27356 Cashford Circle
Wesley Chapel, FL 33544
Phone: (813) 994-7000
Fax: (813) 994-3781
md@newtampaeyes.com

NEW TAMPA EYE INSTITUTE

Gretta Fridman, M.D.
Laurie B. Small, M.D.
Scott M. Friedman, M.D.
David W. Richards, M.D.

Patient's Name		Nickname	Referring Physician
Address		City/State/Zip	
Preferred Phone No. ( )	Alternate Phone No. ( )	Email	How did you hear about us?
Sex (circle one) Male Female	Birth Date	Age	SS#	Marital Status (circle one) Single Married Widowed Divorced
Patient's Employer		Occupation	
Employer's Address		City/State/Zip	Phone No. ( )
Spouse's Name	Spouse's Phone No. ( )	Spouse's Employer	
Language preferred (optional)	Race (optional)		Ethnicity (optional)
Notify in case of emergency	Address (street, city, state)		Phone No. ( )
Primary Care Physician	Name/Address		Phone No. ( )
Name of Insurance Company	Name of insured		Is pre-approval required? (circle one) Yes No
Name of Insurance Company (secondary)	Date of Birth	S.S. # (of insured)	Patient's relationship to insured

We are not credentialed with any form of Medicaid. If you have Medicaid as your primary or secondary insurance please know that due to strict patient privacy acts in place we are not set up or permitted to bill or receive reimbursement for services rendered. If Medicaid is your primary insurance you will be considered a "Self Pay" client, if Medicaid is your secondary you will be 100% responsible for any out of pockets costs not covered by your primary insurance:

Patient Signature: _____

NEW TAMPA EYE INSTITUTE uses an automated system Athena Communicator to confirm all appointments. Please initial below giving us consent to contact you to confirm upcoming office visits via this automated system.

Initials of patient: _____

Preferred method of communication:
Telephone Call [ ] Text Message[ ] Email Message[ ] Mail/US Postal [ ]

Email Address: _____ Portal Only [ ]

Cell Phone Number: _____

Home Phone Number: _____

Patient Signature: _____

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Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-Shows" and late cancelations inconvenience those individuals who need access to medical care in a timely manner. We would like to inform you of our office policy regarding missed appointments. This policy enables us to better utilize our available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call us promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call 813-994-7000. If you do not reach the receptionist, you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late cancelations: Any cancellation made less than 24 hours prior to the appointment is considered a late cancelation.

No Show Policy

An appointment is considered a "no-show" when the appointment is missed and has not been canceled within a timely manner. A failure to be present for a scheduled appointment will be recorded in your medical record as a "no-show".

- First missed appointment there will be no charge

- All missed appointments thereafter will be subject to a $25.00 missed appointment fee, which will be billed to your account.

** In order to reduce the number of missed appointments we make several attempts to remind our patients of their upcoming appointments.

Patient Signature_____Date_____

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Patient Consents

I hereby authorize the Physicians at *New Tampa Eye Institute* to perform such treatments to me as may be prescribed by any attending physician during any and all of my visits to *New Tampa Eye Institute.*
I understand that I am financially responsible for ALL charges arising from services rendered to me by *New Tampa Eye Institute*.

Patient's Signature: _____ Date: _____

I authorize *New Tampa Eye Institute* to file any charges that I incur to my insurance(s). I request that all payments from my insurance(s) for services rendered be sent directly to *New Tampa Eye Institute*. I authorize any holder of medical information about me to release information to health care financing, administration and its agents or insurance company, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature:_____Date: _____

If the patient is a MINOR

It is the policy of our office not to treat minors without the written consent of a parent or legal guardian.

If the patient is a minor, please complete.

Responsible Party	**Relationship to Patient**	**Responsible Party DOB**	**Responsible Party SSN**
Address	**City/State/Zip**	**Phone No.**	

Responsible Party Signature:_____ Date:_____

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HIPAA Notice

I consent to the use and disclosure of protected health information for treatment, payment, healthcare operations, and as otherwise allowed by law.

New Tampa Eye Institute will maintain a record of the care and services you receive at ***New Tampa Eye Institute***. This consent only covers your protected health information created while you are a patient of ***New Tampa Eye Institute***. Your protected health information pertains to your diagnosis and/or treatment at ***New Tampa Eye Institute*** including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to ***New Tampa Eye Institute*** use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our Notice of Health Insurance Portability and Accountability Act (HIPAA) provides information about how ***New Tampa Eye Institute*** and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you also acknowledge that you have received a copy of ***New Tampa Eye Institute*** Health Insurance Portability and Accountability Act (HIPAA) and an opportunity to review it before signing this consent.

