

Vassallo Eye Institute, P.A
John M. Vassallo, M.D.

PATIENT INFORMATION FORM

APPOINTMENT DATE: _____ REASON FOR VISIT: _____

LAST NAME: _____ FIRST NAME _____ : MIDDLE NAME: _____

SOCIAL SECURITY#: _____ DATE OF BIRTH: _____ SEX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELLPHONE: _____ Email address: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

REFERRING PHYSICIAN NAME: _____ PHONE: _____ ADDRESS: _____

IF NOT REFERRED BY A PHYSICIAN, PLEASE CIRCLE AND PROVIDE SOURCE BELOW:

Insurance Company _____ Friend/Relative _____ Advertisement _____ Word of Mouth _____

EMPLOYER INFORMATION:

EMPLOYER (IF RETIRED. PLEASE STATE RETIRED):

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ ID#: _____ GROUP #: _____

POLICY HOLDER: _____ DOB: _____ SS#: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ ID#: _____ GROUP#: _____

POLICY HOLDER: _____ DOB: _____ SS# _____ RELATIONSHIP TO PATIENT: _____

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN AND RELEASE -INFORMATION:

I request that payment of authorized Medicare/insurance benefits be made on my behalf to Vassallo Eye Institute, P.A, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Any service not covered or paid by your insurance plan will be my responsibility.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____ DATE: _____

CONSENT FOR TREATMENT:

I hereby authorize treatment/care from Dr. John M. Vassallo

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____ DATE: _____

Vassallo Eye Institute, P.A
John M. Vassallo, M.D.

PATIENT HISTORY: GENERAL MEDICAL BACKGROUND

NAME: _____ DATE: _____

PLEASE CHECK ALL ANSWERS THAT APPLY:

1. DO YOU HAVE OR HAVE YOU EVER HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Elevated Thyroid Levels | <input type="checkbox"/> Severe low blood pressure | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Low Thyroid Levels | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Arthritis or skeletal problems |
| <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> Retinal Detachment | |
| <input type="checkbox"/> Tumor of _____ | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Psych. Therapy | <input type="checkbox"/> Seizures or meningitis | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple sclerosis | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | |

2. DO ANY BLOOD RELATIVES HAVE:

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Bleeding or clotting disorder | <input type="checkbox"/> Other major medical problems such as those above. |
- Please list: _____

3. MEDICATION ALLERGIES (Please specify if No Known Allergies): _____

4. LIST ALL CURRENT MEDICATIONS AND DOSES (INCLUDE BIRTH CONTROL PILLS AND VITAMINS):

5. DO YOU USE EYE DROPS? YES NO WHAT KIND? _____ HOW OFTEN? _____

6. DO YOU WEAR GLASSES OR CONTACT LENSES? YES NO

7. DO YOU HAVE AN OPTOMETRIST? YES NO

NAME:

8. LIST OPERATIONS: _____

9. SMOKING HISTORY:

____ Never.

____ Quit. When? ____ Smoked about ____ per day for ____ years.

____ Smoke ____ packs per day. Have smoked for ____ years.

____ Used to smoke ____ packs per day.

10. ALCOHOL:

____ No (rarely) alcohol.

____ Yes. How much of what per day?

11. LIST OTHER DRUGS YOU USE:

____ Marijuana

____ Cocaine

____ Other
Please list:

12. ARE YOU CURRENTLY CONTEMPLATING OR INVOLVED IN LITIGATION (LEGAL ACTION) RELATED TO YOUR HEALTH? ____ Yes ____ No

I agree to arbitrate any disagreement, controversy, or claim, which cannot be otherwise resolved to my satisfaction, arising out of or relating to any services provided by Vassallo Eye Institute and to settle any dispute by arbitration in accordance with the rules of the American Arbitration Association, which provides dispute resolution services.

I have read and fully understand this agreement.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____

DATE: _____

WITNESS SIGNATURE: _____

DATE: _____

Acknowledge of Receipt of Privacy Notice for Vassallo Eye Institute, P.A

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

We are required by law to make available to you a copy of our Notice of Privacy Practices. A copy is available for you at the reception window and you may take this copy with you if desired. Please sign below to acknowledge that a copy of our privacy practices was made available to you.

Signature of Patient _____ Date _____

You may authorize certain individuals to be involved in your care. This consent for disclosure includes both health and financial as it relates to your care. Below you may list those individuals for which our office is allowed to release your Protected Health Information.

Individual's Name (Please Print)

Relationship to Patient

Your Signature is needed for Permission

Date

Welcome to Vassallo Eye Institute, P.A!

Our goal is to provide you with quality, state of the art patient care in a cost effective manner. In order to maintain that goal we have established the following policies to improve communication regarding appointments, medical records, and your financial responsibility at the time of service or prior to any scheduled surgery. If you have any questions, please feel free to ask a staff member.

YOUR INSURANCE POLICY:

Copay/Coinsurance and Deductibles: It is the policy of Vassallo Eye Institute to collect all applicable Co-pays, coinsurances and/or deductibles prior to seeing the physician or prior to surgery. In the event you are unable to pay the co-pay, coinsurance and/or deductible, your appointment may be rescheduled. Please be aware that your insurance may require a higher co-payment for a specialist office visit.

Pre-Certification or authorization for a service is not a guarantee of benefits. Benefits are determined when your insurance company receives our claim. If no benefits are due, you will be responsible for any balance pertaining to denied services

Federal Law prohibits our office from writing off any balance due after insurance. Patients that are experiencing financial difficulties should speak to the office manager prior to their office visit.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment and we reserve the right to charge \$40 for missed or late cancelled appointments. This fee is not covered by your insurance company. Excessive abuse of scheduled appointments may result in discharge from the practice. Our office understands that emergencies do arise, but please call our office to discuss this with a staff member.

MEDICAL RECORDS: Upon request we will provide you with copies of your medical records. However, this can be time consuming, so we charge \$1 a page with a minimum of \$5. Your insurance company does not cover this fee.

MEDICAL FORMS: A fee of \$25 is charged for completion of a medical form. A charge of \$40 will apply to forms consisting of more than one page or for narrative reports.

Your Account: You will be mailed a statement on a monthly basis for any balance due. We request that you pay upon receipt of the statement. Should you have any questions concerning your statement, please do not hesitate to contact our office. We will make an attempt to collect any prior balance at your office visit, as well as applicable copayment and deductible. Your account must be current prior to any scheduled appointments. If your account is past due, then future services may be postponed.

Seriously past due accounts - those older than 90 days or those failing to honor agreed upon payment terms - will be sent to a collection agency. Our office will forward your account balance plus any fees charged by the collection agency. Once the collection agency receives your information, your past due debt will be reported on your credit history. Additionally you may be dismissed from our practice and may need to enlist the care of a new health care provider. As a courtesy, we bill our patient's insurance companies, but any remaining insurance balances after 90 days become the patient's responsibility and are subject to collections as well.

PATIENT DISMISSAL: Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice.

I hereby understand and agree to the financial policies of Vassallo Eye Institute, P.A.

Patient Signature: _____ Date: _____

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Information to be Used or Disclosed

The information covered by this authorization includes:

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of person or organization

Address of person or organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to

VASSALLO EYE INSTITUTE

3780 US HWY 1 S.

PH#(904)797-7722

ST. AUGUSTINE, FL 32086

FAX #(904)797-6626

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **THE VASSALLO EYE INSTITUTE, P.A.** You should contact the Privacy/Compliance Officer to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (Print)

Witness (Print)

Signature of Patient

Signature of Witness

Date

Date

Signature of Patient Representative

Relationship to Patient

Date