Nicolitz Eye Consultants

7051 Southpoint Parkway South 3rd Floor, Jacksonville, FL 32216 (904) 398-2720

Date:________________________________ Sex: M F

Name Date of Birth	Age	Marital Status S M W Sep Div
Address Apartment No.		
City State Zip	SSN -- --	
Home Phone	Cell Phone	Alternate Phone
Email Address		Can we email you Our Specials? D YES D No
Employer	Employer's Address	
City State Zip	Business Phone Ext	
Spouse Date of Birth	SSN -- --	
Spouse's Employer	Address	
City State Zip	Business Phone Ext	
Emergency Contact	Relationship	Contact Number
Who is responsible for account?	Relationship DOB	SSN -- --
Insurance Company	Policy Number	Group Number
Secondary Insurance	Policy Number	Group Number
Best time to reach you	Date of last physical examination	Doctor's name
Reason for last visit		
Referred by	How did you hear about our practice?	
Hobbies and recreation	Would you be interested in cosmetic Surgery? ◻YES ◻ No Would you be interested in reducing your dependency on glasses or contacts? ◻ YES ◻ No	

PLEASE PROVIDE INSURANCE CARD AND DRIVER'S LICENSE

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Assignment Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________________, and assign directly to Dr. Nicolitz and his associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all 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 insurance submissions.

________________________________	________________	____________
Responsible Party Signature	Relationship	Date

Medicare Authorization

I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Nicolitz and his associates for any services furnished me by that physician. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of any medical information necessary to pay the claim. If secondary health insurance is indicated above or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier aggress to accept the charged determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____	______________
Beneficiary Signature	Date

Nicolitz Eye Consultants

Authorization to Discuss Medical Information

Name:____________________________________ DOB:__________________

In accordance with the Health Information Privacy and Portability Act (HIPPA), clinical information cannot be discussed with spouses, family members or friends without written authorization. I authorize the following person(s) to obtain clinical information on my behalf.

______________________________ __________________________

______________________________ __________________________

______________________________ __________________________

______________________________ __________________________

This authorization may be amended at my discretion with written directive from me.

PHOTOGRAPH AND VIDEO RELEASE FORM

Nicolitz Eye Consultants collects and uses photographs and videos of various procedures and conditions to use in public service endeavors, educational and charitable programs, and teaching program materials. By signing the release below, you are agreeing to allow photographs or videos of yourself, and your medical history connected to the material, to be used by Nicolitz Eye Consultants. If your picture has been taken in reference to a particular medical condition. your name will not be used in connection with the photographs or medical information.

I DO or DO NOT GIVE MY PERMISSION, without restriction, for consideration received, for Nicolitz Eye Consultants to take, reproduce and publish, in all media including electronic formats known or unknown, photographs or videos of me, or to have this done on their behalf. I understand that these photographs or videos may be used, in whole or in part, in informational, educational or commercial publications of any kind (including without limitation, electronic publishing), by Nicolitz Eye Consultants or their affiliated corporations. I understand that although the materials will not contain my name or any other identifying information, I may or may not be identified by the photos.

If selecting "DO" above, I agree that this also grants my permission to use in connection with the photographs or videos, for any purposes whatsoever, all or any portion of any writing, summary, description or synopsis setting forth my medical diagnosis, treatment and results, and also give my permission for my physician to release medical information about my diagnosis, treatment or results in connection with the photographs. I understand my name will not be used in connection with medical information or photographs.

I UNDERSTAND AND AGREE THAT:

1. I will not have any right to inspect the finished work or product or to approve its use.
2. The originals and all copies of the photographs, videos, and negatives and any copyright rights in them will be owned by Nicolitz Eye Consultants, and it will have all rights to use, not use or dispose of the photographs or videos, in any manner whatsoever.
3. I will not retain any rights of privacy or publicity or any other rights I may have in the use of my photographs or videos.
4. The agreements in this Release are binding and cannot be changed by me or someone who has been given my rights.

PLEASE TURN OVER AND SIGN

Nicolitz Eye Consultants

BILLING [POLICY

PLEASE NOTIFY US OF ALL YOUR CURRENT MEDICAL INSURANCE PLANS AT EACH VISIT.

MEDICARE

1. We file and accept Medicare assignment.
2. As a courtesy to our patients we will file your secondary insurance, if not filed by Medicare through Medigap.

HMO PATIENTS

1. Please ensure you have a current referral on file with us
2. A current referral is needed for every visit and to schedule surgery.
3. It is solely the patient's responsibility to secure this referral from the primary care physician.
4. Without a current referral, it will be necessary to reschedule your appointment.

