Eye Associates
Fort Myers ♦ Naples

PATIENT DEMOGRAPHICS

Name: _____ ___ _____ **Gender:** ❑ Male ❑ Female
First M Last

Date of Birth: ____ / ____ / _____
M D XXXX

Address: _____
Street address 1

Address: _____ ❑ Employed ❑ Student ❑ Retired ❑ Minor
Street address 2

_____ ____ _____ ❑ Single ❑ Married ❑ Widowed
City State ZIP

Cell Phone: (____) ____-_____ **It is ok to leave a voice message on my phone:** ❑ Yes ❑ No
Home Phone: (____) ____-_____ **Email:** _____
Work Phone: (____) ____-_____ **Employer:** _____

Emergency Contact: _____ Phone: (___) ____-_____

Please Complete

How did you hear about us? _____

Primary Care Physician:_____ **Phone:** (__) ____-_____

Pharmacy: _____ **Address or Phone:** _____

_____

INSURANCE INFORMATION

Insurance Company: **PRIMARY** ❑ PPO ❑ HMO **SECONDARY** ❑ PPO ❑ HMO

Name of Insurance: _____ _____

Policy ID# _____ Policy ID# _____

Effective Date: ___ / ___ / _____ Effective Date: ___ / ___ / _____
M D XXXX M D XXXX

Policy Holder Name: _____ Social Security # (SSN): xxx-xx-_____
(If other than self) **(AS IT APPERARS ON CARD)**

Date of Birth: ___ / ___ / _____
M D XXXX

PATIENT'S OR AUTHORIZED SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits and/or medical insurance benefits either to myself or to the party who accepts assignment.

For Minors: I give my permission for my child to be treated by: ❑ Dr. Stephen E. Smith ❑ Dr. Jessica A. Cameron
❑ Other: _____

_____ **Date** _____ / _____ / _____
Patient/Guardian Signature M D 20XX

– Please turn page for additional information –

Guarantor Information (Person responsible for payment **if different from self**):

Name: _____ _____ ___ SSN: xxx-xx-____ Birth:___/___/_____
First Last M M D XXXX

Address: _____ Relationship to Patient:_____

Employer:_____ Phone: (___) ____-_____

Additional information:
Are you a year-round resident of Florida? ❑ Yes ❑ No If no, please check the months you reside in Florida:

❑ Jan ❑ Feb ❑ Mar ❑ Apr ❑ May ❑ Jun ❑ Jul ❑ Aug ❑ Sep ❑ Oct ❑ Nov ❑ Dec

Second Address: _____ _____ ___ _____
Street Address City State ZIP

Alternate Phone: (___) ____-_____

OFFICE POLICY REGARDING PAYMENT:
Please read over the following information very carefully before seeing the doctor. This is to eliminate any confusion regarding office policies. Thank you!

Medicare: We accept Medicare assignment. Medicare assignment means we will be reducing our fees to the Medicare allowed amounts. Medicare has a deductible of $257.00 per calendar year. You are required by Medicare to pay the first $257.00 for any Part B medical expenses. Medicare will then pay 80% of the allowed amount leaving 20% coinsurance to your responsibility. As a courtesy, we are happy to file the remaining balance to your supplement/secondary insurance; however, if your supplement pays directly to you, you will be responsible for the deductible/20% today plus any non-covered services (example: refractive exam).
Medicaid Plans: You may be responsible for a $60.00 refractive exam fee at the time services are rendered.

Managed Care Plans (HMO or PPO): You are responsible for payment at time of service. This includes any applicable co-pay, co-insurance and/or deductible. Most HMO plans are required to have an authorization/referral from your primary care physician. If this is not obtained **prior** to your visit, you will be responsible for full payment at the time services are rendered.

Private / Commercial / Group Insurance: You are responsible for payment at time of service. This includes any applicable co-pay, co-insurance and/or deductible.

No Insurance: Unless prior arrangements have been made with our office, full payment is due at the time services are rendered.

Refraction: Eye Associates of Fort Myers/Naples recommends a refractive exam to determine your best corrected vision. It is important for the doctor to know if you have a decrease in your best corrected vision. In addition, a refractive exam will determine if there is improvement with glasses or contacts. The written results of a refractive exam is required to purchase prescription glasses or contact lenses. Unfortunately, this examination is not covered by Medicare, Medicaid and most commercial insurances. Your out of pocket expense for this examination is **$60.00.**

I have read the above office policy completely. I understand and accept this policy. I also understand that I am fully and legally responsible for payment of this account, which includes outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay the outstanding balance, I agree to pay all billing charges, costs of collection agency fees, attorney fees and court costs, if any.

