center of St. Augustine. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my charges.

- I further authorize and request that insurance payments be made directly to Eye Center of St. Augustine if they elect such an arrangement.

- I acknowledge my email may be used solely to relay information regarding appointments or other general information.

- Patients, patient representatives, or visitors that elect to record an exam visit hereby acknowledge and accept among other risks, that the recordings may not provide the opportunity for a third party to pose questions to the provider/staff and that certain nonverbal communications may not be captured by the recording.
  Under no circumstances may a patient, patient representative, or visitor take a Recording of another patient, patient representative, or visitor without explicit permission.

- ***** This policy is not applicable to patients, patient representatives, or visitors in (California, Connecticut, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, Nevada, New Hampshire, Pennsylvania, and Washington). In these states, undisclosed recordings, on the part of physicians or patients, are prohibited by law, as everyone being recorded must consent.***

- I certify that the information I have provided is true and accurate, and I understand and agree to all the patient responsibilities previously outlined.

☐ I have read and fully understand the above consent for treatment, for the release of protected health information, for financial responsibility, and for insurance authorization.

_____ _____

Patient / Parent or Guardian Signature Date

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Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

This form **does not** apply to other physicians in connection with your ongoing care, insurance companies in connection with billing, state or federal healthcare agencies, or law enforcement agencies (which are allowed by federal law), and workers compensation agencies. We cannot release **ANY** of your medical information to any person or organization (including family members, spouse, etc) unless you list their names below.

I give permission to Eye Center of St. Augustine to discuss the following medical and billing information about me **(check all that apply):**

- ☐ Scheduling/Appointment Information
- ☐ Medical Information (including symptoms, diagnosis, medications and treatment plan)
- ☐ Laboratory/Test Results
- ☐ **Financial Details/Payment Information**
- ☐ All of the above
- ☐ Other: _____

Eye Center of St. Augustine has my permission to discuss the above information with:

Name	Phone Number	Relationship to Patient

I understand that I may revoke or terminate this permission at any time by submitting a written revocation to Eye Center of St. Augustine.

- ☐ This authorization expires: _____ - unless revoked or terminated **in writing** by you or your patient personal representative.
- ☐ No expiration date
- ☐ I decline permission to discuss medical information

_____

Signature of Patient/Guardian Date Relationship to Patient

_____

Staff Member Date

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Notice of Privacy Practices Acknowledgement Form

I acknowledge that I have received a copy of the Notice of Privacy Practices for Eye Center of St. Augustine. I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operation purposes.

_____ _____
Signature of Patient or personal representative with appropriate legal authority Date

If signed by a Personal Representative:

_____ _____
Name Relationship to Patient

--- OFFICE USE ONLY ---

If the Patient or Personal Representative did not sign above, document when and how the Notice was given to the Patient or Personal Representative and why the signed acknowledgment could not be obtained.

Notice of Privacy Practices given to the individual on _____(date) **by:** _____

- ☐ Face to face meeting
- ☐ Other: _____

Reason Individual or Personal Representative did not sign this form:

- ☐ Patient or Personal Representative chose not to sign
- ☐ Other: _____

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Patients' Rights and Responsibilities

Eye Center of St. Augustine recognizes that a personal relationship between the physician and the patient is essential for the provision of proper medical ophthalmic care. The traditional physician-patient relationship takes on a new dimension when the care is rendered within an organizational structure such as Eye Center of St. Augustine. These guidelines help Eye Center of St. Augustine assure optimal patient care and greater satisfaction for the patient, his or her physician, and our facility. Therefore, Eye Center of St. Augustine is informing you of your rights and responsibilities in seeking care from our physicians at our facilities. Get to know our physicians and more about Eye Center of St. Augustine at: www.eyecenterstaug.com

Your Patient Rights

You have the right to:

