Patient Demographics

Last Name _____ First Name _____ Middle Initial _____

Address (Local) _____, City _____ State _____ Zip Code _____

Address (Northern) _____, City _____ State _____ Zip Code _____

Phone Number (____)_____ Phone Number (____)_____ EMAIL _____

Date of Birth _____ Sex ____ Marital Status _____ Spouse Name _____

Family Physician _____ Phone Number _____

Referred By _____ Preferred Pharmacy _____

Closest Relative Not Living With You _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Patient's Employer _____ Address _____ Phone Number _____

Primary Insurance _____ Secondary Insurance _____

NAME: _____ AGE:_____REF. BY/PCP: _____ DATE:_____

Please answer the following questions about your medical status and history: (Use the back of the sheet if you need more room to answer any question)

1. Have you ever been treated for *any* medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?
   ☐ Yes ☐ No If YES, please explain_____
   _____
2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment?
   ☐ Yes ☐ No If YES, please explain_____
   _____
3. When was your last eye exam? _____
4. Have you ever had *any* surgery? (e.g. appendix, tonsil, knee, and eye surgeries)
   ☐ Yes ☐ No If YES, please explain_____
   _____
5. Do you take *any* medications?
   ☐ Yes ☐ No If YES, which medications? [ ] see list_____
   _____
6. Do you have any drug or food allergies?
   ☐ Yes ☐ No If YES, please explain._____
   _____

Review of Systems: Do you *currently* have any of the following problems?	Yes	No	If Yes, Please explain
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat Problems (e.g. hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart Problems (e.g. chest pain, irregular heartbeat)	☐	☐	_____
Respiratory Problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal Problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary Problems (e.g. pain or discomfort, blood in urine)	☐	☐	_____
Skin Problems (e.g. rashes, excessive dryness)	☐	☐	_____
Musculoskeletal Problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic Problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric Problems (e.g. depression, anxiety)	☐	☐	_____
Endocrine Problems (e.g. diabetes, thyroid)	☐	☐	_____
Allergic/Immunological (e.g. hayfever, lupus, HIV)	☐	☐	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, and macular degeneration) ☐ Yes ☐ No If YES, please explain: -_____
_____

Do you smoke? ☐ Yes ☐ No If YES, how much? _____
Do you drink alcohol? ☐ Yes ☐ No If YES, how much? _____
If employed, how many hours per week do you work? _____

Neil B. Zusman M.D./ Daniel Solano D.O. _____

Harborside EYE SPECIALISTS

Patient Name: _____ Date: _____ DOB: _____

Medication (Rx, vitamin, herbal, etc)	Dosage (Ex: 80mg)	Frequency (ex: twice a day)	Route (ex: by mouth)

Are you a current smoker?

Yes ☐ No ☐

Have you been counseled on smoking cessation?

Yes ☐ No ☐

_____

Physician's Signature

_____

Date

INFORMATION REGARDING DILATING DROPS

Dilating eye drops are used to enlarge (dilate) the pupils so that the ophthalmologist or optometrist can obtain a clear and thorough view of the inside of the eye. These drops are an important and necessary part of your eye examination and help your doctor properly diagnose and evaluate your eye condition. After dilation, your vision may become blurred, and you may experience increased sensitivity to light. The degree and duration of these effects vary from person to person and cannot be predicted in advance. Because of light sensitivity, sunglasses are recommended while your eyes are dilated. Disposable sunshields are available at the check-out desk upon request. Due to the effects of dilating drops on vision, your ability to drive or safely operate machinery may be impaired following your examination. For this reason, you are advised not to drive and to arrange transportation to and from your appointment.

Patient Acknowledgment and Consent

I acknowledge that I have read and fully understand the information above regarding dilating eye drops. I understand that my vision may be temporarily affected and that I should not drive or operate machinery while my eyes are dilated. If I choose to drive or operate machinery despite this warning, I assume full responsibility—financial and otherwise—for any consequences resulting from this decision. I agree that my doctor, Harborside Eye Specialists, and its employees are released from all liability related to my decision to drive or operate machinery while my eyes are dilated.

