Collins VISION

PATIENT REGISTRATION FORM

Last Name:_____ First Name:_____ MI:_____

Date of Birth: _____ Social Security #:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non- Hispanic Preferred Language: ☐ English ☐ Spanish ☐ Other

Local Address:_____

City:_____ State:_____ Zip Code:_____

Northern Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____) _____-_____ Employer: _____

Cell Phone: (_____) _____-_____ Occupation: _____

Work Phone: (_____) _____-_____ Email:_____

Emergency Contact:_____ PH:_____ Relationship:_____

Responsible Party: ☐ Self ☐ Other. _____

REFERRING DOCTOR:_____

How did you hear about Collins Vision? ☐ Yellow Pages ☐ Newspaper ☐ ER ☐ Radio _____ / TV_____

☐ Insurance ☐ Website/Internet ☐ Other_____ ☐ Relative/Friend/Patient Name:_____

Primary Insurance:_____ Secondary:_____

I, the undersigned authorize payment of medical benefits to Michael J. Collins, Jr., M.D. FACS and Collins Vision for any services furnished to me. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the release to my insurance company or their agent information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I acknowledge that I am aware of the Notice of Privacy Practices (HIPAA) for Collins Vision. **I understand that a copy of the Notice of Privacy Practices (HIPAA) will be provided and/or given a copy upon request.**

_____ _____

Patient, Parent or Guardian Signature *Date*

Medicare Lifetime Signature on File: (Medicare Patients Only)

I request that payment of authorized Medicare Benefits be made on my behalf to Michael J. Collins, Jr., M.D. FACS and Collins Vision for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____

Patient Signature *Date*

Guarantor Information (Person responsible for payment if different from self):

Name: _____ _____ _____ SSN: _____-____-_____ Birth: ____/____/_____
First MI Last M D YEAR

Address:_____ Relationship to patient:_____

Employer:_____ Phone: (_____) _____-_____

Additional information: ☐ ☐

Are you a year round resident of Florida? YES / NO If no, please check the months that you reside in Florida:

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Second Address: _____ _____ _____ _____
Street Address City State ZIP

OFFICE POLICY REGARDING PAYMENT:

Cancellation/No Show Policy: Cancellations must be made 24 hours in advance of the scheduled appointment or Collins Vision reserves the right to assess a fee to your account.

Insurance is a contract between you and your insurance company. We are not a party to this contract. We bill participating insurance companies as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Medicare: We accept Medicare assignment. Medicare assignment means we will be reducing our fees to the Medicare allowed amounts. Medicare will pay 80% of the allowed amount leaving you with the 20% co-payment to your responsibility. As a courtesy to you we will happily file your supplement to your secondary insurance company should you have one, however if your supplement pays directly to you, you will be responsible for that 20% today plus any non-covered services (example: refractions). Medicare has an annual deductible per calendar year which you are required by Medicare to pay, and your 20% co insurance for any outpatient medical expense as well.

Managed Care Plans (HMO or PPO): Your plan requires you to pay your co-pay at the time of service. HMO plans are required to have an authorization number or referral slip from your primary care physician. If this is not obtained **prior** to your visit, you will be responsible for full payment at the time services are rendered.

Private/Commercial/Group Insurance: You are responsible for payment of services today unless a surgical procedure is performed. This is the only instance in which we file this type of insurance. You will be provided with an itemized receipt to file to your insurance company.

No Insurance: Unless prior arrangements have been made with our office, full payment is due at the time services are rendered. **Refractions are a non-covered service with most insurance companies – Medicare & Medicare HMOs and secondary insurances included. You are responsible for payment of such at the time of service.**

I have read the above office policy completely. I understand and accept this policy. I also understand that I am fully and legally responsible for payment on this account, which includes outstanding balances not covered by Medicare and or other insurance companies. In the event that I fail to pay the outstanding balance, I also agree to pay all billing charges, costs of collection agency fees in the amount of 30%, attorney fees and court costs if any.

PATIENT'S OR AUTHORIZED SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or to the party who accepts this assignment.

FOR MINORS: I give my permission for my child to be treated by Collins Vision.

X_____ Date: _____ _____ _____
Patient/ Parent/ Guardian/Guarantor Signature

_____
Witness

Collins Vision

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Please CHECK one of the following:

☐ I give my permission to the employees of Collins Vision to disclose my protected Health Information to me **AND** the following friends or family:

Name: _____Relation:_____

Name: _____Relation:_____

Name: _____Relation: _____

Name: _____Relation: _____

OR

☐ I request that all my Protected Health Information be disclosed **ONLY** to me and no other friends or family.

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to serve you better Collins Vision would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is the policy of Collins Vision to call you at any phone number you provide to us. When we contact you by calling you at any phone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? ☐ **YES** **or** ☐ **NO**
If no, we will leave a message with just enough information for you to call us back.

I understand that I may revoke or change this authorization at anytime by filling out 'Consent to Disclose Medical Information' forms. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that the information used or disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by Federal and State privacy laws. I understand that I have a right to receive a copy of this authorization if I request one. I also understand that this authorization will not expire.

_____ _____
Signature of Patient or Personal Representitve Date

_____ _____
*Printed name if not signed by Patient *Relationship/Authority to Act on behalf of the Patient

*If not signed by the patient you must provide Collins Vision with a copy of the document of authority that makes you the patient's Personal representive (i.e. Health Care Power of Attorney, Health Care Surrogate, Health Care Proxy, Guardian, etc.)
We also need a copy of your driver's license.

