EYE CENTERS OF SOUTH FLORIDA

"Excellence in Collaborative Eye Care since 1986"

Welcome to Eye Centers of South Florida!

On behalf of all the doctors and staff, we would like to thank you for selecting us for your eye care needs.

At Eye Centers of South Florida, putting our patients and their vision first is our primary mission.

We strive to provide outstanding and compassionate eye care every step along the way. That is why we are recognized as one of South Florida's top eye care practices since 1986. We want you to see your best!

We have enclosed important registration forms to complete in the comfort of your home to make your office visit more efficient and enjoyable. If you have any questions, please do not hesitate to call or email.

We ask that you please bring the completed forms along with the following items with you to your first appointment:

1. Current Insurance Card(s)
2. Photo ID Card (Drivers License or Passport).
3. List of all Medications or supplements and daily dosage

If convenient, please fax or email the completed forms to our office prior to your visit; please use the efax numbers or email address below.

Please plan to arrive to your appointment 10-15 minutes prior to the scheduled appointment time, so that we may complete the registration process.

Again, we welcome you as a new patient and look forward to caring for your eyes and your vision!

Sincerely,

The Team at Eye Centers of South Florida

Rev. 8/25

EYE CENTERS OF SOUTH FLORIDA
Joseph I. Hoffman, M.D. (Comprehensive / Refractive Cataract Surgery)
Jose Daniel Diaz, M.D. (Retina/Vitreous) • Benjamin J. Reinherz, D.O. (Retina/Vitreous)
Andres G. Sarraga, M.D. (Oculoplastics) • Lana Srur, M.D. (Comprehensive / Refractive Cataract Surgery)
Lanelle S. Williams, O.D. (Clinical Optometry)
1701 N.E. 164th Street • Suite 200 • N. Miami Beach, FL 33162-4018 • 305-947-0027 • Fax 305-945-8734
5333 North Dixie Hwy. • Suite 101 • Fort Lauderdale, FL 33334-3453 • 954-493-5033 • Fax 954-493-5058
E-mail: info@myeyecenters.com -- Internet: www.myeyecenters.com

NEW PATIENT REGISTRATION FORM – PLEASE PRINT CLEARLY

Today's Date: _____

_____
First Name MI Last Name

Email Address
Required: _____

Permanent Address: ❑ Home ❑ Apt. ❑ Other: _____

Street Address_____

_____

City _____ State ____ Zip _____

Name of Area/Building _____

Country _____ County _____

Social Security No._____ - _____ - _____

Birthday _____/_____/_____ Age _____

Home Phone: _____

Mobile Phone: _____

Mobile Carrier: ❑ AT&T ❑ Boost ❑MetroPCS ❑Sprint
❑ T-Mobile ❑ Verizon ❑Virgin Mobile ❑Other_____

Patient Gender: ❑ Male ❑ Female
Marital Status: ❑Married ❑Single ❑Divorced ❑Widow(ed)

Local Address (If other than permanent):

_____

City _____ State ____ Zip _____

Country _____ County _____

EMPLOYMENT / STUDENT INFORMATION:

Employment Status: ❑ Full-Time ❑ Part-Time
❑ Unemployed ❑ Retired ❑ Student ❑ Disabled

Employer _____

Work Address _____

City _____ State ____ Zip _____

Business Phone: _____

Student Status:❑ Not-Student ❑ Full-Time ❑ Part-Time

School: _____

EMERGENCY CONTACT INFORMATION:

_____
First Name MI Last Name

Relationship: _____

Emergency Contact Phone: _____

INSURANCE INFORMATION: ❑ None

Insured's Name: _____

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent

Insured's Social Security No. _____

Primary Insurance Company:

_____

Secondary Insurance Company:

_____

PRIMARY CARE PHYSICIAN: ❑ I Don't have a PCP

Doctor: _____

Phone: _____

REFERRED BY OR CHOSE THIS OFFICE BECAUSE OF:

❑ Dr. _____

❑ Family _____ ❑ Friend _____

❑ Insurance ❑ Internet ❑ Location ❑ Yellow Pages

❑ Other_____

PAYMENT INFORMATION:

Payment for self-pay visits, co-pays and deductible is expected when services are rendered unless other arrangements are made in advance. How will you be paying for today's services?