- Be treated with respect, consideration, and dignity.
- Be free of all forms of abuse, neglect, or harassment.
- Receive care in a safe setting.
- Be provided with appropriate personal privacy.
- Expect privacy of health information: all disclosures and records to be treated confidentially, and, except when required by law, be given the opportunity to approve or refuse their release.
- Be provided, to the degree known, complete information concerning your diagnosis, evaluation, and treatment, alternative treatments and appropriate preventative measures, risks and benefits of treatment, and your prognosis; in appropriate understandable language. When it is medically inadvisable and/or the patient is unable to understand such information, the information is provided to a person designated by the patient as legally authorized (a patient representative or surrogate). Depending on the designation the patient has made, the patient's representative or surrogate may make all healthcare decisions for the patient during his/her surgery center visit, or may act in a more limited role, for example, as a liaison between the patient and the surgery center to help the patient communicate, understand, remember, and cope with the interactions that take place during the visit, and explain any instructions to the patient that are delivered by the surgery center staff. If a patient is unable to fully communicate directly with the surgery center staff, then the surgery center may give the patient's rights information to the patient's representative or surrogate. If the patient is judged incompetent by a court, the appropriate representative has rights to exercise on behalf of the patient.
- Be given the opportunity to have all your questions answered promptly to your satisfaction in an appropriate, understandable language.
- Be given the opportunity to participate in decisions involving your ophthalmic care, except when participation is contraindicated for medical reasons.
- To voice grievances regarding treatment that is or fails to be furnished with methods of expressing/filing grievances, complaints, and suggestions to the organization including those required by State and federal regulations.

- To have all violations/grievances reported immediately to the practice and/or surgery center manager relating, but not limited to; mistreatment, neglect verbal, mental, sexual, or physical abuse. Substantiated allegations must be reported to State or local authority.
- Be informed as to:
    - These patient rights
    - Expected conduct and responsibilities
    - Services available in the organization
    - Provisions for after-hours and emergency care
    - Fees for services and payment policies
    - The right to refuse participation in experimental research
    - The credentials of your healthcare providers upon request
    - Any facility advanced directives
    - Description and availability of applicable State health
    - Safety laws and State advanced directives brochures/information
- Know by name the physician responsible for coordinating your care.
- Change your healthcare provider if you choose and if other qualified providers are available.
- Receive from your physician full information necessary to give informed consent prior to the start of any operative or invasive procedure. Except in emergencies, such information for informed consent should include, but not be limited to, the specific procedure and/or treatment, medically significant risks involved, the probable duration of incapacitation, the benefits of the treatment in appropriate understandable language.
- Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning the medical alternatives, the patient will receive such information. (i.e. Informed Consent).
- Have all Eye Center of St. Augustine services made available to persons with disabilities.
- Decline treatment after being informed of the possible consequences of such a decision. Your decision will be respected to the extent permissible by law.
- Refuse examination or observation by any person not directly responsible for your care.
- Receive instructions regarding your care after you leave the facility.
- Receive an explanation of your doctor and facility bills.
- Notification of physician's financial interest/ownership.
- A second opinion or referral.

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Your Patient Responsibilities

Your responsibilities are to:

- Inform Eye Center of St. Augustine of your need for interpretation services prior to appointment.
- Arrive as scheduled for appointments and notify Eye Center of St. Augustine in advance of canceled appointments. Provide accurate and complete information, to the best of your ability, about your medical history, medications (including over the counter products and dietary supplements), any allergies or sensitivities to medications and other items, current health concerns, and current eye concerns.
- Ask sufficient questions to ensure understanding of your illness or problem, as well as your provider's recommendations for continuing care.
- Follow the agreed-upon treatment plans prescribed by your doctors and other health professionals working under your doctor's direction, and participate in your care.
- Either carry out treatment and educational recommendations or accept responsibility for the outcome.
- Question any and all instructions you do not understand.
- Communicate with your health care provider if your condition does not follow the expected outcome.
- Provide a responsible adult to remain in the surgery center during surgery, to transport you home from the facility, and remain with you for 24 hours, if required by your provider or indicated on discharge instructions.
- Inform the facility of any medical power of attorney, living will, or other directive that could affect your care.
- Become informed of service costs and the requirements of your medical/vision insurance coverage such as: required referrals, co-payments, deductibles, and your out-of-pocket responsibilities.
- Make payment or arrange for payment of services accepting personal financial responsibility for any charges not covered by your insurance.
- Behave respectfully toward all the health care professionals and staff, as well as other patients and visitors.
- Maintain a healthy lifestyle.

Eye Center of St. Augustine Contact Information for complaints and grievances:

Practice Administrator, Samantha Crunden
Eye Center of St. Augustine
1400 US Highway 1 South, St. Augustine, FL 32084
Phone: (904) 829-2286
Fax: (904) 679-3727

Website to contact the Office of Medicare Beneficiary Ombudsman:
https://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Medicare beneficiaries: The Ombudsman's role is ensure that you receive this information and helps you understand your Medicare options and your Medicare rights and protection.