ALL INSURANCE

1. Please check if we participate in your health care plan and present your current insurance card.
2. Co-pay / Coinsurance / and Deductibles are due at the time service is rendered. We accept cash, checks, VISA, MasterCard, Discover and American Express.
3. If your insurance has not paid within 35 days, you are responsible for your bill.
4. Once your insurance has paid, you will be billed for the balance due.
5. Only three (3) requests for payment will be sent, after which your account will automatically be referred to an outside collection firm.
6. PLEASE NOTE: You will be responsible for all late fees and collection costs assessed by the collection firm.
7. There is a $40.00 charge for all returned checks. Paid by CASH or MONEY ORDER ONLY.
8. There is a minimum charge of $20.00 to fill out disability or other forms. There is a 14 BUSINESS DAY MINIMUM turn around time.
9. There will be a reproduction fee of$1.00 per page for the first 25 pages and $0.25 for each additional page, plus postage, PREPAID, for copying all medical records.
10. There is a $40 refraction fee (glasses exam) and $85 Prism refraction fee are not covered by insurance payable at time of refraction exam. Initial if you have received the refraction form____•
11. There will be a $30 NO SHOW fee for any missed pre-surgical testing appoints. This is not paid by your insurance company. This will be your responsibility to pay.
12. There will be a $20 NO SHOW fee for any patient who fails to show for a scheduled appointment without contacting the practice to cancel the appointment within 24 HOURS prior to the scheduled appointment.
13. There will be a $50 surgical fee for all in-office surgeries payable on the day of surgery. This is to cover the cost of the surgical supplies and it is not covered by your insurance.
14. A. $25.00 fee will be charged for any co-payments are not paid at the time of services rendered and $25.00 fee will be charged for any co-insurance or any out of pocket responsibility not paid within 30 days of services rendered.
15. There is a $5.00 fee for each Return to work/out of work letter.
16. Be advised that this is not an inclusive list of patient out of pocket responsibilities

I have read and understood the billing policy, authorization to discuss medical information and photograph and video release form.

ADULTS:
Signature:______________________________ Date:__________

Printed Name:______________________

FOR MINORS:
Signature:______________________________;Date:_________

Printed Name:______________________
Status: Parent:______ Guardian:______

Name of Nicolitz Eye Consultants' Physician, Employee, Author, or Staff Person Who Obtained Paperwork:

Signature:

____

Printed Name:

____

Date:

____

Double vision Yes No Please explain ______________________________

Flashes or floaters Yes No Please explain ______________________________

Crossed eyes Yes No Please explain ______________________________

Other: ______________________________

Have any of these eye problems caused you to decrease or discontinue any of the following:

Driving during the day Yes No Please explain ______________________________

Driving during the night Yes No Please explain ______________________________

Reading Yes No Please explain ______________________________

Hobbies or sports Yes No Please explain ______________________________

Employment Yes No Please explain ______________________________

Other ____________ Yes No Please explain ______________________________

Review of Overall Health

Constitutional
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Chills
- ☐ Malaise
- ☐ Appetite Changes
- ☐ Weight Changes

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Attack
- ☐ Varicose Veins
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Mitral Valve Prolapse

Gastrointestinal
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Indigestion
- ☐ Trouble Swallowing
- ☐ Stool Changes
- ☐ Hemorrhoids

Endocrine
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Cold/Heat Intolerance
- ☐ Goiter
- ☐ Hair Loss
- ☐ Hypoglycemia
- ☐ Thyroid

Ear/Nose/Throat
- ☐ Headache
- ☐ Hearing Loss
- ☐ Earache
- ☐ Head Trauma
- ☐ Ringing in Ears
- ☐ Hay Fever
- ☐ Sinus Pain
- ☐ Stuffiness
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Sore Throat
- ☐ Dentures

Respiratory
- ☐ Cough
- ☐ Audible Wheeze
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ COPD
- ☐ Cough up Blood
- ☐ TB

Genitourinary
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of bladder control
- ☐ Enlarged Prostate
- ☐ Frequent UTIs
- ☐ Benign Prostatic Hyperplasia
- ☐ Kidney Stones

Neurological
- ☐ Dizziness
- ☐ Stroke
- ☐ Neuropathy
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Migraines
- ☐ Alzheimers
- ☐ Paralysis
- ☐ Parkinsons
- ☐ Seizures
- ☐ TIA
- ☐ Tremors

