

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Spouse <input type="checkbox"/> 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:
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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:
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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.

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 or 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:** _____

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:

LASIK VISUAL ASSESSMENT

Name:	Date:
1. How did you hear about us?	2. What is your occupation?
3. When was the last time you wore contact lenses? <input type="checkbox"/> N/A Date:	<input type="checkbox"/> Hard <input type="checkbox"/> Soft
4. Check any problems you have experienced while wearing contact lenses: <input type="checkbox"/> Dirt <input type="checkbox"/> Dust <input type="checkbox"/> Poor Vision <input type="checkbox"/> Irritation/Intolerance <input type="checkbox"/> Infections <input type="checkbox"/> Other Explain other: _____	
5. Do you work in an environment that makes it difficult to wear contact lense: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Dirt <input type="checkbox"/> Dust <input type="checkbox"/> Chemicals Other: _____	
6. I use my <input type="checkbox"/> Right <input type="checkbox"/> Left eye to look through the viewfinder of a camera (or rifle scope, microscope).	
7. Check any problems you have experienced while wearing eyeglasses: <input type="checkbox"/> Slipping down the nose in humid climate <input type="checkbox"/> Hurting the nose and ears <input type="checkbox"/> Fogging up <input type="checkbox"/> Undesirable appearance <input type="checkbox"/> Limited peripheral vision <input type="checkbox"/> Other	
8. Check any activities that you have had difficulty participating in because of your vision: <input type="checkbox"/> Water-skiing <input type="checkbox"/> Swimming <input type="checkbox"/> Scuba diving <input type="checkbox"/> Profession <input type="checkbox"/> Other	
9. What are the most important reason(s) why you are interested in having LASIK? <input type="checkbox"/> Appearance <input type="checkbox"/> Meeting occupational requirements <input type="checkbox"/> Ability to participate in more sports <input type="checkbox"/> Freedom from inconvenience of glasses and/or contact lenses <input type="checkbox"/> Safety <input type="checkbox"/> Security <input type="checkbox"/> Other: _____	
10. Without your glasses or contact lenses, can you see well enough to: a. Drive in an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No b. See the alarm clock at your bedside? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Rescue a family member in case of fire? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Your <i>distance</i> prescription in glasses/contacts has been stable for how many years? Do you have prism in your eyeglasses? <input type="checkbox"/> Don't know <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Have you been pregnant or nursing within the last six weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Do you have keratoconus? <input type="checkbox"/> Don't know <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Have you had herpes simplex infection of your eye in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Do you have nighttime visual symptoms such as glare, halos or starbursti <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
16. Perfect vision after LASIK cannot be guaranteed. Are you willing to accept this fact <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. What do you expect LASIK will do for you? _____	
18. If you have any questions about LASIK, please write them down: _____	

Filutowski Cataract & LASIK Institute

LASIK Screening Date: _____
(Please print legibly)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Occupation: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

How did you hear about us? _____

Were you referred by your eye doctor? yes no

If yes, doctor's name and office location: _____

When was your last full eye exam? _____

Have you had any previous eye surgery? yes no

If yes, please explain: _____

Do you have keratoconus? do not know yes no

When was the last time you wore contact lenses? Date: _____

Type of lenses worn: N/A Hard Soft

Are you pregnant or nursing? yes no

How long have you been considering LASIK vision correction? _____

Why haven't you had LASIK yet? _____

What would be your greatest benefit from not having to wear glasses or contact lenses following LASIK? (This could be a personal or professional reason) _____

Do you know anyone who has had LASIK? _____

Konrad W. Filutowski, M.D.

Medical Director
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American Board of Eye Surgery

Angela K. Dempsey, M.D.

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Board Certified Optometric
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FILUTOWSKI
CATARACT & LASIK
INSTITUTE
★ ★ ★ ★ ★
Vision For Life

Exclusive Provider of
HIGH DEFINITION™
LASIK
in Florida

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386.788.6696
FX 386.788.2219

1070 Greenwood Blvd.
Lake Mary, FL 32746
407.333.5111
FX 407.333.2434

2295 S. Hiawasse Rd.
Suite 101
Orlando, FL 32835
407.902.2533
FX 407.902.2535

800.LASIK.4U
800.EYE.EXAM
FilutowskiEye.com



**Also please remember to bring the following for your
LASIK CONSULTATION**

- ✓ **Medical Insurance Cards**
- ✓ **Drivers License**
- ✓ **\$100 Refractive Surgery Exam Fee (If consultation and exam)**
- ✓ **Completed LASIK Paperwork**

Please call if you have any questions or if you need to Cancel or Reschedule your appointment at (800) 393-3926



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 1070 GREENWOOD BLVD.
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 407.333.5111



Daytona Beach
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800.EYE.EXAM
FILUTOWSKI EYE . COM
WEEKEND & AFTER HOURS HOTLINE: 407.461.4500

Exclusive Provider of
HIGH DEFINITION™
LASIK
 in Florida



"The path I chose for my life's work was one that I selected with great care. I wanted to make a difference, to have an impact on the lives of my patients. Even so, I never imagined that my performing LASIK would bring such a magnitude of excitement and life changing experience to my patients' lives. The thrill that I experience through my patients' eyes, with their clear natural vision after LASIK, has become one of my life's greatest rewards. I look forward to changing the way you see the world!"

KONRAD FILUTOWSKI, MD

FILUTOWSKI
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