Signature of the Patient or Legal Representative: _____

Date: _____

Witness: _____

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Name:_____ Date:_____

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle & explain

SKIN: itching, rash, infection, ulcer, tumors (growths), other Explain:	none
LYMPH NODES: swelling, tenderness, other. Explain:	none
BONES, JOINTS, MUSCLES: muscle pain/cramps, joint pain/swelling, other. Explain:	none
ENDOCRINE: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, excessive hair growth, other Explain:	none
ALLERGY/IMMUNOLOGY: recurrent infections, hay-fever, hives, food allergy, drug sensitivity /allergy, other. Explain:	none
HEAD: headaches, dizziness, vertigo, other. Explain:	none
EARS: hearing loss, ringing, infections, other. **NOSE:** bleeding, loss of smell, congestion, other. **THROAT:** dry mouth, loss of taste, difficulty swallowing, hoarseness, other. Explain	none
NECK: pain swelling stiffness, other. Explain:	none
BREASTS: tenderness, swelling, lumps, discharge, other. Explain:	none
BLOOD: easy bruisability, prolonged bleeding, skin hemorrhages, significant blood loss, other. Explain:	none
RESPIRATORY: wheezing cough (productive/blood), difficulty breathing, other. Explain:	none
CARDIOVASCULAR (HEART/BLOOD VESSELS): chest pain, cold hands/feet, swelling of extremities, shortness of breath, exercise intolerance, other. Explain:	none
GASTROINTESTINAL (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, bleeding, pain/cramps, other. Explain:	none
GENITOURINARY (genitals/kidneys/bladder): frequency, burning, hesitancy, pain or bleeding on urination, stones, infections, incontinence, impotence, other. Explain:	none
NERVOUS SYSTEM: weakness in arms/legs, numbness/tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other. Explain:	none
PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other. Explain:	none

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Notice of Refraction Fee

Dear Patient:

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but Medicare and most private insurances do not cover this service. Our office fee for routine refraction for eyeglasses is **$50.00**, and this fee is collected **in addition** to any copayment.

Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. My co-payment is separate from and not included in the refraction fee. I understand that I may refuse this part of the exam.

Patient Signature: _____ Date:_____

Print name: _____

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Patient Authorization to Release Protected Health Information

I authorize **NEW TAMPA EYE INSTITUTE** to release protected health information to the individual (s) listed below for the purpose of assisting with my care and/or payment.

Name	Relation	Phone Number

Description of the information to be used or disclosed (*check all that apply):*

☐ Patient's demographic information ☐ Patient's medical information

☐ Patient's billing information ☐ Appointment Status

I understand that this authorization will be in effect during the time period I am a patient at ***New Tampa Eye Institute.*** I further understand that this authorization is voluntary and that my health care and the payment of my healthcare will not be affected if I do not sign this form. I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying ***New Tampa Eye Institute*** in writing at 27356 Cashford Circle, Wesley Chapel, FL 33544. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of the Patient or Legal Representative: _____

Date: _____

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Name:	Date:

REASON FOR VISIT TODAY:_____

OCULAR HISTORY:

Do you currently have, or have you ever had:	Yes/No	Eye	Diagnosis	Current Treatment/ Previous Surgery	When?
Eye disease	□Yes □No				
Eye Injury	□Yes □No				
Eye Surgery	□Yes □No				

List all current eye medications and drops: ☐ none

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Name:	Date:
Address:	Telephone #:
Referring physician:	Telephone #:
Primary care physician:	Telephone #:

MEDICAL, FAMILY & SOCIAL HISTORY: Please check the following as they apply to yourself **(S)** or to family members **(F)**

S	F		S	F		S	F	
		anemia			Emphysema			kidney disease
		arthritis			Glaucoma			sleep apnea
		blindness			heart disease/attack			stroke
		cancer			Hepatitis			thyroid disease
		diabetes			high blood pressure			vascular disease

List all current medications (do not include eye medicines):	none
List all previous:	
Surgeries & dates – not eye surgeries	None
Hospital stays – not eye surgeries (dates & reason)	None
Allergies – not eye related (include drug reactions)	None

Are you using non-prescription drugs?	no	yes,_____
Do you use street drugs?	no	yes,
Do you drink alcohol?	no	yes, how much?
Do you smoke?	no	yes, how much?
Have you ever been exposed to the AIDS virus?	no	yes,_____
Have you ever had a sexually transmitted disease?	no	yes,_____

Marital status: single, married, widowed, divorced, other			
Work status: Current occupation: Previous occupation:			
Any known toxic exposure? no / yes			
Living arrangements: home, apartment, nursing home, other			
Live alone? yes / no	Status: independent / need assistance		
Education level: high school, college, post-graduate degree, other			
Driving: Do you drive in the day?	yes / no	with difficulty?	yes / no
Do you drive at night?	yes / no	with difficulty?	yes / no

Name:_____ **Date:**_____

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NOTICE OF INFORMATION PRACTICES
Health Insurance Portability and Accountability Act (HIPAA)

1. NEW TAMPA EYE INSTITUTE may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; and collection agencies. Healthcare operations includes, but is not limited to, internal quality control and assurance including auditing of records.

2. NEW TAMPA EYE INSTITUTE is permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

3. NEW TAMPA EYE INSTITUTE will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. NEW TAMPA EYE INSTITUTE may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

5. NEW TAMPA EYE INSTITUTE will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

6. NEW TAMPA EYE INSTITUTE reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information of the patient. Copies may also be obtained at any time at our offices.

7. NEW TAMPA EYE INSTITUTE will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at 27356 Cashford Circle, Wesley Chapel, FL 33544, (813) 994-7000. All complaints will be addressed and results will be reported to the Corporate Compliance Officer.

8. It is NEW TAMPA EYE INSTITUTE's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

9. The person in the office to contact for further information is the Administrator, (813) 994-7000.

The effective date of this Notice is April 1, 2012.