Filutowski Cataract & LASIK Institute
PATIENT REGISTRATION

3.11

Last Name:	First Name:	MI:
Local Address:		
City:	State:	Zip Code:
DOB:	Sex:	Marital Status:	Race:
SSN [Required for reporting to Agency for Health Care Administration]:		
Were you referred by an eye doctor? [ ] Yes [ ] No	If yes, doctor's name:	

PERSON TO CONTACT IN CASE OF EMERGENCY

Last Name:	First Name:
Telephone #: ( )	Relationship to Patient:

RESPONSIBLE PARTY/BILLING INFORMATION

Last Name:	First Name:	MI:
Home Phone #: ( )	Work Phone #: ( )	
Mobile #: ( )	E Mail:	

Please indicate which of the above phone numbers is best for reach you **during the day (8 a.m. – 5 p.m.):**

_____ Home _____ Work _____ Mobile _____ Other: ___________________________________

Billing address:		
City:	State:	Zip Code:

MEDICAL INSURANCE INFORMATION – please submit card(s) to receptionist

Please complete the following if the insured person is NOT the patient:

Name of Insured Person:	DOB:
Relationship to Patient: [ ] Spouse [ ] Parent	

IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Our doctors are here to provide you with the best medical care and their primary concern is your health and well-being. That is why it is very important for you to read and understand what your policy may or may not cover. We participate with numerous different insurance companies and each company has many different plans, therefore it is impossible for us to be aware of what each patient's particular plan will cover. **FCLI does not participate with Vision Plans.**

We will verify your benefits and provide you with an ESTIMATE of what your patient responsibility will be. However, again this is only an ESTIMATE and true benefits cannot be determined until your insurance processes the claim. You are responsible for any additional patient responsibility once the explanation of benefits is received.

IMPORTANT: PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S) AND DRIVER LICENSE WITH YOU.

Filutowski Cataract & LASIK Institute
MEDICAL HISTORY INFORMATION

Date:

Last Name:	First Name:	MI:

Reason for Today's Visit:

[Please provide strength and dosage for all medications]

	Yes	No	
Previous Eye Injuries			List:
Previous Eye Surgery			When: Dr:
Previous Eye Disease			Treated with:
Respiratory Difficulty (Asthma/Bronchitis/Emphysema			Treated with:
Heart Failure			Treated with:
Slow/Fast/Irregular Heart Rate			Treated with:
Heart Attack(s)			When:
Stroke(s)			When:
Diabetes			Treated with: Last blood sugar reading: A1C:
High Blood Pressure			Treated with:
Other Medical Problems			List:
Drug Allergies			List:
Family History of Glaucoma			Who:
Prescription Eye Drops			List:
Current Medications (not listed above) w/Dosage			List:
Smoker			Amount:
Alcohol Use			Amount:
History of Hepatitis			Type: Active now? Yes [ ] No [ ]
History of Tuberculosis			Active now? Yes [ ] No [ ]
Are you pregnant?			Number of months:
Are you HIV positive?			
Do you have AIDS?			

Name of local Eye Doctor(s) who have treated you:	
Name and location of your preferred Pharmacy:	Phone number:
Would you like to learn about LASIK (Laser Vision Correction)? [ ] Yes [ ] No	

Please note: patients confined to wheelchairs must be accompanied by an assistant at all times in the clinic and surgical centers.

Filutowski Cataract & LASIK Institute
FINANCIAL POLICY

(8.11)

Payment in full is due at the time of service, unless this office participates with your insurance company or arrangements have been made prior to your appointment. We accept cash, check, Visa, MasterCard, Discover and American Express.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. You are responsible for knowing which physicians in our practice are participating with your insurance company. You are responsible for knowing what diagnosis and/or procedure(s) may or may not be considered for payment. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than supply factual information. You are responsible for any charges not paid by your insurance company within 60 days. (See also: "Important Information Regarding Insurance Billing" on Patient Registration form)

FEE FOR REFRACTION: Refraction (testing for eyeglass correction) is a billable service that is NOT COVERED by medical insurance and is therefore **100% the patient's responsibility.**

Patient Initials: ☐

YOU ARE RESPONSIBLE FOR ANY POLICY DEDUCTIBLES AND CO-PAYMENTS AT THE TIME OF SERVICE

This office will file claims only with insurance companies with whom we participate. We will file with no more than two (2) insurance companies. If you have additional insurance coverage, it is your responsibility to file the claim.

