

Please fill out these forms and either submit them or print and bring to your appointment

Today's date: _____ Full name of patient: _____

If patient is a minor:

Full name of parent or guardian and how related:

Mailing address: Street: _____
City: _____
State/Zip code: _____

Telephone number with area code: _____

Email address: _____ (For use in sending out information and communication. By providing the email address you accept that we may use it for communicating with you and receiving your feedback on Google, etc.)

Patients date of birth: _____ Patient's Age: _____ Gender: __M __F

SSN of patient: ____-____-____ SSN of parent or guardian: ____-____-____

New Patient's Only:

Who may we thank for referring you to our office? _____

If not referred, how did you hear about us? _____

What is the main reason for the eye/vision examination today? _____

Insurance

If you would like us to submit a claim to your medical insurance company, please provide the following information. **Note: if you allow us to make a photocopy of the cards then you do not need to fill-in the information below.**

Medical Insurance Co. _____

Subscriber Name _____

Relationship to Patient _____

Secondary Medical Insurance Co. _____

Subscriber Name _____

Insurance ID# _____ Group# _____

Medicare Part B # _____

Subscriber Name _____

PLEASE NOTE: Video or audio recording is not permitted anywhere in the clinic.

Patient Eye/Vision Information

Do you wear glasses? Y N Age of current glasses _____
 Do you wear contact lenses? Y N Type _____
 Have you had any eye injuries? Y N Describe _____
 Your age at first glasses prescription _____

Place an **X** if you have had any of the following conditions and how long you have had them:

<input type="checkbox"/> High Blood Pressure: _____	<input type="checkbox"/> Cancer: _____
<input type="checkbox"/> Diabetes: _____	<input type="checkbox"/> Emphysema/Asthma: _____
<input type="checkbox"/> Heart Trouble: _____	<input type="checkbox"/> Arthritis: _____
<input type="checkbox"/> Stroke: _____	<input type="checkbox"/> Thyroid Problems: _____
<input type="checkbox"/> Migraine: _____	<input type="checkbox"/> Kidney Disease: _____
<input type="checkbox"/> Cataracts: _____	<input type="checkbox"/> Liver Disease: _____
<input type="checkbox"/> Macular Degeneration: _____	<input type="checkbox"/> Stomach Ulcer: _____
<input type="checkbox"/> Diabetic Retinopathy: _____	<input type="checkbox"/> Other Eye Disease: _____

Any other medical problems not listed above? _____

List any family members who have any of the above diseases: _____

Patient General Health

How would you describe your general health? _____

Who is your primary care physician? _____

What is the city and state location of your primary care physician? _____

Date of last physical? _____

Please list any allergies you have (include medication allergies):

Please list any injuries (excluding eyes) you have had:

Please list any hospitalizations you have had:

Please list any surgeries (excluding eyes) you have had:

Patient Social History

Please indicate with an **X** your current living conditions:

- Lives alone
- Lives with family
- Lives in assisted living facility
- Lives in nursing home
- Lives in retirement center
- Lives with caretaker
- Sleep under a running ceiling Fan

	Yes	No	
Do you drive?	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco Use?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type and frequency: _____
Alcohol Consumption?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type and frequency: _____
Influenza Immunization?	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumococcal Vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	

If you are over the age of 15, please choose the best answer for how you have felt over the past week:

- Are you basically satisfied with your life? ___ Y ___ N
- Have you dropped many of your activities and interests? ___ Y ___ N
- Do you feel that your life is empty? ___ Y ___ N
- Do you often get bored? ___ Y ___ N
- Are you afraid that something bad is going to happen to you? ___ Y ___ N
- Do you feel happy most of the time? ___ Y ___ N
- Do you often feel helpless? ___ Y ___ N
- Do you prefer to stay at home rather than go out and do things? ___ Y ___ N
- Do you feel you have more problems with memory than most? ___ Y ___ N
- Do you think it is wonderful to be alive now? ___ Y ___ N
- Do you feel pretty worthless the way you are now? ___ Y ___ N
- Do you feel full of energy? ___ Y ___ N
- Do you feel that your situation is hopeless? ___ Y ___ N
- Do you think that most people are better off than you are? ___ Y ___ N
- Are you in a good mood most of the time? ___ Y ___ N

**** Signature of patient (or parent/guardian):** _____ **Date:** _____
(You may sign this when you bring it to your appointment)

Report Requests

If you would like a report for yourself or one sent to a third party, please sign below to give us permission to release information about yourself or child to the sources below (valid for 365 days only). This authorization may be revoked by you in writing at any time.