❑ Cash ❑ Check ❑ MC ❑ Visa ❑ AMEX ❑ DSC

INSURANCE AUTHORIZATION: 1. I hereby authorize the physicians of Eye Centers of South Florida to furnish information to insurance carriers concerning my illness, accident and/or treatments and I hereby irrevocably assign to the above physicians all payments for medical services rendered to myself or to my dependents. 2. I understand that I am financially responsible for all charges whether or not covered by insurance. 3. I also hereby authorize you to obtain copies of my medical records from other physicians if necessary. A photocopy of this authorization shall be considered as effective and valid as the original.

X_____ _____
Patient's Lifetime Signature Date

NEW PATIENT EYE HISTORY RECORD

Today's Date: _____ This Form is Completed By: ___ Myself ___ Other: _____

Who Recommended us or Referred you to our office?

_____

Reason(s) for Today's Visit: ❑ Comprehensive Eye Evaluation

❑ Cataracts ❑ Contacts ❑ Cornea ❑ Glaucoma ❑ Diabetes

❑ Double Vision ❑ Dry Eye ❑ Eyelids ❑ Flashes ❑ Floaters

❑ Infection ❑ LASER ❑ Macular Degeneration ❑ Pain ❑ Red Eye

❑ Retina ❑ Stye(s) ❑ Tearing ❑ Vision Problem ❑ Other:

Do you have Visual Difficulties or Disturbances? ❑ No ❑ Yes:

❑ Driving in Daytime ❑ Driving at Night ❑ Reading Small Print

❑ Computer Work ❑ Watching TV ❑ Night Vision Adaptation

❑ Seeing steps, stairs or curbs ❑ Other: _____

Do you have any Eye Symptoms? ❑ No ❑ Yes:

❑ Burning ❑ Dry ❑ Irritation ❑ Itching ❑ Red ❑ Discomfort

❑ Light Sensitivity ❑ Gritty/Sandy Feeling ❑ Eye Pain or Soreness

❑ Flashes ❑ Floaters ❑ Other: _____

Have you ever had your Eyes Checked? ❑ No ❑ Yes;

❑ Optometrist:_____

City: _____ Phone: _____

Date First Visit: _____ Date Last Visit: _____

❑ Ophthalmologist:_____

City: _____ Phone: _____

Date First Visit:: _____ Date Last Visit: _____

Are you satisfied with your current vision? ❑ Yes ❑ No

Do you Wear Eyeglasses? ❑ No ❑ Yes; How old are they? _____

Are your Eyeglasses for: ❑ Distance ❑ Reading ❑ Computer

Are you pleased with your Eyeglasses? ❑ Yes ❑ No

Do you want a prescription for new glasses today? ❑ Yes ❑ No

Do you wear Contact Lenses? ❑ No ❑ Yes;

Are your Contacts Replaced: ❑ Daily ❑ Bi-Weekly ❑ _____

Are you pleased with your Contact Lenses? ❑ Yes ❑ No;

Where do you get your contacts? _____

Do you use any Eye Medications or Eye Drops? ❑ No ❑ Yes:

List Names, Dosage and Directions (which eye and how often)

_____

_____

Have you had any Eye Problems or Injuries? ❑ No ❑ Yes:

Please List Problems, Date of onset and Eye Doctor seen

_____

_____

Have you ever had any Eye Operations? ❑ No ❑ Yes:

List Operations, Date(s) performed and Eye Surgeon's Name

_____

_____

Have you ever had a diagnosis of Lazy Eye? ❑ No ❑ Yes:

_____

How would you describe your Eye (iris) Color? ❑ Amber ❑ Blue

❑ Brown ❑ Gray ❑ Green ❑ Hazel ❑ Other_____

Is there a Family History of Eye Problems? ❑ No ❑ Yes;

Please Check all applicable and indicate family relationship:

(M = Mother F = Father S = Sibling GP = Grand Parent)

❑ Blindness ❑ Cataracts ❑ Retinal Detachment

❑ Diabetes ❑ Glaucoma ❑ Macular Degeneration

❑ Lazy Eye ❑ Other: _____

How would you describe your Eye Health?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

----------*Do Not Write Below This Line*----------

Please review above for completeness and obtain additional history as needed.