We are a Medicare participating practice. If you are a Medicare Beneficiary, we will file a claim for you. You will be responsible for the annual $162.00 deductible and the 20% co-payment.

MINORS ACCOMPANIED BY AN ADULT: The adult accompanying a minor and his/her parents (or guardian) are responsible for payment at the time of service.

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I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

PATIENTS WITH MEDICARE COVERAGE:
I certify that the information given by me in applying for payment under Title XVIII of the Medicare Act is correct. I authorize any holder of medical of other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician and authorize such physician to submit a claim to Medicare.

NON-MEDICARE PATIENTS:
I authorize the release of all medical information to my insurance company/companies and request that payment of my insurance benefits be sent directly to Filutowski Cataract & LASIK Institute (unless payment in full has been made at the time of service).

Patient Name (print): ____ **Chart #:**______________

Patient/Guardian Signature: ____ **Date:**________________

Filutowski Cataract & LASIK Institute
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers (insurance companies).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I may request a copy of your *Notice of Patient Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Filutowski Cataract and Lasik Institute (FCLI) restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand FCLI is not required to agree to my requested restrictions, but if FCLI does agree then FCLI is bound to abide by them.

For patients who bring companions to their appointments: I understand that my private health information may be discussed at any time during any interaction between myself and the staff of FCLI. If I allow my companions to be present during such interactions, my companions may be exposed to my private information. It is MY responsibility to exclude my companions from such conversations between myself and FCLI staff if I do not wish my companions to be exposed to my private information.

Patient Name (print): ____

Signature: ____

Relationship to Patient: ____________________________________

Date: ____________________________________

I authorize access to my protected health information for the following persons (optional):

Name: ____ Relationship: ________________

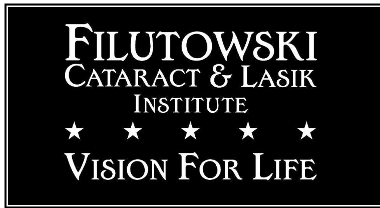
Name: ____ Relationship: ________________

OFFICE USE ONLY

I attempted to obtain the patient’s (or legal guardian’s) signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

Filutowski Cataract & LASIK Institute



[Office use only] Pt's Record #: _______________

CONSENT FOR DILATING EYE DROPS

In order to thoroughly examine your eyes and diagnose certain eye diseases such as glaucoma and macular degeneration, it is usually necessary to administer dilating drops. Dilating drops enlarge the pupil of the eye to allow for the examination of the inside of your eye; without pupil dilation, the doctor gets only a limited view of the eye. These drops usually cause blurred vision and make reading and focusing on near objects difficult or impossible until pupils return to normal size. The length of time that vision will be blurred and the degree of eyesight impairment varies from person to person. It is not possible to predict how much or how long your vision will be affected.

Driving even in low-light conditions may be difficult or impossible after an examination with dilating drops, and, if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

PATIENT STATEMENT

I, (print name) ____, hereby authorize Filutowski Cataract & LASIK Institute's staff doctors, technicians or other assistants to administer dilating eye drops during the course of my treatment. I understand that these eye drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating eye drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated or by wearing sunglasses while driving.

If I am aware of any reason that I cannot or should not receive dilating drops, I agree to inform the clinic staff and my eye doctor *before any eye drops are administered* during the course of my exam.

____ ___________________
Patient signature (or patient's authorized representative) Date

____ ___________________
Witness Date