_____ **Date** _____ / _____ / _____
Patient/Guardian/Guarantor Signature

REVIEWED 5/20/25

Eye Associates
Fort Myers ♦ Naples

PATIENT MEDICAL HISTORY

Name: _____ ____ _____ Date of Birth___ / ___ / _____ Age_____
First M Last

Allergies and Reactions: _____

Smoking: ☐ YES ☐ NO If Yes: How much? _____ How Long? _____ When quit? _____

Alcohol: ☐ YES ☐ NO If Yes: How much? _____

Drugs: ☐ YES ☐ NO If Yes: How much? _____ How Long? _____ When quit? _____

Please list all surgeries and year: _____

_____

Please list all previous hospitalizations and year:_____

_____

Please list all medications you are currently taking:

Name of Medication	Dose	How Often	Treatment for

Please list all Herbal Supplements you are currently taking:

Name of Herbal Supplements	Dose	How Often	Treatment for

Please list all Vitamins you are currently taking:

Name of Vitamins	Dose	How Often	Treatment for

Please list all Eye Drops you are currently using:

Name of Drop	Dose	How Often	Treatment for

Family History: Check all that apply & explain _____

☐ Diabetes	☐ Stroke	☐ Blindness	☐ Macular Degeneration	☐ Arthritis
☐ Cancer	☐ TB	☐ Cataracts	☐ Retinal Disease	☐ Lazy Eye
☐ Heart Disease	☐ Kidney Disease	☐ Glaucoma	☐ High Blood Pressure	☐ Other

_____ **Date** ____ / ___ / _____
Patient/Guardian Signature

REVIEW OF SYSTEMS

Have you ever been treated for or told you have any of the following?

Eyes	YES	NO
Previous Surgery	☐	☐
Contact Lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐

Ear, Nose, Throat		
Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐

Cardiovascular		
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heartbeat	☐	☐
Difficulty Lying Flat	☐	☐

Constitutional		
Fatigue/Weakness	☐	☐
Severe Fever	☐	☐
Weight Gain/Loss	☐	☐

Infectious Disease		
HIV	☐	☐
Hepatitis	☐	☐
MRSA	☐	☐
Shingles	☐	☐

Respiratory	YES	NO
Chronic Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐

Gastrointestinal		
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hepatitis	☐	☐

Genito-urinary		
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
History Kidney Stones	☐	☐
History STD's	☐	☐

Psychiatric		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐

Endocrine		
Increased Thirst	☐	☐
Increased Hunger	☐	☐
Increased Urination	☐	☐
Increased Sweating	☐	☐
Fingernail Changes	☐	☐

Blood/Lymph	YES	NO
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolonged Bleeding	☐	☐
Heavy Aspirin Usage	☐	☐

MusculoSkeletal		
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swelling	☐	☐

Skin		
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐
Rosacea	☐	☐
Sun Damage	☐	☐

Neurological		
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐

Immunological		
Hives	☐	☐
Itching	☐	☐
Runny Nose	☐	☐
Sinus Pressure	☐	☐
Autoimmune Disease	☐	☐

Additional Comments: _____

_____

_____

_____ **Date** ____ / ___ / _____

Patient/Guardian Signature

PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

By signing this form, I _____, authorize the use and disclosure of my health information as described in the Eye Associates Notice of Privacy Practices. I have received the Eye Associates Notice of Privacy Practices and I have been provided an opportunity to review it. This notice is effective as of the date below and will remain effective until further notice.

_____ Date: ___ / ___ / _____

Signature of Patient, Guardian or
Personal Representative

_____

Print Name of Guardian or
Personal Representative

_____

Description of Personal Representative's Authority (e.g., state law, court order, etc…)

I hereby authorize Eye Associates of Ft Myers/Naples to communicate information regarding my care or billing with:

Please Initial

Name(s): _____ Relation: _____ _____

Name(s): _____ Relation: _____ _____

Name(s): _____ Relation: _____ _____

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.

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. Your information may be stored electronically and if so, is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
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 or disclose your information to payors to determine whether you are enrolled or eligible for benefits. 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, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may 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, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the 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 or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
□ 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.
□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
□ You have the right to request that we amend your information.
□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

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 to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

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

Contact Person
If you have any questions, requests, or complaints, please contact:

Meghan Lighthall, MBA, Admin
4225 Evans Ave., Ft. Myers, FL 33901
(239) 936-7685

I,_____,
Print Name
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signature:_____

Date:_____

If not signed, reason why acknowledgement was not obtained:
_____

Version 3.0 **Effective Date: September 18, 2013**

Ocular Surface Disease Index© (OSDI)

Patient's Name:_____ Date:_____

Please answer the following 12 questions and circle the number in the box that best represents each answer.

Have you experienced any of the following during the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light?	4	3	2	1	0
2. Eyes that feel gritty?	4	3	2	1	0
3. Painful or sore eyes?	4	3	2	1	0
4. Blurred vision?	4	3	2	1	0
5. Poor vision?	4	3	2	1	0

Subtotal score for answers 1 to 5 ☐

Have problems with your eyes limited you in performing any of the following during the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
6. Reading?	4	3	2	1	0	N/A
7. Driving at night?	4	3	2	1	0	N/A
8. Working with a computer or bank machine (ATM)?	4	3	2	1	0	N/A
9. Watching TV?	4	3	2	1	0	N/A

Subtotal score for answers 6 to 9 ☐

Have your eyes felt uncomfortable in any of the following situations during the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time	N/A
10. Windy conditions?	4	3	2	1	0	N/A
11. Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
12. Areas that are air conditioned?	4	3	2	1	0	N/A

Subtotal score for answers 10 to 12 ☐

Thank you for completing this form, ***your technician will calculate your final OSDI score****.*

Add subtotals from all 3 boxes (= sum of scores for all questions answered) ☐

Total number of questions answered (do not include questions answered N/A) ☐

Results: Score - _____ Normal Mild Moderate Severe