EYE CONSULTANTS
STEPHEN E PASCUCCI | MD | FACS

PATIENT DEMOGRAPHICS

Name :_____ _____ _____
FIRST MIDDLE LAST

Date of Birth: _____-_____-_____ **Age:**_____ **Gender:** ☐ **Male** ☐ **Female**
MONTH DAY YEAR

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Alternate Address:_____ _____ _____ _____
STREET CITY STATE ZIP CODE

Phone: ↓

Home (_____) _____-_____ **Cell (_____)** _____-_____ **Work (_____)** _____-_____

Social Security # : _____-_____-_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐ **Widower**

Spouse's Name: _____

Whom should we contact in case of emergency: ↓

Name:_____ **Phone Number( )** _____- _____

Race: ☐ **Hispanic** ☐ **Non-Hispanic**

Email: _____@_____.com

Employer: _____

Occupation:_____

What is the reason for your visit today?_____

Who can we thank for your referral? _____ ☺ **Thank you!**

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Allergies: Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery (eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other_____

Current Eye Medications: (Please list)

_____

_____

_____

Systemic Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke

Other_____

General Surgeries / Operations: (Please list)

_____

_____

_____

Please continue on the back side of this page →

Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other_____

Family History:

□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often?_____

Personal History:

Are you pregnant? □ Yes □ No □ Maybe

Have you had the pneumonia vaccine? □ Yes □ No If yes, approximate date _____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

NOTICE OF EXCLUSION FROM MEDICAL INSURANCE BENEFITS

There are items and services for which insurance **will not pay.**

- Medical health insurance does **not** pay for all of your health care costs. Medical health insurance only pays for covered benefits. **Some items and services are not covered insurance benefits and insurance will not pay for them (see examples below).** Many of these services will enhance the medical care you will receive, though.

- When you receive an item or service that is **not** a covered insurance benefit, **you are responsible** for payment in full at the time of service.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. ***Before you make a decision, you should read this entire notice carefully.*** Ask us to explain, if you don't understand why your insurance won't pay.

Ask us how much these items or services will cost you.

Medical insurance will not pay for:

- Routine annual/complete eye care (no disease or pathology on exam) - **$185 – $260**.
- Refraction (measurement of eyeglass prescription)- **$45.00**
- Premium intraocular lenses and post refractive care, refractive surgery (Lasik, PRK, ASA, CK, etc) **$1500.00- $3250.00 per eye** depending upon procedure.
- Specialized eye imaging test such as wavefront analysis, corneal topography measurements, and retinal OCT 3D imaging in the absence of corneal and or retinal diseases. **$75.00 per test**. **One or more of these tests are often performed during a comprehensive exam to diagnose eye diseases and prior to cataract surgery.**

  **** If you have any questions regarding these tests and why they are being performed please ask the technician to explain this to you.**

Because of the following exclusions* from medical health insurance benefits

- Routine eye care
- Cosmetic surgery
- Refractive surgery

Insurance considers refractive surgery performed to reduce the patient's dependence on eyeglasses or contact lenses to be cosmetic, and therefore excluded from coverage. Additional services associated with such surgery are also excluded.

**This is only a general summary of certain exclusions from insurance benefits. It is not a legal document. The official insurance program provisions are contained in relevant laws, regulations, and rulings.*

Under no circumstances will ECBS submit claims for any elective procedures, such as Lasik, ASA, Lifestyle IOL's, AK, etc. The fees are the patient's responsibility only and up to the patient to submit to their insurance if they deem necessary. This is a policy set by the administration of ECBS and there will be no exceptions.

Beneficiary Agreement

The undersigned acknowledges receipt and review of the above and accepts full financial responsibility for the services not covered by their insurance.

_____ _____

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

EYE CONSULTANTS OF BONITA SPRINGS, PLLC

HIPAA PRIVACY RELEASE

___Patient Reviewed HIPAA Privacy Statement

___Patient Reviewed Privacy Alert

APPOINTMENT INFORMATION:	**MEDICAL INFORMATION:**
Home Phone (Include Auto Call)?	Home Phone (Include Auto Call)?___
Mobile Phone (Include Auto Call)?__	Mobile Phone (Include Auto Call)?___
Mobile Text (Include Auto Call)?___	Mobile Text (Include Auto Call)?___
Work Phone?	Work Phone?___
Send Via Mail?___	Send Via Mail?___
Send Via E-Mail?___	Send Via E-Mail?___
With Another Person?___	With Another Person?___

Person(s) authorized to release medical information. By signing below, you authorize the following person(s) to receive information regarding your treatment of care.

