2595 Tampa Rd., Suite R
Palm Harbor, FL 34684

1701 Rickenbacker Dr., #102
Sun City Center, FL 33573

Lighthouse for the Visually Impaired and Blind
9130 Ridge Road
New Port Richey, FL 34654

P: 727-463-2579 F: 727-934-4409

NuEyes
low vision solutions

Welcome to our office!

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.

Patients date of birth: _____ Patient's Age: _____ Gender (circle): 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 choose our office for your needs?

_____

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, please provide the following information. Note: if we 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_____

Insurance ID#_____ Group#_____

Subscriber Birth Date_____

Do you have a secondary insurance? If so, please complete the following:

Secondary Medical Insurance Co._____

Subscriber Name _____

Insurance ID#_____ Group#_____ 2023/10/06

NOTE: at no time is video or audio recording 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_____

Check if you have had any of the following conditions and mark how long you have had them:

- ☐ **High Blood Pressure: _____**
- ☐ **Diabetes: _____**
- ☐ **Heart Trouble: _____**
- ☐ **Stroke: _____**
- ☐ **Migraine: _____**
- ☐ **Cataracts: _____**
- ☐ **Macular Degeneration: _____**
- ☐ **Diabetic Retinopathy: _____**
- ☐ **Cancer: _____**
- ☐ **Emphysema/Asthma: _____**
- ☐ **Arthritis: _____**
- ☐ **Thyroid Problems: _____**
- ☐ **Kidney Disease: _____**
- ☐ **Liver Disease: _____**
- ☐ **Stomach Ulcer: _____**
- ☐ **Glaucoma: _____**

Any other medical problems not listed above? _____

____

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

_____

Patient General Health

Who is your primary care physician? _____

City and state of your primary care physician? _____

_____

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:

_____

_____

Patient Social History

Please indicate with a checkmark your current living conditions:

☐ **Lives alone** ☐ **Lives in retirement center**

☐ **Lives with family** ☐ **Lives with caretaker**

☐ **Lives in assisted living facility** ☐ **Lives in nursing home**

☐ **Lives in nursing home**

	Yes	No	
Do you drive?	___	___	
Tobacco Use?	___	___	**If yes, type and frequency:** _____

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

How long have you been bothered by each of the below symptoms the past two weeks?

Little interest of "Pleasure in Doing Things:"

☐ **not at all** ☐ **several days** ☐ **more than half the days** ☐ **nearly every day**

Feeling down, depressed, or hopeless:

☐ **not at all** ☐ **several days** ☐ **more than half the days** ☐ **nearly every day**

During the past two weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

☐ **not at all** ☐ **several days** ☐ **more than half the days** ☐ **nearly every day**

Have you fallen in the past twelve months?

☐ **not at all** ☐ **several days** ☐ **more than half the days** ☐ **nearly every day**

Do you have problems with balance or difficulty walking?

☐ **yes** ☐ **no**

Did you have a fall that has resulted in an injury?

☐ **yes** ☐ **no**

During the past four weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, became sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

☐ yes, as much as needed ☐ yes, some ☐ yes, a little ☐ no, not at all

During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

☐ heavy ☐ moderate ☐ lite ☐ very lite

Please answer Yes or No as it pertains to the following questions:

Can you get to places not within walking distance without help?

☐ Yes ☐ No

Can you shop for groceries or clothes without help?

☐ Yes ☐ No

Can you prepare your own meals?

☐ Yes ☐ No

Can you do your own housework without help?

☐ Yes ☐ No

Can you handle your own money without help?

☐ Yes ☐ No

Do you need help eating, bathing, dressing, or getting around your home?

☐ Yes ☐ No

During the past four weeks, how would you rate your health in general?

☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

How have things been going for you during the past four weeks?

☐ very well ☐ pretty good ☐ good ☐ bad ☐ very bad

Are you having difficulties driving your car?

☐ yes, often ☐ sometimes ☐ no ☐ not applicable, I do not drive.

During the past four weeks, how much bodily pain have you generally had?
□ no pain □ mild pain □ moderate pain□ severe pain

How often during the past four weeks have you been bothered by any of the following problems?

Fall or dizzy when standing up?
☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Trouble eating well?
☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Teeth or dentures?
☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Problems using the telephone?
☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Tired or fatigued?
☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Have you been given any information on the following?

National Library Free Talking Book Program?
☐ yes ☐ no, and not interested ☐ no, but I would like to know more

U.S. Treasury Free Currency Reader
☐ yes ☐ no, and not interested ☐ no, but I would like to know more

Disabled Person Parking Permit (even if you don't drive)?
☐ yes ☐ no, and not interested ☐ no, but I would like to know more

Vision Rehabilitation provided in your home by an occupational therapist (OT)?
☐ yes ☐ no, and not interested ☐ no, but I would like to know more

Local support group for visually impaired persons?
☐ yes ☐ no, and not interested ☐ no, but I would like to know more

Reduced or eliminated property taxes for vision impairment?
☐ yes ☐ no, and not interested ☐ no, but I would like to know more

**** Signature of patient (or parent/guardian): _____ Date: _____**
Reviewed by Edward Huggett, Jr., O.D.: _____

Reports

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_____

(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) $195.00 ($95.00 if you are using Medicare B) will be collected today by credit card, check, or cash. We are happy to submit a claim to your insurance company at your request. 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, please ask.

Signature of responsible party: _____

Date: _____/_____/_____

Effective: January 01, 2023

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., 2595 Tampa Road, Suite R, Palm Harbor, FL 34684.