Skin
- ☐ Unusual Rashes
- ☐ Itching
- ☐ Lumps
- ☐ Dryness
- ☐ Melanoma

Psychiatric
- ☐ Panic Attacks
- ☐ Anxiety
- ☐ Depression
- ☐ Manic-Depression
- ☐ Mania
- ☐ Past Suicide Attempts

Musculoskeletal
- ☐ Joint pain/swell
- ☐ Weakness
- ☐ Abnormal Gait
- ☐ Back Pain
- ☐ Stiffness
- ☐ Muscle Aches
- ☐ Leg Cramps
- ☐ Arthritis

Hematologic
- ☐ Easy Bruisability
- ☐ Excessive Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Anemia

OTHER
- ☐ AIDS
- ☐ Hepatitis
- ☐ Herpes Virus

Please sign: ______________________________ **Reviewed by:** ____________________

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Health Questionnaire

Date________________

Name:____**DOB:**___________

Past Medical/Family/Social History

Do you smoke? ☐ Yes ☐ No How many packs a day? _______ How many years? ________

Do you drink alcohol? ☐ Yes ☐ No How much? ☐ Rarely ☐ Occasionally ☐ Daily ☐ In excess

Do you use street drugs? ☐ Yes ☐ No What kinds? ________________________________

Do you drive? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No *(In case any surgical procedures are necessary)*

***Please list all major conditions/illnesses, hospitalizations, and surgeries with their approximate dates*:**

1) ________________________________ Date: ________________

2) ________________________________ Date: ________________

3) ________________________________ Date: ________________

4) ________________________________ Date: ________________

Family History (Check or answer all that apply)

Relation	Living	Age	Deceased	Cause	Cataracts	Glaucoma	Macular Degeneration	Detached Retina	Diabetes
Father									
Mother									
Brothers									
Sisters									
Children									

***Please list medications you are allergic to*:** ____

Medications: *Please list all of the medications that you take regularly, their doses and how often taken*:

1) ________________________ Dose: __________mg How often: ______________

2) ________________________ Dose: __________mg How often: ______________

3) ________________________ Dose: __________mg How often: ______________

4) ________________________ Dose: __________mg How often: ______________

5) ________________________ Dose: __________mg How often: ______________

Review of Eye Health (please circle)

Cataracts	**Yes**	**No**	Glaucoma	**Yes**	**No**
Retina or macula condition	**Yes**	**No**	Dryness	**Yes**	**No**
Excess tearing or discharge	**Yes**	**No**	Redness	**Yes**	**No**
Halos around lights	**Yes**	**No**	Gritty Feeling	**Yes**	**No**
Light sensitivity	**Yes**	**No**	Burning	**Yes**	**No**
Loss of vision	**Yes**	**No**	Itching	**Yes**	**No**
Blurred vision	**Yes**	**No**	Eye pain	**Yes**	**No**

Nicolitz Eye Consultants

Refraction Policy

Upon your visits at Nicolitz Eye Consultants, it may be necessary to perform a refraction test. While Medicare and some major insurance companies do not cover this test, it is necessary to determine your visual acuity.

1. What is Refraction, and why are you charged for it?

   You may know the tests as a determinant for your need of glasses, this is so but it can also detect vision loss. Some of the time vision loss is slow and progressive and the patient may not even notice, that is why a physician will check the patient's vision by performing a refraction. The test can also uncover other problems a patient may be unaware of. This test is integral to determining a patient's eye health.

2. Why is this charge separate from the exam?

   Medicare has deemed that a refraction is not a medical service and therefore not a covered service. Medicare does acknowledge that this is separate to the rest of the eye exam and therefore there is a separate fee for this service. Most insurance companies have followed Medicare's lead and do not cover the refraction, because they consider the test to be "Vision Care" and unrelated to the office visit. However, this is the only way to detect some types of vision loss.

3. Do we have to charge for the refraction?

   Yes, especially for Medicare patients. The Office of the Inspector General has deemed that no charging for a provided service is an "inducement" to the patient and therefore illegal. The Federal Government therefore insists that if an exam, procedure, or test is performed, we must charge for it. They do this because they are worried some physicians may try to lure patients in by offering them an incentive such as a reduced fee, and want it to be a fair playing field for all physicians who accept Medicare. We are obligated by the government to charge for all of our services.

Please be aware that we will call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plans benefits when your healthcare insurance company received and processes the claim.

Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full fmancial responsibility for the cost of the refraction and agree to pay for the refraction at the time of service. Any co-payments due are separate from and not included in the $40 fee for the refraction.

PATIENT'S COPY