Signature _____ Date: _____
patient or parent/guardian (if patient is a minor)

Would you like copies of any reports for yourself? Yes No
Would you like copies sent anywhere? (If so indicate where below) Yes No

Please indicate who you would like reports to go to (full name and mailing address is required):

Name: _____
Address: _____

Name: _____
Address: _____

(For additional reports, please use the back of this form)

Note: reports may take up to 30 days from the time of request. Please plan accordingly if you need a report.

Financial Policy, Release of Information and Assignment of Benefits

Edward J. Huggett, Jr., O.D., P.A. is a provider for Medicare B and accepts assignment for that insurance plan only.

- 1) It is agreed by the Insured or Responsible Party: "Edward J. Huggett, Jr., O.D., P.A., d.b.a., *NuEyes Low Vision Solutions*, extends the courtesy of filing to your insurance company. However, insurance coverage is a contract between the Insured and the insurance company, the Insured is ultimately responsible for the payment of services whether an authorization was obtained or not. I agree that all co-payments, deductible amounts or non-covered service fees are due to be paid within 30 (thirty) calendar days as invoiced."
- 2) I agree as the Insured/Responsible Party I will be required to pay for services as invoiced.
- 3) I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, interest fees, attorney fees, court costs and agency fees.
- 4) We will collect today \$185.00 (\$85.00 if you are using Medicare B) by credit card, check, or cash. We are happy to submit a claim to your insurance company unless

you direct otherwise. Your payment collected today will be applied toward the refraction, office visit, eye exam and other services or testing if required.

I hereby authorize my insurance company to make payment directly to Edward J. Huggett, Jr., O.D., P.A. for any services rendered to me. I authorize Edward J. Huggett, Jr., O.D., P.A. to release any information required by my insurance company, and their agents needed to determine these benefits for related services. A photocopy of this assignment shall be considered as effective and valid as the original.

A full listing of our fees is posted and available for review as needed.

Signature of responsible party: _____ **Date:** ____/____/____

Effective: January 01, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit Edward J. Huggett, Jr., O.D., P.A. we make a record of the information gathered during your visit. This information is used for several purposes. These uses are set forth below. You have certain rights regarding this information. Your rights regarding this information are set forth below. Finally, we have certain responsibilities regarding our use of your information. Our responsibilities are set forth below.

USES AND DISCLOSURES OF HEALTH INFORMATION

We are permitted by law to use your health information to provide treatment to you. For example, we will provide your physician and our other clinicians involved in your care and treatment with the information in our records to assist the physician in providing proper care to you. We will also provide this information to subsequent health care providers. These individuals may create additional information related to the care and treatment they provide you.

We are permitted by law to use your health information to obtain payment for our services.

For example, we may send your insurance company or other payor a bill that may include your

health information. We are permitted by law to use your health information to perform our regular healthcare operations. For example, we may use your health information to assess the quality of care we provide to maintain our standards.

In addition to these uses and disclosures, we may use your information to contact you to provide appointment reminders to you or to advise you of treatment alternatives available to you. For us to service your account or to collect any amounts you may owe; we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded / artificial voice messages and / or use of an automatic dialing device as applicable.

We are permitted, and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

- o To public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse, and other public health issues.

- o To health oversight agencies, such as governmental auditors, the Florida Department of Health, and other agencies when required;
- o To any individual when ordered by a court or other legal process to do so;
- o To law enforcement officials when necessary for law enforcement purposes and required by law;
- o To a coroner or medical examiner when necessary to enable them to perform their duties;
- o To organ procurement organizations, to enable them to make suitability determinations; in cases of emergency.
- o When otherwise required by law.

We will not use your information for any other purpose without your written authorization.

A written authorization is required, for example, to disclose records to your employer for fitness for duty or other purposes. You have the right to revoke any authorization you provide us.

YOUR INDIVIDUAL RIGHTS

You have certain rights regarding your health information. These rights include:

- o the right to obtain a paper copy of this notice.
- o the right to inspect and copy your health information (copies are available for a reasonable fee);
- o the right to request amendments to your health information you believe to be inaccurate.
- o the right to obtain an accounting of our uses and disclosures of your health information, subject to certain exceptions.
- o the right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request, unless the request related to disclosure to a health plan of information pertaining to items and services for which you have paid in full);
- o the right to request that communications regarding your health information be sent by alternative means or at alternative locations.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your information in accordance with this notice. We are also required to provide you with this notice explaining our legal duties and privacy regarding your health information and to notify you of any breach of unsecured protected health information. We are required to abide by the terms of this notice.

We reserve the right to change the content of this notice and to make new provisions regarding your protected health information. We will provide you a revised notice during your first visit after the revisions are effective.

If you have any questions regarding this notice, have any complaints regarding your rights or our policy or wish to exercise any of your rights as described herein, you may contact Edward Huggett, O.D., 2323 Curlew Rd., Suite 7A, Dunedin, FL 34698.