CC:_____

_____

_____

HPI:_____

_____

_____

_____

_____

_____

_____

_____(❑over)

ODS/OA/OT Name: _____MD/OD Sig _____

EYE CENTERS OF SOUTH FLORIDA (rev. 1/9/22) NAME: _____

NEW PATIENT EYE HISTORY RECORD w2hp (D) DOB: _____ CHART#: _____

JIH

NEW PATIENT MEDICAL HISTORY RECORD

Today's Date: _____ Form Completed By: ___Self ___Other: _____

LAST MEDICAL CHECK-UP? ❑ This year ❑ Last year
❑ More than a year ago ❑ Don't remember ❑ Never

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?
❑ Excellent ❑ Good ❑ Fair ❑ Poor

HEIGHT: _____ **WEIGHT:** _____

Primary Physician _____
Specialty _____ Phone _____

Other Physician _____
Specialty _____ Phone _____

PAST MEDICAL HISTORY: Please list any medical conditions you have or had, date of onset or duration and doctor's name:

1. _____
Date: _____ Doctor: _____
2. _____
Date: _____ Doctor: _____
3. _____
Date: _____ Doctor: _____

PAST SURGICAL HISTORY (Not Eye Surgeries): Please list any surgeries or procedures performed, dates and doctor's name:

1. _____
Date: _____ Doctor: _____
2. _____
Date: _____ Doctor: _____
3. _____
Date: _____ Doctor: _____

HAVE YOU HAD THE SHINGLES VACCINE?
❒ **No** ❒ **Yes:** ❒ Zostavax ❒ Shingrix Date _____

OTHER MEDICATIONS: Do you take any medications, vitamins or supplements? ❒ No ❒ Yes; List names, dose and frequency or attach a copy of your medication list if you have one.

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES: ❑ No Known Allergies ❑ Yes; (check below)
❑ Aspirin ❑ Codeine ❑ Ibuprofen ❑ Iodine
❑ IV contrast ❑ Neomycin ❑ Penicillin ❑ Sulfa
❑ Airborne_____ ❑ Contact _____
❑ Food _____ ❑ Other _____

REVIEW OF SYSTEMS: Do you have any problems in the following areas? If Yes, please specify.

Ear, Nose & Throat.	❒.No	❒ Yes_____
Cardiovascular	❒.No	❒ Yes_____
Respiratory	❒ No	❒ Yes_____
Gastro-Intestinal	❒.No	❒ Yes_____
Urinary	❒.No	❒ Yes_____
Skin	❒ No	❒ Yes_____
Muscle	❒ No	❒ Yes_____
Neurological	❒ No	❒ Yes_____
Psychiatric	❒ No	❒ Yes_____
Rheumatologic	❒ No	❒ Yes_____
Hearing loss / aids	❒ No	❒ Yes_____
Disability*	❒ No	❒ Yes_____

SOCIAL / PERSONAL HISTORY:

Primary Language Spoken: English Spanish French Creole Hebrew Russian Italian Portuguese Other_____

Country of Origin: _____

Work History: Employed Unemployed Retired Homemaker

Current or Previous Occupation: _____

School History: No Yes: Full Time Part Time

Marital Status: Single Married Divorced Widowed Separated

Do you drive? ❑ Yes ❑ No _____

Living At: Home Assisted Living Nursing Home Away/College

Living With: Self Spouse Family Parents Roommate Other

Tobacco Use: No Yes: ___ packs/day Quit: _____ yrs ago

Alcohol Use: No Yes: ___ drinks/day Quit: _____ yrs ago

----------Do Not Write Below This Line----------

Please review above for completeness and obtain additional history as needed.

