Welcome To Our Office

"Homosassa Eye Clinic is dedicated to providing our patients with state-of-the-art eye care of uncompromising quality, with personalized attention to each patient's needs."

Last Name:_____ First Name: _____MI: _____ DOB: _____ Sex: M / F

Spouse/ Legal Guardian: _____Relation: _____ Race:_____ Primary Language: _____Birth State: _____

Emergency Contact Person:_____ Phone Number: _____

Primary Address: _____ City: _____ State: _____ Zip: _____

Secondary Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ **Cell:** _____ Work: _____

Email: _____ **We will be contacting you through your cell phone and email for appointment reminders and also through email for your patient portal. This patient portal is optional. If you would like to opt out of this portal please initial. OPT OUT OF PORTAL** _____

Occupation: _____Who referred you to our office: _____

How will you be paying today? _____ Check _____ Cash _____ Credit Card _____Care Credit _____ Insurance

Please list any insurance you have and provide the front desk with your insurance cards.....

Primary Insurance: _____ **Secondary Insurance:** _____

Do you currently wear glasses? _____ Do you have sunglasses with 100% UV Protection? _____

Do you wear contact lenses? _____ If no, would you be interested in contact lenses? _____

Do you have any hobbies? _____

*** I am responsible for payment of services on this account.**

Signature: _____ **Date:** _____

Medical History

Who's your Primary Care Physician? _____

Please list any previous history of eye treatment and date of last eye exam? _____

_____

What problems are you having with your eyes? _____

Please list all prescription & non-prescription medications: _____

_____

Please list any medication allergies: _____

No Known Drug Allergies _____ Latex Sensitivity _____yes _____no

Review Of Systems

What is your height? _____ and your weight? _____

Patient Name: _____ **DOB:** _____

Do you have any of these conditions now? If yes, circle condition and explain:

Skin: Psoriasis/ Rash/ Shingles _____

Head: Headache/ Migraines/ Temporal Arteritis _____

Eyes: Cataract/ Glaucoma/ Retina _____

Ears: Hearing Loss/ Aids _____

Nose/ Mouth/ Throat: Dentures/ Sinus _____

Neck: Restrictions of Movement/ Difficulty Swallowing _____

Pulmonary: Cough/ Shortness of Breath/ Wheeze _____

CV: Chest Pain/ Palpitations _____

GI: Ulcers/ Pain _____

MS: Leg Cramps/ Swelling _____

Neuro: Tremor/ Speech Problems _____

Psych: Anxiety/ Depression/ Insomnia/ Panic Attachs _____

Family History

Please list any family history of eye disease or eye surgery: _____

Is there any family history of Diabetes, TB, Heart Disease or High Blood Pressure? Which Family Member?

_____

Social History: Do You Smoke? _____ If so, how much per day_____ Are you a former smoker? _____

Do you drink alcohol _____How much per day _____ Do you have any recreational drug use? _____

Past Medical History: Please check YES or NO for each of the following.

Y	N		Y	N		Y	N	
		Rheumatic Fever			**Heart Attack**			**Arthritis**
		Pneumonia			**Congestive Heart Failure**			**Phlebitis**
		Tuberculosis			**Stroke**			**Anemia**
		Asthma			**Claustrophobia**			**Bleeding Problems**
		Emphysema			**Thyroid Disorder**			**Blood Disease**
		Bronchitis			**Diabetes**			**Radiation/ Chemo**
		Carotid Artery Disease			**Liver Disease /Hepatitis**			**Memory Loss**
		High Blood Pressure			**Kidney Disease**			**Alzheimer's**
		Heart Disease			**Hiatal Hernia**			**Psychiatric Disorder**
		Angina			**Ulcer**			**Seizures**
		Irregular Heartbeat/ Pacer			**Diverticulosis**			**MRSA**

Please list and date any surgeries and hospitalizations: _____

_____

Patient Financial Responsibility

Eye Exam: Our office provides a full scope of eye care services, to include routine vision exams and medical eye care. Payments for all services rendered by this office are the responsibility of the patient. If we are providers for your insurance we will bill this for you, but any unpaid amounts will be your responsibility. The reason for your visit and the doctor's findings will tell us if your exam will be medical, or routine. If it is medical, we will bill your medical insurance. If it is routine, it will be out of pocket.

We are contracted (in network) with traditional Medicare and Blue Cross & Blue Shield. If you have a PPO Medicare Advantage Plan we will bill your medical eye care only as an out of network provider. Just keep in mind your out of pocket is generally higher if you go out of network. At this time, we do not take any routine eye insurance. Upon request, we will provide you with a copy of your bill if you would like to submit it to your vision insurance.

Materials: We do require a 50% deposit on all materials purchased: the balance being due upon delivery of your order. Due to the custom nature of the order, any cancellations are necessary as soon as possible. Once the manufacturing starts on your lenses no refunds will be given, however, frame costs are refundable.

Authorization Of Benefits Statement: I authorize Medicare benefits be made on my behalf to Newcomer Eyecare 1, P.A. for any services furnished to me by this provider. I also authorize release of my medical information to the Health Care Financing Admin and its agents to determine benefits and payments.

Forms of Payment: We accept Master Card, Visa, Discover and American Express, personal checks (with copy of drivers license), Care Credit with a $200.00 minimum balance and cash.

If I am a contact lens patient I acknowledge: I will receive an updated contact lens prescription upon check out.

If you have any questions please do not hesitate to ask at the front desk.

I have read and understand my financial responsibilities:

_____ _____

Signature **Date**

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: April 14, 2003

Homosassa Eye Clinic
4564 S. Suncoast Blvd.
Homosassa, FL 34446
Phone: 352-628-3029 Fax: 352-628-6377
hec@drsnewcomer.com www.drsnewcomer.com

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

At Homosassa Eye Clinic, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of our file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company or even give your insurance company personal information in order to acquire an authorization for services.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may use or disclose your health information when calling in prescriptions to a pharmacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person answering your telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we are not to use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to see your health information, or even transfer copies to another practice, by providing a written request regarding the information you want to see, or that has been sent, and we will mail or fax it to you.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

If you have a question or complaint in regards to our privacy practices, please contact Homosassa Eye Clinic at 352-628-3029.

ACKNOWLEDGEMENT:

I have received a copy of the Homosassa Eye Clinic's Notice of Privacy Practices. Date: _____

Signed: _____ Print Name: _____

If signing as a parent or guardian, please note the name of the patient: _____

Optomap

***This is an OPTIONAL digital retinal scan which assists the doctor with early detection of sight threatening diseases such as: glaucoma, macular degeneration, diabetic retinal changes, retinal detachment, retinal holes, and ocular melanoma.**

_____ Yes, I want the Optomap done during my exam today, which is recommended **yearly** by the doctor. **This is a $35.00 charge which is NOT covered by insurance.** I understand that the Optomap does not exclude me from dilation during my exam, and that these images will be available for instant review with me today.

_____ No, I do not want the Optomap digital images, and I understand this is against the recommendation of my doctor. I understand the Optomap digital technology is my doctor's preferred method of reviewing the health of my peripheral retina.

Patient Signature _____ Date _____