I hereby authorize my doctor at Harborside Eye Specialists, and/or any assistants designated by my doctor, to administer dilating eye drops. I understand that dilating eye drops are necessary to diagnose and evaluate my eye condition. I consent to the use of dilating drops at this visit and at all future visits unless I notify my doctor otherwise.

_____ _____

Print Patient Name Date

_____

Patient Signature

_____ _____

Witness Date

INSURANCE AND PAYMENT AUTHORIZATION

AUTHORIZATION AND ASSIGNMENT - I assign payment to the physician/office at Harborside Eye Specialists for any medical benefits due to services rendered.

MEDICARE AUTHORIZATION - I request that payment of authorized Medicare benefits be made to me and/or the physician for any services furnished to me at or billed through this facility.

MEDIGAP AUTHORIZATION - If I have Medigap supplement insurance, I authorize payment to be made to me and/or the physician providing the services.

PAYMENT PLAN - Payment for copays, deductibles, and non-covered services such as **REFRACTIONS** (test for eyeglasses) is expected at the time of service. If you are unable to meet this obligation, please make arrangements with the office manager.

Appointment Cancellation & No-Show Policy We kindly request at least 24 hours' notice if you need to cancel or reschedule your appointment. Appointments not canceled within 24 hours or missed without notice are subject to a $50 no-show fee. This fee is not covered by insurance and is the patient's responsibility. Repeated missed appointments may result in dismissal from the practice.

RETURNED CHECK FEES/Collection Agency - Should your check be returned by the bank, a $30.00 fee will be added to your account. I am directly and fully responsible for all charges for the services rendered to me, including balances remaining after insurance payments, if any. I understand that all co-payments, deductibles, and coinsurance are due at the time of service unless otherwise agreed upon. I also acknowledge that failure to make timely payments may result in the balance being sent to a collection agency.

I understand that it is my responsibility to notify (Clinic/Physician's name) of any changes in my insurance coverage, address, or contact information. Out of courtesy to our patients, we file with your insurance company. If your insurance company does not pay within 60 days, you will be responsible for the bill.

- ☐ **By signing this binding agreement, I acknowledge that I have read, understand, and agree to the terms set forth above.**

_____ _____

Guarantor Signature Date

Harborside
EYE SPECIALISTS

HIPAA CONSENT FORM

Health Insurance Portability and Accountability Act (HIPAA)
Health Information Technology for Economic and Clinical Health Act (HITECH)

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, I consent to Harborside Eye Specialists using and disclosing my protected health information ("PHI") as permitted by law for purposes of treatment, payment, and healthcare operations ("TPO"). I understand that a more complete description of how my PHI may be used or disclosed is available in Harborside Eye Specialists' Notice of Privacy Practices ("NPP"). I have the right to review the NPP prior to signing this consent. Harborside Eye Specialists reserves the right to revise its NPP at any time. A current copy may be obtained by submitting a written request to:
Privacy Officer
Harborside Eye Specialists
P.O. Box 495658
Port Charlotte, FL 33949

With my consent, Harborside Eye Specialists may contact me at my home or other designated location and may leave voicemail messages or send mail related to TPO, including appointment reminders, billing statements, and insurance matters. With my consent, Harborside Eye Specialists may also communicate with me by email regarding appointment reminders, billing statements, insurance matters, and general office communications. I understand that email may not be a secure form of communication and that there is a risk my PHI could be accessed by unauthorized individuals. By providing my email address and consenting to email communication, I accept this risk. Harborside Eye Specialists will make reasonable efforts to protect my PHI in all communications and will limit email communications to appropriate content whenever possible.
I understand that I have the right to request restrictions on how my PHI is used or disclosed for TPO purposes. I understand that Harborside Eye Specialists is not required to agree to such restrictions, but if it does agree, it will comply with those restrictions.
By signing this form, I acknowledge that I am consenting to the use and disclosure of my PHI by Harborside Eye Specialists for TPO purposes. I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on my prior consent.

I understand that if I choose not to sign this consent, Harborside Eye Specialists may decline to provide treatment to me.

Other authorized person(s) to whom PHI may be disclose: _____

_____
Signature of Patient or Legal Guardian

_____ Date _____
Printed Name