EYE CLINIC & LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

CONTACT RECORD

Patient's Name _____ Date of Birth _____/_____/_____

Pharmacy Name _____ Phone # (_____) _____-_____

Physician Name _____ Phone # (_____) _____-_____

Eye Clinic & Laser Institute will leave confidential messages on your answering machine, with a family member or other individual answering the phone when you are not at home unless you indicate otherwise. We will safeguard your privacy by limiting the amount of information disclosed. For example, when calling your home we will only leave our name and number and other information necessary to confirm an appointment, or ask you to call back.

Please contact me as follows:

* Home Telephone (_____) _____-_____ Cell (____) _____-_____

E-MAIL ADDRESS_____

- □ OK to leave a message with healthcare information.
- □ Leave message with call back number only.
- □ Do NOT leave messages.
- □ E-MAIL ONLY

- Work Telephone (_____) _____-_____
  - □ OK to leave messages with healthcare information.
  - □ Leave a message with call back number only.
  - □ Do Not leave messages.
  - □ Retired or not working.

* List the names of individuals you authorize us to speak with regarding your healthcare.

□ None.

□ Spouse _____

□ Child _____

□ Other _____

If we are unable to reach you by any other means, we will send information through the U.S. Postal Service to your home address.

_____ _____

EYE CLINIC & LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

Signature of Patient Date

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment or health information.
- The Practice has a Notice of Privacy and that I have received this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.
- I may revoke this Consent in writing at any time and all future disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent.

This consent was signed by:_____

Signature of Patient or Representative Date

Relationship to Patient (if other than patient):_____

Witnessed by:_____

Signature of Witness Date

EYE CLINIC & LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

AUTHORIZATION TO BILL MEDICARE AND UNDERSTANDING NON-COVERED SERVICES

The fee for a medical eye exam varies depending on the level of service provided by the physician. Any additional test and or procedures will be charged and billed as allowed by Medicare. The patient is always responsible for the Medicare deductible each calendar year. Medicare pays 80% of their allowed charge. The remaining 20% is the patient's responsibility.

When assignment is accepted on a claim, physicians may bill beneficiaries for services that are denied as non-covered services. While the assignment agreement prohibits physicians from collecting more than the Medicare allowed charge for services, it does not prohibit collecting non-covered services. Collection for non-covered services applies to services that are not normally covered by Medicare, such as annual or routine exams, as well as services deemed not medically necessary.

The following are examples of non-covered services, collected the day of services:

1. Eye Refraction 92015
2. Contact lens / fitting
3. Medications
4. Cosmetic Procedures

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of Medical or Other information about me to release to the Social Security Administration or its intermediaries of carries any information needed for Insurance related claims. I request that the payment of authorized benefits be made on my behalf to the physicians and /or organization. I accept financial responsibility for any denied services or uncovered services as stated above.

IMPORTANT INFORMATION ABOUT YOUR EYE EXAMINATION

If you choose to be checked for an eye glass prescription (refraction) there will be a $35.00 charge. This charge is totally independent of whether the prescription changed. _____ Initial

Payment is required for **any charges not covered** by your Insurance Company at the time of service. **NO EXCEPTIONS!**
_____ Initial

Any co-payment of the eye examination charges is due on the day of service.
_____ Initial

If you have not met your insurance's annual deductible for the year, payment **of services is due on the same day of your examination.** _____ Initial

It is your responsibility to get an authorization for your visits, should your insurance require it. Should you fail to do so and the insurance does not pay, it will be your responsibility to pay the amount due.
_____ Initial

_____ _____ _____/_____/_____

EYE CLINIC & LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

Patient Signature Printed Name Date

PATIENT REGISTRATION

LAST NAME_____FIRST NAME & MIDDLE INITIAL_____
ADDRESS_____CITY_____ST_____ZIP_____
HOME PHONE(_____) _____-____ ___ CELL PHONE (_____)_____-_____ WORK (___)_____-_____
E-MAIL_____
PRIMARY CARE PHYSICIAN_____
REFERRING PHYSICIAN_____
DATE OF BIRTH___/_____/_____SEX_____ MARITAL STATUS_____
SOCIAL SECURITY NUMBER_____-_____-_____ETHNICITY_____RACE_____
LOCAL PHARMACY_____LOCATION_____
EMPLOYER NAME_____
EMPLOYER ADDRESS_____
PRIMARY INSURANCE_____MEMBER/GROUP#_____
SECONDARY INSURANCE_____ MEMBER/GROUP#_____

FOR INSURANCE PURPOSES, PLEASE LIST THE RESPONSIBLE PARTY'S (SUBSCRIBER'S):

LAST NAME_____FIRST NAME & MIDDLE INITIAL_____
ADDRESS_____CITY_____ST_____ZIP_____
HOME PHONE(_____) _____-____ ___ CELL PHONE (_____)_____-_____ WORK (___)_____-_____
E-MAIL_____
RELATIONSHIP TO PATIENT_____RESPONSIBLE PARTIES D.O.B___/_____/_____
SOCIAL SECURITY NUMBER_____-_____-_____LANGUAGE OF CHOICE_____

EMERGENCY CONTACT INFORMATION

NAME_____PHONE (___)_____-_____-_____

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

PATIENT SIGNATURE (OR PARENT IF A MINOR)_____DATE_____/_____/_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTED TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES.