Spouse:_____ Date:_____

Parent:_____ Date:_____

Other:_____ Date:_____

PRINTED NAME:_____

Signature:_____

Date:_____

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

RIGHTS:

- A Patient has the right to respectful care given by competent personnel.
- A Patient has the right, upon request, to be given the name of his attending practitioners, the names of all other practitioners directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.
- A Patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination, treatment, and medical records are considered confidential and shall be handled discreetly.
- A Patient has the right to confidential disclosures and records of his medical care except as otherwise provided by law or third party contractual arrangement.
- A Patient has the right to participate in decisions involving his health care except when such participation is contraindicated for medical reasons.
- A Patient has the right to know what The Eye Consultants of Bonita Springs, PLLC rules and regulations apply to his conduct as a patient.
- A Patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- A Patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
- A Patient has the right to full information, in layman's terms, concerning diagnosis, evaluation, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the person designated by the patient or to a legally authorized person.
- Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure.
- A Patient, or if the patient is unable to give consent, a legally authorized person, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program. The patient or responsible person shall give informed consent prior to participation in the program. The patient or responsible person may refuse to continue in a program to which he has previously given informed consent.
- A Patient has the right to refuse drugs or procedures. A practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.
- A Patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, or disability.
- Eye Consultants of Bonita Springs, PLLC shall provide the patient, or patient designees, upon request, access to the information contained in his medical records, unless the attending practitioner for medical reasons specifically restricts access.
- A Patient has the right to expect good management techniques to be implemented within Eye Consultants of Bonita Springs, PLLC. These techniques shall make effective use of time for the patient and avoid personal discomfort of the patient.
- When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
- A Patient has the right to examine and receive a detailed explanation of his bill.

- A Patient has the right to expect that Eye Consultants of Bonita Springs, PLLC will provide information for continuing health care requirements following discharge and the means for meeting them.

- A Patient has the right to be informed of his rights prior to or at the time of admission.

- A Patient who does not speak English shall have access, where possible, to an interpreter.

- **RESPONSIBILITIES:**

- A Patient is responsible to keep appointments or telephone the office when he/she cannot keep a scheduled appointment.

- A Patient is responsible for bringing information about past illnesses, hospitalizations, medications, and other matters relating to their health with them at the time of their visit. Patients should ask questions immediately if they feel they cannot follow the instruction.

- While practicing at Eye Consultants of Bonita Springs, PLLC, the physician is obligated to exercise good medical judgment in order to help each patient. It is the patient's responsibility to cooperate in the treatment program that the physician specifies.

- Eye Consultants of Bonita Springs, PLLC has a privacy policy, which requires patients to identify those individuals who are authorized to receive reports and test results. No information will be given to anyone who has not been authorized to receive information unless it is necessary for continued or emergency care by another provider.

- A Patient is expected to be considerate of other patients, their family members, and the property of other persons.

- Duly authorized members of a patient's family are expected to be available for review of the patient's treatment in the event that the patient is unable to communicate with the physicians or nurses.

- A patient has a responsibility to provide information necessary for insurance processing of his/her bills, to be prompt about payment of Eye Consultants of Bonita Springs, PLLC, and to ask any questions he/she may have concerning bills.

- A Patient has a right to have advance directives; however, if he/she is having a procedure done in this facility and signs a consent form, we will not honor advance directives during the procedure time.

- Communication between a patient and our team is an important element in good health care. If the patient is concerned about or displeased with any aspect of their care, we ask that he/she first discuss the problem with the nurse or physician. We strongly encourage each patient to complete their patient questionnaire so that we can continually improve our services.

- Florida Department of Health 2295 Victoria Avenue #206, Fort Myers, Fl. 33901. Phone: 239-690-2100

- CMS Website for the Medicare Beneficiary Ombudsman (www.cms.hhs.gov/center/ombudsman.asp)

Stephen E. Pascucci, MD
Scott Prickett, OD
Eye Consultants of Bonita Springs, PLLC

By signing below, I acknowledge that I read the Eye Consultants of Bonita Springs, PLLC Patient Bill of Rights prior to the date of my service.

_____

Print Name

_____

Signature **Date**

5/18/09

PERMISSION TO BILL INSURANCE

I request that payment of authorized benefits be made on my behalf to Eye Consultants of Bonita Springs for any services furnished me by that Physician or Eye Consultants of Bonita Springs. I authorize any holder of medical information about me released to the payer and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the CMS 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In assigned cases, the physician or Eye Consultants of Bonita Springs agrees to accept the charge determination of the payer as the full charge, and the non-covered services. Coinsurance and deductible are based upon the charge determination of the payer.

PATIENT NAME:_____

SIGNATURE:_____

DATE:_____