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Financial Policy

Missed Appointment Policy
Eye Center of St. Augustine is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice it may prevent another patient from being seen. Kindly provide 24-hour notice to cancel an appointment. If prior notice is not given, you may be charged $30 for the missed appointment.

Refraction Fee
A refraction is a test that is used to determine any optical defect present in the eye. A refraction is necessary for a prescription for best corrective lenses, a determination of the progression or diagnosis of certain ocular conditions, and/ or a determination for the basis of your visual complaints. Refractions are not always covered by insurance, and you may be responsible for the $40 fee at the time of service. Refractions are never covered by Medicare.

Administrative Forms Fee
The completion of administrative paperwork requires time, record review, and provider involvement. For this reason, a $25 administrative fee will be charged for the completion of non-clinical forms, including but not limited to:

- FMLA forms
- Disability forms
- Workers' compensation forms
- Any additional administrative documents requiring detailed provider input

This fee must be collected prior to releasing completed forms unless otherwise prohibited by law or insurance requirements.

Routine vs. Medical Coverage
Office visits may be categorized as either "routine" or "medical". A comprehensive "routine" vision exam may contain the same elements as a comprehensive "medical" eye exam. The type of eye exam you have is determined by the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. Routine vision exams typically produce diagnoses such as nearsightedness or astigmatism, while medical eye exams may produce diagnoses such as glaucoma or conjunctivitis.

As an ophthalmology practice, it is customary for all visits to be billed as medical eye exams and submitted to your medical insurance.

If you have a routine vision exam benefit (through your medical plan or a separate vision insurance) and prefer to use that benefit instead, please notify our staff before your appointment begins.

If we are not informed ahead of time, we will proceed with filing the visit as a medical claim.

☐ I have read and understand the policies listed above.

_____ _____
Patient / Parent or Guardian Signature Date

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Contact Lens Examination and Fees

Contact lens exams and fittings are not included in a routine eye exam. They require additional testing, measurements, and professional evaluation to determine the best lens for each patient. The fees below reflect the time, expertise, technology, and customization involved. These services are typically not covered by insurance and are the patient's responsibility.

What Your Contact Lens Fitting Fee Includes:

- Comprehensive contact lens evaluation of lens type best suited for your eyes and lifestyle
- Corneal measurements and ocular surface assessment
- Trial lens fitting and modifications as needed
- Instruction on proper lens insertion, removal, and care (if applicable)
- Follow-up visits during the global period for fit refinement and troubleshooting

CONTACT LENS FITTING – NEW WEARER OR LEVELING UP
(Includes new contact lens wearers, patients transitioning to a more complex lens, or new patients to our practice)

Lens Type	Global Period	Charge
Spherical Soft Lenses	60 days	$100.00
Toric Soft Lenses	60 days	$125.00
Multifocal / Monovision Soft Lenses	60 days	$145.00
Spherical Rigid Gas Permeable Lenses	90 days	$145.00
Bifocal or Toric Rigid Gas Permeable Lenses	90 days	$250.00
Specialty Scleral Lenses	90 days	$500.00

CONTACT LENS RENEWALS – CURRENT WEARERS

Lens Type	Global Period	Charge
Spherical Soft Lenses	60 days	$50.00
Toric Soft Lenses	60 days	$60.00
Multifocal / Monovision Soft Lenses	60 days	$70.00
Spherical Rigid Gas Permeable Lenses	90 days	$125.00
Bifocal or Toric Rigid Gas Permeable Lenses	90 days	$150.00
Specialty Scleral Lenses	90 days	$250.00

Understanding the Global Period
The global period is the timeframe during which all necessary follow-up visits related to lens fitting, adjustments, and troubleshooting are included in your fitting fee. Visits during this period allow for fine-tuning the lens power or design, addressing comfort concerns, and ensuring proper eye health and lens performance. Visits outside of the global period may require an additional fitting fee.

Patient Acknowledgement
I understand that a contact lens fitting is a specialized service separate from my routine eye exam and that these fees are not typically covered by insurance. I acknowledge that the above pricing and global periods have been explained to me, and I agree to proceed with the recommended contact lens fitting.

_____ _____
Patient / Parent or Guardian Signature Date