HALLANDALE
EYE CENTER

2500 E. Hallandale Beach Blvd.
Suite N, Hallandale, FL 33009
T: (954) 457-7445 • F: (954) 456-7469
www.HallandaleEyeCenter.com

Patient Information: (Please Print)

Name: First _____ **Last** _____ **Middle** _____

Address: _____ **Suite/Apt** _____

City: _____ **State:** _____ **Zip:** _____

Date of birth: _____ **S.S.** _____ - _____ - _____ **Gender:** _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Phone: (day) _____ **(cell)** _____ **(evening)** _____

Best time to call: _____ **E-Mail Address:** _____

Pharmacy Address & Phone Number: _____

Health Insurance Information: (Please Print)

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: _____

Primary Care Physician/Dr. Name: _____ **Phone#** _____

Health Insurance Company: _____ **ID #:** _____ ☐ **HMO** ☐ **PPO**

Health Insurance Company: _____ **ID #:** _____ **Plan#** _____

Health Insurance Through: ○ **Employer** **OR** ○ **Self. (Please Circle)**

What is the primary policy holder Name? _____ **Relationship** _____

DOB: _____ **SS#:** _____ - _____ - _____ **Gender:** _____

How did you hear about our practice? _____

Employer Name: _____ **Phone#** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

I the undersigned give my authorization to treat and assign directly to Moshe Yalon MD PA, (DBA Hallandale Eye Center) 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 submission. 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 X _____ **Date X** _____

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Medical Information Sheet

Patient First Name: _____ **Last Name:** _____ **Date:** _____

Allergies to Medications: _____

Current Medications: _____

_____

_____

Height: _____ **Weight:** _____

Medical History: (Please Mark All That Apply)

- ☐ Aids
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Eczema
- ☐ Enlarged Prostate
- ☐ Fibromyalgia
- ☐ Headache / Migraine
- ☐ Herpes Simplex
- ☐ Herpes Zoster / Shingles
- ☐ Heart Disease
- ☐ Hepatitis A / B / C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Polymyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other: _____

Past Eye History: (Please Mark All That Apply)

- ☐ Amblyopia (Lazy Eye)
- ☐ Cataracts
- ☐ Diabetic Eye Disease
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma
- ☐ Iritis
- ☐ Keratoconus
- ☐ Macular Degeneration
- ☐ Optic Neuritis
- ☐ Retinal Detachment / Tear
- ☐ Other: _____

Major Surgical History: _____

_____

Eye Surgeries: (Please Mark All That Apply)

- ☐ Blepharoplasty (Eye Lids)
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ Glaucoma Laser (LPI, Shunt, iStent, SLT)
- ☐ Eye Trauma
- ☐ Punctul Plugs
- ☐ Refractive Surgery (Lasik, Lasek, RK, PRK)
- ☐ Retinal Laser Surgery
- ☐ Strabismus Surgery (Crossed Eyes)
- ☐ Retinal Detachment
- ☐ Other: _____

Family History: (Please Mark All That Apply & Write: <u>Father</u>, <u>Mother</u>, <u>Sibling</u> or <u>Children</u> next to checked Disease)

- ☐ Arthritis _____
- ☐ Blindness _____
- ☐ Cancer _____
- ☐ Cataracts _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Lazy Eye _____
- ☐ Macular Degeneration _____
- ☐ Retinal Disease _____
- ☐ Stroke _____
- ☐ Other: _____

Social History:

- ☐ Smoking: ☐ Never Smoked ☐ Current Every day Smoker ☐ Social Smoker (sometimes) ☐ Former Smoker
- ☐ Alcohol: ☐ Yes ☐ No ☐ Social
- ☐ Drug Use: ☐ Yes ☐ No

Important Notice To Our Patients - Dilating Drops

Please be aware that your vision could be temporarily impaired following eye examinations at our office. Eye drops that dilate your pupils may be a necessary part of your exam to assure accurate results and to aid in the diagnosis and treatment of your eye disease. The use of dilating drops as well as other methods of examination and treatments may cause blurred vision, possibly interfering with your ability to drive safely. If your vision is blurred, please feel free to stay in our office until your vision returns to normal. If necessary, my staff can assist you in arranging for alternative transportation. If you have any questions, please ask our staff.

Patient Signature _____ Date: _____

Reviewed By Doctor _____ Date: _____

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Please Read and Sign

Before Your Visit

What is a Refraction and why is it important?

You may have a **REFRACTION** performed during your visit with us today. The refraction gives our physicians very important information about the condition of your eyes. It is critical in assessing the effect of any corneal changes, cataracts, retinal conditions or optic nerve disease found in the course of your exam. It is also the most precise method in which our physicians can determine that your eyes are corrected for the best vision possible.

If you are a new patient at our Center, a baseline refraction will likely be performed today if you are not seeing 20/20 with your present correction. You may or may not be given a prescription for new glasses based on the results of your refraction.

Refractions are not covered by Medicare or Private Insurance Companies. We do not accept vision plans as they only refer to Optometrists. There will be a **$50 charge,** to be paid on the day of the visit for the refraction, even if the patient later decides not to fill the new prescription.

*Medicare guideline states: "Routine eye examinations for the purpose of prescribing, fitting or changing eye glasses contact lens(es); eye refractions are non-covered."

***Medicare** law states: (Social Security Act, 1861(s)(8)), Beneficiaries are covered for post-cataract eyeglasses following cataract surgery with implantation of an IOL. **However, Medicare does not pay for the refraction to prescribe those eyeglasses.**

Please inquire at the front desk if you have any questions.

I have read and I understand the above policy regarding refractions:

_____ _____

Patient Signature Date

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Charges for Missed Appointments

1. **SUMMARY OF CHANGES: CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments.**
2. **The charge for a missed appointment is a charge for a missed business opportunity.**
3. **Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.**

ALL missed appointments or cancelations within 24 hours will incur a charge of $25.00

I have read and I understand the above policy regarding missed and canceled appointment:

Patient Signature _____

Witness Signature _____

Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient Last Name: _____ First Name:_____

Street Address:_____ City:_____ State:_____Zip:_____

Social Security Number:_____ Date of Birth _____

Phone Number:_____

Section B: PLEASE READ THROUGH THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice is posted in the office. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apple to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Moshe Yalon M.D.
Address: 2500 E. Hallandale Beach Blvd. Suite N Hallandale Beach, FL 33009
Phone: 954-457-7445

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, revocation of this Consent is not retroactive. We may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient Signature:_____ Date:_____