Internal Use Only:

COLLINS VISION
Dr. Michael J. Collins Jr., MD, FACS

INFORMATION ABOUT REFRACTIONS & WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, *but they typically do not cover the eye service called "refraction*".

What is Refraction?

Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

When Does Insurance NOT Pay for a Refraction?

Most health insurance was not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs, and most private policies will not pay for refraction. Almost all insurance payers consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

When DOES Private Insurance Pay for Refraction?

Most health insurance will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, refraction will be performed as part of your eye evaluation. Refraction in this instance is necessary to learn your eye's best vision capability at the time of the examination. **That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated**. **It is a necessary part of the exam for both medical and legal purposes.** In this case, it is possible that the refraction may be covered by your insurance. **However, Medicare will not cover refraction under any circumstances.**

Who Has Made This Distinction for Insurance Coverage?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

What is Our Policy?

At Collins Vision we are dedicated to providing our patients with the very best medical and surgical eye care in the region. Therefore, a refraction will be performed when medically necessary (typically *this includes all new patients*, those presenting with decreased vision, and on a yearly basis thereafter). Additionally, we are happy to perform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.

**The Refraction fee will be collected at the time of your visit, in addition of any co-payments or deductible due for your examination. **

I have read the above information and understand that the refraction is a **non-covered** service. I accept full financial responsibility for the cost of this service. The co-payment and deductible are separate from and not included in the refraction fee.

_____ _____

Patient Signature or Signature of person acting on patient's behalf *Date*

Collins Vision- ***Bringing Your World Into Focus***

Collins VISION
(239) 936-4706

PATIENT QUESTIONNAIRE

The sole purpose of this questionnaire is to assist our physicians and staff in your evaluation, diagnosis, and recommended treatment.

Patient: _____ Date of Birth: _____

Present or past occupation: _____

Have you previously been seen by Doctor: ☐ Collins ☐ Jones ☐ Rosen ☐ Alessi

How did you hear about Collins Vision? _____

Who did you bring with you today? _____

Have any of your family members ever had surgery with Collins Vision? ☐ Yes ☐ No

If yes, what kind of surgery? _____

Do you wear contacts? ☐ Yes ☐ No If yes: ☐ Soft ☐ Toric ☐ RGP Date Last Worn: _____

Do you have prism in your glasses? ☐ Yes ☐ No

Do you experience double vision? ☐ Yes ☐ No

I struggle with the following activities with or without glasses:

☐ Reading fine print
☐ Driving daytime
☐ Watching TV
☐ Reading traffic signs
☐ Playing golf
☐ Driving night/evening
☐ Doing computer work

I currently have problems with:

☐ Glare/Halos
☐ Hazy/Blurry vision
☐ Blurred vision
☐ Seeing in poor/dim lighting

My hobbies include:

☐ Crafts/Sewing/Painting
☐ Piano/Music
☐ Sports
☐ Computer/Tablet
☐ Reading
☐ Shooting/Hunting
☐ Boating/Fishing
☐ Swimming/Water Activities
☐ Golf

Fill in the circle on the scale below that would best describe your personality.

EASY GOING | PERFECTIONIST

COLLINS VISION

MEDICAL HISTORY / REVIEW OF SYSTEMS (Page 1 of 2)

NAME:_____ **D.O.B.**_____**DATE:**_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: ☐None ☐Latex ☐Iodine ☐Penicillin ☐Codeine ☐Sulfa ☐Aspirin ☐Other_____

Who is your primary care physician? Name:_____ Ph:_____
Who is your cardiologist? Name:_____ Ph:_____
Who is your pulmonologist? Name:_____ Ph:_____
Who is your endocrinologist? Name:_____ Ph:_____

REVIEW OF SYMPTOMS: (Please check any that may apply to you or symptoms you have.) **OR** ☐ **I do not have any problems.**

EYE HISTORY DIAGNOSIS
_____Cataracts
_____Glaucoma
_____Macular Degeneration
_____Retinal Disease
_____Amblyopia
_____Corneal Disease
_____Dry Eye Syndrome
_____Other: _____

SYSTEMIC INFECTIONS
____Usual Childhood illness: Measles, Chickenpox, Mumps
____HIV
____Hepatitis
____Herpes Virus
____Meningitis
____Shingles
____TB
____Other: _____

EYE SURGERIES: List all eye surgeries and performing doctor
_____
_____
_____
_____

SYSTEMIC ILLNESSES
____Diabetes
____High Blood Pressure
____High Cholesterol
____History of Stroke
____Cancer
____Heart Disease
____Lung Disease
____Environmental Allergies
____Enlarged Prostate/Increase BPH
____Thyroid Disease
____Other:_____

HEAD / OCULAR TRAUMA: Please list below
_____
_____
_____

GENERAL SURGERIES: Please list below
_____
_____
_____
_____
_____

FAMILY HISTORY:
Diabetes ☐Yes ☐No _____
Macular Degeneration ☐Yes ☐No _____
Glaucoma ☐Yes ☐No _____
Eye disease ☐Yes ☐No _____

SOCIAL HISTORY:
Do you smoke? ☐Yes ☐No How many packs per day? _____
Do you drink alcohol? ☐Yes ☐No How many drinks per day?_____
Do you use other recreational drugs? ☐Yes ☐No _____

_____ _____
Patient Signature / Representative Signature Date

COLLINS VISION

PATIENT MEDICAL HISTORY FORM

NAME:_____**D.OB.**_____**DATE:**_____

PHARMACY:_____**LOCATION:**_____ **PH:**_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Medication Name	**Dose**	**Frequency**