YOUR EYE SPECIALISTS
POWERED BY AMERICAN VISION GROUP

NEW PATIENT FORMS

Completing your new patient forms in anticipation of your appointment will ensure a timely appointment and seamless process on the day of your visit with our specialists. **Please complete this packet prior to your visit.**

TWO CONVENIENT WAYS TO COMPLETE

PRINT and turn into our front desk staff on the date of your appointment

E-MAIL after completion to info@yeseyespecialists.com

Any questions prior to your visit, feel free to give us a call at 954-452-9922

AVENTURA
2801 NE 213 St, Suite 1006

PEMBROKE PINES
601 N Flamingo Rd, Suite 315

WESTON
2200 N. Commerce Pkwy, Suite 110

PLANTATION
1776 N. Pine Island Rd, Suite 214

JUPITER
550 Heritage Drive, Suite 105

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PATIENT INFORMATION

FIRST NAME | MIDDLE INITIAL | LAST NAME

SOCIAL SECURITY # | DATE OF BIRTH | AGE

☐ MALE ☐ FEMALE
SEX

☐ MARRIED ☐ SINGLE ☐ WIDOWED
MARITAL STATUS

ADDRESS

CITY | STATE | ZIP CODE

OUT OF STATE ADDRESS (IF ANY)

CITY | STATE | ZIP CODE

HOME PHONE # | CELL PHONE #

EMPLOYER | OCCUPATION

WORK PHONE # | EMAIL ADDRESS

EMERGENCY CONTACT | RELATIONSHIP | EMERGENCY CONTACT PHONE #

PHARMACY AND REFERRALS

PHARMACY NAME, LOCATION & PHONE #

PRIMARY CARE PHYSICIAN'S NAME, LOCATION & PHONE #

REFERRING PHYSICIAN'S NAME, LOCATION & PHONE #

IF YOU WERE NOT REFERRED BY A PHYSICIAN, PLEASE TELL US HOW YOU HEARD ABOUT OUR OFFICE

PRIMARY INSURANCE

POLICY HOLDER/SUBSCRIBER | DATE OF BIRTH | SOCIAL SECURITY # | POLICY/GROUP #

SECONDARY INSURANCE

POLICY HOLDER/SUBSCRIBER | DATE OF BIRTH | SOCIAL SECURITY # | POLICY/GROUP #

I am the above patient and attest this information is correct to the best of my knowledge.

SIGNATURE | DATE

REASON FOR VISIT?

PAST MEDICAL HISTORY (SELECT ALL THAT APPLY)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes HgA1c= ____________
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Other ____________
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None

PAST SURGICAL HISTORY (SELECT ALL THAT APPLY)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Masectomy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Lumpectomy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Breast Biopsy (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement - Knee (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Joint Replacement - Hip (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Other ____________
- ☐ Joint Kidney Replacement Within Last 2 Years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (☐ Right, ☐ Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (☐ Right, ☐ Left, ☐ Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

OCULAR HISTORY (SELECT ALL THAT APPLY)

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract
- ☐ Contact Lenses
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy, Background
- ☐ Diabetic Retinopathy, Proliferative
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Macular ERM
- ☐ Narrow Angles
- ☐ Ocular Hypertension
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Tear
- ☐ Strabismus
- ☐ PVD OD
- ☐ PVD OS
- ☐ Vitreous Floaters
- ☐ None
- ☐ Other ____________________

OCULAR SURGERY (SELECT ALL THAT APPLY)

- ☐ Blepharoplasty
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ DSAEK
- ☐ Eye Muscle Surgery
- ☐ Intravitreal Injections
- ☐ LASIK
- ☐ LPI
- ☐ LTP
- ☐ PRK
- ☐ Ptosis Repair
- ☐ Punctal Plugs
- ☐ Strabismus Surgery
- ☐ Retinal Laser
- ☐ Trabeculectomy
- ☐ Tube Shunt
- ☐ Yag Capsulotomy
- ☐ Other ____________________
- ☐ None

MEDICATIONS

Please list all medications that you are currently taking including supplements:

DRUG	DOSAGE	FREQUENCY	DRUG	DOSAGE	FREQUENCY
DRUG	DOSAGE	FREQUENCY	DRUG	DOSAGE	FREQUENCY
DRUG	DOSAGE	FREQUENCY	DRUG	DOSAGE	FREQUENCY

ALLERGIES

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

ALLERGY	REACTION	SEVERITY
ALLERGY	REACTION	SEVERITY
ALLERGY	REACTION	SEVERITY

SOCIAL HISTORY

SMOKING STATUS

- ☐ Never
- ☐ Former Smoker
- ☐ Light Tobacco Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Current Some Day Smoker
- ☐ Current Everyday Smoker
- ☐ Cigar Smoker
- ☐ Chewing Tobacco User

ALCOHOL CONSUMPTION

- ☐ None
- ☐ Less Than 1 Drink Per Day
- ☐ 1-2 Drinks Per Day
- ☐ 3+ Drinks Per Day
- ☐ Other ______________________

OTHER DETAILS

- ☐ Not Sexually Active
- ☐ Sexually Active With One Partner
- ☐ Sexually Active With Multiple Partners
- ☐ Drug Use
- ☐ IV Drug Use
- ☐ Patient Feels Safe at Home

DRIVING STATUS

- ☐ Drives in the Daytime
- ☐ Drives at Night

FAMILY HISTORY (SELECT ALL THAT APPLY)

- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ CVA
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Other ______________________
- ☐ Heart Disease
- ☐ Macular Degeneration
- ☐ Migraine
- ☐ Retinal Detachment
- ☐ Strabismus
- ☐ None

YOUR EYE SPECIALISTS
POWERED BY AMERICAN VISION GROUP

FINANCIAL POLICY

Your Eye Specialists is dedicated to providing patients with high quality eye health care. Our financial policy describes the mandatory procedures regarding payment for our services. Please read and agree to this financial policy by signing below prior to any treatment. If you are unable to abide by this policy, your appointment may be rescheduled or canceled.

You, the patient, are responsible for ensuring that we have your most current insurance information. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.

PATIENTS WITH PARTICIPATING HEALTH INSURANCE PLANS:

- If you provide us with your complete and accurate health insurance information, we will file your insurance claim as a courtesy to you.
- Co-pays, cost-shares, deductibles, and patients balances are due at the time of appointment check-in. We accept cash, check, or credit card.
- A $35 fee will be charged for checks returned by the bank for insufficient funds.
- We may require that you contact your insurance company when payment is not made within a reasonable period; you are ultimately responsible for fulfilling payment for care.
- If full payment from your insurance company is not received within 45 days, we will hold you responsible for the remaining balance.
- You will be fully responsible for payment of any services not covered by your insurance.
- We will fully refund any overpayment to you.
- If an authorization/referral is required by your insurance at the time of service, please provide this to us upon check-in. If you are unable to provide this, we will ask you to reschedule your appointment or pay in full for your visit at the time of service.

PATIENTS WITHOUT PARTICIPATING HEALTH INSURANCE PLANS (OR PATIENTS WITHOUT HEALTH INSURANCE):

- Payment in full is due on the day of service for office visits and in-office procedures.
- Payment in full is due on the day before surgery for non-emergency cases.

MISSED APPOINTMENTS:

- Please notify us at least 24 hours in advance if you need to miss your appointment.

If you have any questions regarding our financial policy, please contact us at (954)452-9922.

I have read and understood the above financial policy of Your Eye Specialists, and agree to abide by all aspects of this policy.

SIGNATURE ______________________ DATE ______________________

PATIENT NAME ______________________

NOTICE OF PRIVACY PRACTICES

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. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information
Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes, payment, billing, and insurance information.

How we use your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health care operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to access the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries or events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subjects to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donations agencies.
Serious threat to health or safety: We may use and disclose information if necessary to prevent a serious threat to your health and safety or the health and safety of public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries of illness.

In any other situation, we will ask for your written authorization before using of disclosing any identifiable health information about you. If you choose to sign and authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Requesting Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send written complaint to the U.S Department of health and Human Services. The person listed below will provide you with appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
Privacy Officer
1776 N Pine Island Road Suite 214
Plantation, FL 33322
954-452-9922
Effective Date: July 1, 2012

I ______________________________ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

SIGNATURE ______________________ DATE ______________________

PATIENT/PHYSICIAN AGREEMENT

Your Eye Specialists is dedicated to providing patients with high quality eye health care. Please read the following paragraphs, and confirm that you have read, understood, and agree to our practice policies set forth below by initialing next to them.

