

# Patient Consultation Sheet

Contact Information (please print clearly): Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street Address Apt/Unit

City State Zip

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Race (circle one): Asian (1) Caucasian (3) Hispanic (4) Black (6) Other (9)

Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip

Emergency Contact: \_\_\_\_\_  
Name Phone Number

## History and Questionnaire

1. Which is the best way to contact you? \_\_\_\_\_

2. What radio stations do you listen to? \_\_\_\_\_

3. Which newspapers do you read regularly? \_\_\_\_\_

4. How did you hear about us? \_\_\_\_\_

Radio -what station? \_\_\_\_\_ Newspaper - what paper? \_\_\_\_\_

Friend Newsletter Internet-what source? \_\_\_\_\_ TV -what station? \_\_\_\_\_

Billboard  Health Fair/Trade show -please specify \_\_\_\_\_

Other \_\_\_\_\_  Corporate account -please specify \_\_\_\_\_

5. My main visual problem (check all that apply):

- Fine Print
- Near Vision
- Intermediate/Computer
- Distance Vision
- Night Driving

6. My current prescription is for (check all that apply):

- Myopia or nearsightedness
- Hyperopia or farsightedness
- Astigmatism
- Presbyopia (bifocals or glasses for reading)
- Unsure at this time

7. Do you currently wear: (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Glasses for distance               | <input type="checkbox"/> Extended wear contact lenses |
| <input type="checkbox"/> Progressive glasses                | <input type="checkbox"/> Toric contact lenses         |
| <input type="checkbox"/> Bifocal or reading glasses         | <input type="checkbox"/> Trial contact lenses         |
| <input type="checkbox"/> 1-2 week disposable contact lenses | <input type="checkbox"/> Monovision contact lenses    |
| <input type="checkbox"/> Monthly disposable contact lenses  | <input type="checkbox"/> RGP/Hard contacts            |
| <input type="checkbox"/> Vial contact lenses                | <input type="checkbox"/> Other _____                  |

8. Do you have a history of any of the following (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Keratoconus         | <input type="checkbox"/> Glaucoma                   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Keloid Former              |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Past eye conditions _____  |
| <input type="checkbox"/> Thyroid Condition   | <input type="checkbox"/> Previous eye surgery _____ |

9. When was your last eye exam? \_\_\_\_\_

10. Who is your present eye doctor? \_\_\_\_\_ Yes No

11. Did he/she refer you to us?  Yes  No

12. Has anyone ever told you that you would be a good candidate for the LASIK procedure?  Yes  No

13. Do you know any friends or family members who have had the LASIK procedure?  Yes  No

14. Is this your first vision correction consultation?  Yes  No

15. If you lost or misplaced your glasses or contacts, would you be able to function throughout the day?  Yes  No

16. Do your glasses or contacts Interfere with your recreational activities?  Yes  No

17. If you could function throughout the day without dependence on glasses or contacts, would you consider the procedure a success?  Yes  No

18. Did you know that LASIK is a two-step procedure?  Yes  No

19. Are you interested in learning about our financing program?  Yes  No

20. What is it about your glasses or contact lenses that currently prevent you from enjoying everyday activities?

\_\_\_\_\_

21. What do you hope to achieve by having the LASIK procedure that glasses and contacts currently do not provide?

\_\_\_\_\_

22. How long have you been considering the LASIK procedure? \_\_\_\_\_

23. Do you have any fears regarding vision correction? \_\_\_\_\_

24. Is there anything preventing you from proceeding with the LASIK procedure prior to your visits other than financial arrangements? \_\_\_\_\_

25. When do you plan on having LASIK? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Place of employment: \_\_\_\_\_

2. Occupation or type of work: \_\_\_\_\_

3. Spouses name: \_\_\_\_\_

4. Spouses place of employment: \_\_\_\_\_

5. Spouses occupation or type of work: \_\_\_\_\_

6. Do you have any children?: \_\_\_\_\_

7. If yes, what are their ages? \_\_\_\_\_

8. What are your hobbies/interests? \_\_\_\_\_

9. How many hours a day are you on the computer? \_\_\_\_\_

**TREATMENT AUTHORIZATION, ASSIGNMENT OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT**

1. AUTHORIZATION FOR ROUTINE DIAGNOSTIC PROCEDURE AND MEDICAL TREATMENT -I hereby consent to such diagnostic procedure and medical treatment which, in the judgment of my physician, may be considered necessary or advisable while a patient at the Jacksonville Eye Center.