OD _____ MD _____

EYE CENTERS OF SOUTH FLORIDA
FINANCIAL POLICY

Purpose: This document outlines our office's financial policy. We appreciate your understanding and prompt compliance with these policies

Insurance: It is the patient's responsibility to provide current and accurate insurance information. Please present your insurance card at each visit. We will verify and bill your insurance as a courtesy. Co-payments, deductibles, and non-covered services are due at the time of service. If you do not make your co-payment or co-insurance at the time of the visit, you will be charged an additional $15 billing fee.

Forms of Payment: We accept Cash, Checks, Care Credit, and most major credit cards.

Returned Checks: We appreciate prompt payment in full for any outstanding balance. Any check payments that do not clear the bank will be subject to a $35.00 returned check fee.

Vision vs. Medical Insurance: Our office participates with most major medical insurance plans. We provide Medical comprehensive eye exams and Surgical ophthalmologic care to our patients, as opposed to routine vision exams. We do not participate in ANY vision plans.

Referrals and Authorizations: If your insurance requires a referral or authorization, it is your responsibility to obtain it before your visit. If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit before your examination.

Non-Covered Services/Refractions: Some services may not be covered by your insurance. A refractive examination (eyeglass prescription) is NOT a covered service by most insurance companies, including Medicare. There is a $50.00 Refraction fee due at the time of service.

Medical Records Copying: Requests for copies of medical records are subject to a fee set by Florida law 395.3025 ($1/page). An additional fee of $1 for each year of records requested. If records are mailed, there is an additional postal charge. According to HIPAA regulations, healthcare providers have up to 30 days to respond to a request for medical records.

Forms Completion: There is a charge for completing various forms. Pre-payment is required for completing forms, or for extra written communication by the doctor. $10.00 fee to complete the DMV form. There is a $30.00 charge for all other organizations and/or forms.

Prescriptions & Refills: Prescriptions or refill requests are handled during office hours and can take up to 48 hours to process. Prior Authorization to insurance companies for medications is time-consuming for our staff. There is a $30.00 fee if you request our assistance in completing prior authorization forms.

Cancellation/No-show policy: Appointments must be canceled at least 24 hours in advance. Failure to do so may result in a $ 25.00 no-show fee. Patients with three or more no-shows may be dismissed from the practice.

Surgery and Procedures: All unpaid balances must be settled before the date of the surgery or procedure

Collection Fees: In the event your account is sent to collections, you will be responsible for any additional fees incurred from the collections process

By signing below, you acknowledge and agree to the above financial policy.

_____ _____

Patient Name Date

_____

Patient Signature

REFRACTION FEE NOTICE

Dear Patient:

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for a refraction is **$50.00** and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

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 and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

Name: _____

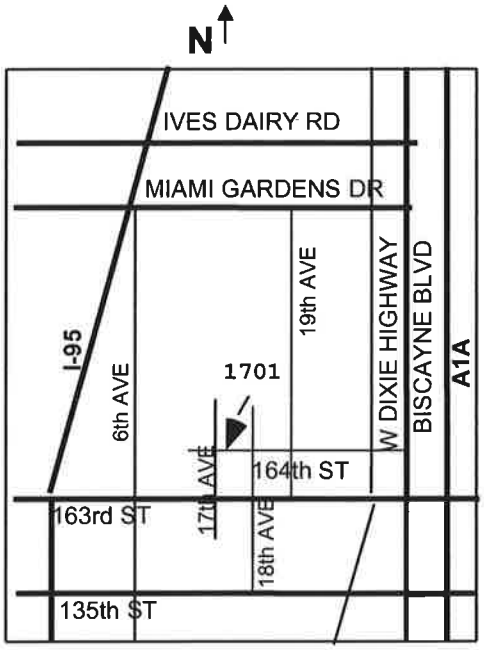
_____ _____

Patient Signature (Parent for Minor) Date

Dan & Hoffman, M.D.'s, P.A.
EYE CENTERS OF SOUTH FLORIDA
www.myeyecenters.com

MAPS and DIRECTIONS

North Miami Beach Office:



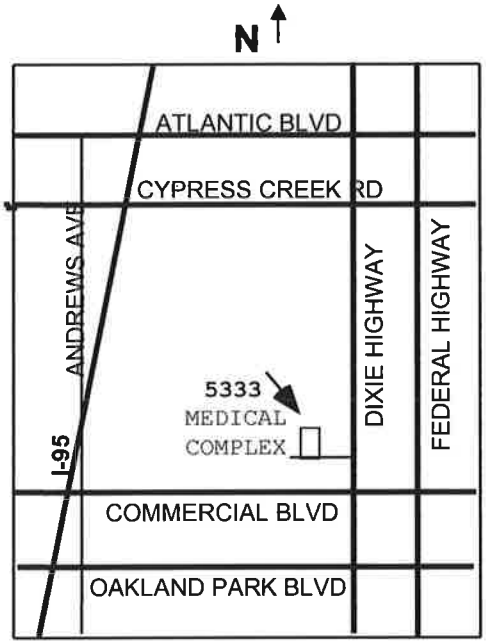
NORTH MIAMI BEACH OFFICE
1701 NE 164th Street
305-947-0027

From I-95 or Turnpike (Points North, South and West)
- Exit at SR 826 East (Beaches) at the Golden Glades Interchange. Go East 2 miles
- Turn LEFT onto NE 17th Ave
- Destination will be on the RIGHT

From Biscayne Blvd. or A1A (Points East)
- Take 163rd St/Sunny Isles Blvd. West
- Turn RIGHT onto NE 17th Ave
- Destination will be on the RIGHT

Parking:
- Self Parking in our private parking lot directly under and behind our building.

Fort Lauderdale Office:



FORT LAUDERDALE OFFICE
5333 N. Dixie Highway
954-493-5033

From I-95 (Points North, South and West)
- Exit I-95 at Commercial Boulevard East-Exit 32
- Go East 1 mile to Dixie Hwy. and turn LEFT
- Go North 2 blocks and turn LEFT at [5333 Medical Complex]

From Federal Highway or A1A (Points East)
- Commercial Boulevard West
- Go West to Dixie Highway and turn RIGHT
- Go North 2 blocks and turn RIGHT at [5333 Medical Complex]

Parking:
- Self Parking in front, sides and back of building.

DAN & HOFFMAN, M.D.'S, P.A. dba EYE CENTERS OF SOUTH FLORIDA
NOTICE OF PRIVACY PRACTICES SUMMARY
Effective April 1, 2003

You have our pledge and commitment to protect your medical information. We understand the medical information about you and your health is very personal. In fact, we are required by law to protect the privacy of your medical information and to provide you with a Notice of Privacy Practices, which describes:

How Medical Information About You May be Used And Disclosed and How you Can Access This Information.

We are required by law to have your written authorization before we use or disclose to others your medical information for purposes other than providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administration activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your authorization.

You also have important rights, which include:

- The Right to inspecting and copy the Protected Health Information (PHI) we maintain about you
- The Right to request restrictions of your Protected Health Information (PHI)
- The Right to request to receive confidential communication from us by alternative means or at an alternative location
- The Right to request an amendment of Protected Health Information (PHI)
- The Right to receive an accounting of certain disclosures we have made of your Protected Health Information (PHI)
- The Right to complain if you feel your rights have been violated

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. Please note we may revise our Notice from time to time and a copy is available by calling our office.

You have the right to receive a copy of our most current Notice in effect or if you have any questions, concerns or complaints about the Notice please contact our Privacy Officer, Penny at 305-947-0047. You will not be penalized for filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Act of 1996 (HIPAA) that I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received a summary of Eye Centers of South Florida Notice of Privacy Practices but know that I can contact their Privacy Officer to obtain a detailed Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree than you are bound to abide by such restrictions.

I authorize my physician to disclose my medical information to the following person or persons: _____

_____

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

JIH