PATIENT PRIVACY:

I have read the Notice of Privacy Practices set forth by Your Eye Specialists, and I understand and agree to the policies described in that document.

____
PATIENT INITIALS

FINANCIAL POLICY:

I have read the Financial Policy set forth by Your Eye Specialists and I understand and agree to the policies described in that document.

____
PATIENT INITIALS

FORM COMPLETION POLICY AND CHARGES:

There will be a fee for the completion of forms at the rate of $25 per completed page (up to a maximum of $50). Forms incurring this fee include: FMLA (Family and Medical Leave Act), disability forms, back-to-work forms, and miscellaneous forms. The completed forms will be returned to the patient upon receipt of appropriate payment.

____
PATIENT INITIALS

FAILURE TO FOLLOW PHYSICIAN ORDERS:

You, the patient, are expected to comply with a physician's orders to manage medical disease and/or symptoms. In the event that the patient does not follow physician's orders, the physician shall be released from any injury or illness claim resulting from the patient's failure to follow orders, and the patient may be discharged from the clinic. Not following physician orders includes, but is not limited to, missing follow-up appointments, as well as missing or postponing or refusing additional tests which may rule out/confirm/discover illness. I have read this policy from Your Eye Specialists regarding following physician orders, and I understand and agree to comply with these policies

____
PATIENT INITIALS

If you have any questions regarding this agreement, please contact us at (954)452-9922.

I have read and understood the above patient/physician agreement from Your Eye Specialists and agree to abide by all aspects of this agreement.

______________________	______________________
SIGNATURE	DATE
______________________	______________________
PATIENT NAME	DATE OF BIRTH

HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER/FRIEND

I, ______________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

NAME ______________________ RELATIONSHIP ______________________

CONTACT INFORMATION ______________________

Health Information to be disclosed upon the request of the person named above (Check either A or B)

- ☐ **A. Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)
- ☐ **B. Disclose** my health record, as above, BUT do not disclose the following (check as appropriate):
  - ☐ **Mental Health Records**
  - ☐ **Communicable Diseases (Including HIV and AIDS)**
  - ☐ **Alcohol/Drug Abuse Treatment**
  - ☐ **Other (Please Specify):** ______________________

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check One):

- ☐ All past, present, and future periods
- ☐ OR Date or Event: ______________ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

NAME OF THE INDIVIDUAL GIVING THIS AUTHORIZATION ______________________ DATE OF BIRTH ______________________

SIGNATURE OF THE INDIVIDUAL GIVING THIS AUTHORIZATION ______________________ DATE ______________________

NO SHOW POLICY

Effective January 1st, 2016 we will be implementing a no-show policy service fee of $25.00. If you must cancel your appointment, we request that you provide us at least 24-hour notice. This will enable us to provide services to other patients with eyecare needs.

Patients who do not show up for their appointment will be considered a no show. The no show fees are the sole responsibility of the patients and must be paid in full before the patients next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice believes that good physician/patient relationship is based on understanding and good communication. Questions about our policy and fees should be directed to the billing department at 954-452-9922.

Thank you for your cooperation and understanding.

Please sign that you have read, understand, and agree to this no-show policy.

SIGNATURE ______________________ DATE ______________________

REFRACTION POLICY

Refraction is a very important part of your eye exam. If you are experiencing blurred vision or a decrease in visual acuity on the eye chart, refractions are performed for the following reasons:

- **Diagnostic Test:** to determine the best possible visual acuity and function of your eyes and diagnose if there are any medical problems with your eyes.
- **Prescription for Glasses:** to determine whether you can be helped in any way by a new glasses prescription either before or after any eye surgery.

Note: Medicare and most medical insurance plans DO NOT cover it. If you have a separate vision plan that covers refraction, please let us know.

I ______________________________ acknowledge there is a $50 fee for the refraction test.
PRINT NAME

______________________________ ______________________________
SIGNATURE DATE