PATIENT SIGNATURE (OR PARENT IF A MINOR)_____DATE_____/_____/_____

EYE CLINIC & LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

MEDICAL HISTORY

Name: Sex: Date of birth: ____/_____/_____Height _____Weight _____

Are you presently under the care of a physician? Yes / No If so, physician's name: _____

List ALL medications you are currently taking _____

List ALL of your allergies _____

PLEASE CHECK ALL OF THE EYE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

__ Redness __ Light sensitivity __ Dry eye feeling __ Eye Pain/Soreness __ Mucous discharge __ Sties/Chalazion

__ Chronic infection of eye or lids __ Sandy or gritty feeling __"Tired" eyes __Itching/Burning __ Fluctuating visual acuity

__ Other _____

Do you use lubricating eye drops? Yes / No What name brand? _____

Do you wear contact lenses? Yes / No How long have you had them? _____

Are they comfortable? Yes / No Have you tried wearing them before and discontinued use? Yes/No

Do you wear glasses? Yes / No How long have you had them? _____

Have you ever had an eye injury? Yes / No Describe: _____

OVERALL MEDICAL HISTORY

Please indicate if you or a blood relative have or have had any of the following conditions:

Macular degeneration	[_] No	[_] Self	[_] Family	Relationship: _____
Diabetes	[_] No	[_] Self	[_] Family	Relationship: _____
Heart disease	[_] No	[_] Self	[_] Family	Relationship: _____
High blood pressure	[_] No	[_] Self	[_] Family	Relationship: _____
Cancer	[_] No	[_] Self	[_] Family	Relationship: _____
Type: _____				
Asthma/Respiratory	[_] No	[_] Self	[_] Family	Relationship: _____
Arthritis	[_] No	[_] Self	[_] Family	Relationship: _____
Epilepsy	[_] No	[_] Self	[_] Family	Relationship: _____
Stroke	[_] No	[_] Self	[_] Family	Relationship: _____
Headaches/Migraines	[_] No	[_] Self	[_] Family	Relationship: _____
Glaucoma	[_] No	[_] Self	[_] Family	Relationship: _____
Allergies	[_] No	[_] Self	[_] Family	Relationship: _____
Gastrointestinal/Liver	[_] No	[_] Self	[_] Family	Relationship: _____
Blood disorder	[_] No	[_] Self	[_] Family	Relationship: _____
Type: _____				
Kidney stones	[_] No	[_] Self	[_] Family	Relationship: _____
Kidney failure	[_] No	[_] Self	[_] Family	Relationship: _____

SOCIAL HISTORY

Do you smoke? Yes / No Number of packs per day: _____

Do you drink alcohol? Yes / No Number of drinks per day: _____

Do you use Illegal drugs? (cocaine, marijuana, etc.) Yes / No

Patient signature _____ Date _____/_____/_____

EYE CLINIC
& LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

Pre- Screening Form

The Eye Clinic & Laser Institute provides a full spectrum of ophthalmic and related services to our patients. Please take a moment to fill out the following form to help us identify any area of concern or interest you may have.

The Hearing Clinic (Get a FREE Hearing Test Today!)

_____ Does a hearing problem cause you difficulty when communicating?
_____ Do hearing limitations affect your personal or social life?
_____ Do you have difficulty in social settings when background noise is present?
_____ Have you had a hearing screening in the last 12 months?
_____ Do you have ringing in your ears? (Tinitus)

THE ALLERGY CLINIC

_____ Do you have long lasting nasal congestion, runny nose, or sinus infections?
_____ Do you have long lasting cold-like symptoms or loss of taste/smell?
_____ Do you experience a poor response to anti-histamines and nasal sprays?
_____ Do you have nasal polyps or have you had surgery for nasal polyps?
_____ Do you have dry or itchy eyes?

EYE CLINIC & LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

How Did You Hear About Us

PATIENT NAME _____

☐ PHYSICIAN NAME

_____

☐ TV

☐ CNN ☐ ESPN2 ☐ OXYGEN ☐ GOLF CHANNEL ☐ NEWS 13 CHANNEL

☐ FLORIDA TODAY NEWSPAPER

☐ MAILER / POSTCARD

☐ Website

☐ Friend or Colleague

☐ Web search (Google / Bing / Yahoo)

☐ Other_____

_____

_____

EYE CLINIC
& LASER INSTITUTE
SINCE 1980

MUKESH C. AGGARWAL, M.D.
Board Certified Ophthalmologist

NICHOLAS A. PEFKAROS, M.D.
Board Certified Ophthalmologist

CRAIG COLE, M.D.
Board Certified Ophthalmologist

OMAR M. KAZI
Board Certified Ophthalmologist

We are excited to announce that all Eye Exams Now Include a Hearing Screening

Why are we doing this?

As we progress in age, a hearing loss can happen and develop gradually and often can be undetected. This creates safety and health issues that can affect your independence and quality of life. Because of the documented link between Vision and Hearing, Eye Clinic & Laser Institute has added a hearing services department as part of our commitment to become a dual sensory practice.

As a part of your visit today, we will perform a brief hearing screening. You will be asked by our technician to identify a series of tones to determine if you are experiencing any hearing loss.

Our Physician will address the results of your hearing screening. If needed, a follow-up visit for an Expanded Hearing Exam with our Hearing department professional will be recommended. There is no additional fee for this service as we now include it as a part of our eye care appointment.

Thank you,

Mukesh C. Aggarwal M.D.