2. SOCIAL SECURITY MEDICARE (if applicable) -I the undersigned, certify that the information given by me in applying for Medicare benefits is correct. I authorize Jacksonville Eye Center and my physicians to release to the Social Security Administration or its representatives any information needed to process this or any other related Medicare claims. I hereby assign payment on my behalf of all authorized benefits to Jacksonville Eye Center. I am personally responsible for any non-covered services health Insurance deductibles and co-insurance.

3. MEDICAID (if applicable) -I, the undersigned, certify that I am a recipient of Medicaid benefits. I authorize Jacksonville Eye Center and my Insurance carrier to make available to the Medicaid agency in my state any requested information concerning medical, insurance. and financial records relating to my care.

4. COMMERCIAL INSURANCE AND ASSIGNMENT -By signing in the space below as a patient and/or insured, I hereby assign patient from all insurance carriers with whom I have coverage or from whom benefits are. or may become payable to me, to be paid directly to Jacksonville Eye Center and to physicians who rendered services covering this period of treatment If related to the incident of condition giving rise to my treatment. This assignment shall include settlements or judgments flowing from the incident for which I was receiving treatment and/or master medical benefits otherwise payable to me, but shall not exceed the regular charges for this and any other period of treatment.

5. RELEASE OF MEDICAL INFORMATION BY JACKSONVILLE EYE CENTER -By signing In the space below as patient and/or guardian, I hereby authorize Jacksonville Eye Center and physicians providing serviced during my care to release information from and/or copies of my medical records, and other information as may be required for my medical care and to secure payment for charges Incurred by me or on my behalf, to Jacksonville Eye Center or my physician.

6. GUARANTOR AGREEMENT -By signing in the space below as patient and/or guardian, or guarantor or as a patient's/guardian's spouse, or guarantor's spouse. I hereby agree that all charges connected with treatment, and past and future treatment if related to the incident or condition giving rise to the care not covered I may have are due and payable by me at the time of checking out I hereby acknowledge that, unless Jacksonville Eye Center and my insurance company or third party carrier have agreed that I will not be billed. Jacksonville Eye Center has the right to demand payment in full from me at the time prior to full payment from any insurance carrier. I hereby acknowledge having been told that I may be billed by my treating physician and/or Jacksonville Eye Center. If my account is referred to collections, I agree to pay attorney's fees, court costs and/or collection agency fees associated with the collection process. In addition, accounts older than 90 days referred to collections are subject to an 18% per annum interest charge. I specifically waive any exemption of wages from garnishment which might be available by law, and agree that my wages can be garnished in the event a judgment is entitled against me for the collection of services I have agreed to pay.

In addition to the above Information, I also understand the following information:

1. YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION. This means you may request an amendment of protected health information about you In a designated record set for as long as we maintain this Information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will PI'9v1de you with a copy of such rebuttal. Please contact our Privacy Contact to determine If you have questions about amending your record.

2. YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE OF ANY OF YOUR PROTECTED HEALTH INFORMATION. This right applies to disclosures other than treatment, payment or healthcare operations as described In -Notices of Privacy Practices-, which, by signing below, you acknowledge receiving a copy of this document It excludes disclosures we may have made to you, to family members, or to friends involved in your care, or for notification purposes. You have the right to receive specific Information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exception, restrictions, and limitations.

3. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US.

4. COMPLAINTS. You may file a complaint to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact. Linda Vencil, at 904-355-5555 ext. 139 for further Information about the complaint procedure.

Patient/Guardian \_\_\_\_\_

Insured (if different than above) \_\_\_\_\_

Witness \_\_\_\_\_

Date: \_\_\_\_\_