PATIENT DATA SHEET

Date _____ Emp. Initials _____

NAME: LAST _____ FIRST _____ MI _____ AGE _____ SEX: M/F

PREFERRED NAME:_____ HOME PHONE_____

BIRTH DATE _____/____/_____ CELL PHONE: _____

ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP _____ SSN _____ - ___ - _____

E-MAIL ADDRESS: _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE_____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS: SINGLE WIDOWED DIVORCED MARRIED SPOUSE: _____

SPOUSE'S EMPLOYER: _____

Insured/Patient information

PRIMARY INSURANCE _____ PHONE NUMBER _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ID# _____ GROUP#_____

INSURED'S EMPLOYER_____ PHONE _____

DATE OF BIRTH _____ SSN _____ - ___ - _____

PRIMARY PHYSICIAN _____ PHONE_____

SECONDARY INSURANCE _____ PHONE_____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ID# _____ GROUP#_____

DATE OF BIRTH _____ SSN _____ - ___ - _____ WORK PHONE_____

IF PATIENT IS A CHILD, ALL INFORMATION BELOW MUST BE COMPLETED

PARENT/GUARDIAN NAME_____

ADDRESS_____ APT# _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ DATE OF BIRTH _____

PARENT SSN _____ - ___ - _____ EMPLOYER_____

SPOUSE'S NAME _____ WORK PHONE_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

EMERGENCY CONTACT (FAMILY, CLOSE FRIEND, NEIGHBOR):
NAME _____ **PHONE**_____
ADDRESS _____**CITY** _____ **ZIP**_____
CLOSEST RELATIVE NOT LIVING WITH YOU:
NAME _____ **PHONE**_____
ADDRESS _____**CITY** _____ **ZIP** _____

*******INSURANCE INFORMATION*******

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I hereby assign any and all payment of benefits to Sighttrust eye institute, upon their acceptance of assignment. A photocopy of this release/assignment of benefits is to be considered as valid as an original. In addition, **I understand that my signature below constitutes a once in a lifetime signature on file.**

Payment or co-payment is expected at time of service. We accept cash, checks, visa, MasterCard, or American Express. We can arrange a payment plan in some cases, but they must be made in advance**.**

If your account is placed with a collection agency, you will be charged all costs relating to collecting this account (collection fees, court costs, atty. fees, etc.)

You are responsible for: Any unmet deductibles - non-covered services - all charges not paid by insurance.

IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN REFERRALS FROM PRIMARY CARE PHYSICIANS, IF REQUIRED, AND TO KEEP INSURANCE INFORMATION UP TO DATE.

In filing your insurance claims, remember, however that your insurance contract is between you and the insurance company. The final responsibility for your bill is with you. If your insurance company does not pay within 60 days, or your coverage has terminated prior to services being rendered, you will be responsible for payment of these services at our customary rates.

I hereby consent to the examination and treatment as deemed necessary by physicians of Sighttrust eye institute. I have read (or had read to me) the above information and have a full understanding of its meanings.

I give consent for the following: (Circle one)

Messages left at home: Yes No / At work: Yes No
E-mail messages: Yes No
Mail regarding personal health information: Yes No

I HAVE READ OR HAVE BEEN OFFERED THE OPPORTUNITY TO READ THE "NOTICE OF PRIVACY PRACTICE".

***** PLEASE GIVE 24HOUR NOTICE WHEN CANCELLING AN APPOINTMENT*****

_____ _____
SIGNATURE **DATE**

HEALTH HISTORY

PATIENT NAME_____ **DATE**_____

Yes	No		Yes	No	
☐	☐	Lung Disease -Type:_____	☐	☐	Head or Spinal Injuries _____
☐	☐	Kidney Disease:_____	☐	☐	Seizures, Convulsions, Fainting_____
☐	☐	Arthritis:_____	☐	☐	Temporal Arteritis_____
☐	☐	Diabetes_____ #of Yrs____	☐	☐	Carotid Artery Disease _____
☐	☐	Neurological Disease:_____	☐	☐	(Women) Are you pregnant or nursing? _____
☐	☐	Migraines _____	☐	☐	Stroke_____
☐	☐	Psychiatric Disorder_____	☐	☐	HIV/AIDS _____# of Yrs _____
☐	☐	Nervous Disorder _____	☐	☐	Extensive Confinement from Illness or Injury_____
☐	☐	Heart Disease _____	☐	☐	Permanent Defect from Illness, Disease or Injury _____
☐	☐	Gastrointestinal Disease – Type: _____	☐	☐	Suffering from any other Disease _____
☐	☐	High Blood Pressure:_____ #of Yrs____	☐	☐	Do You Smoke? #___Packs per ☐Day ☐ Week ☐Month
☐	☐	Scarring / Keloids	☐	☐	Do You Drink? # ___per ☐Day ☐Week ☐Month
☐	☐	Are You Allergic to Latex, Rubber (Balloons)?	☐	☐	Are You Allergic to Bananas, Pears Avocado, Chestnuts?
☐	☐	Thyroid Disease	☐	☐	Do You Live Alone?
☐	☐	Herpes:	☐	☐	Prostate Disease:_____

YOUR MEDICAL DOCTOR_____

Please List All Medications You Are Currently Taking:

_____

_____

_____

_____

Please List All Medication Allergies:

_____

_____

_____

_____

Have You Been Diagnosed With or Treated for Any of the Following:

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Corneal Disease
☐	☐	Crossed Eyes	☐	☐	Glaucoma
☐	☐	Retinal Disease _____	☐	☐	Iritis
☐	☐	Injury _____	☐	☐	Other Eye Disorders: _____

Cataract Surgery Date: _____Right Eye _____Left Eye

Do You Have a Lens Implant? Yes ☐ No ☐

Other Eye Surgery/Date: Right Eye_____ Left Eye_____

Type of Eye Injury (if any): _____

Has any Family Member (Mother, Father, Sisters or Brothers) Been Treated for the Following?

Yes	No		Yes	No	
☐	☐	Glaucoma _____	☐	☐	Retinal Detachment _____
☐	☐	Cataracts _____	☐	☐	Corneal Disease _____
☐	☐	Macular Degeneration _____	☐	☐	Retinitis Pigmentosa _____
☐	☐	Diabetic Retinopathy _____	☐	☐	Other Eye Problems _____
☐	☐	Diabetes _____	☐	☐	Heart Disease _____
☐	☐	Stroke _____	☐	☐	Other Health Conditions _____

Please List any Previous Surgeries and their Date: (Please continue on back of form)

_____ _____

_____ _____

Tech. Signature: _____ Doctor Signature: _____

Date_____ Name_____

Cataract and Refractive Lens Exchange Questionnaire

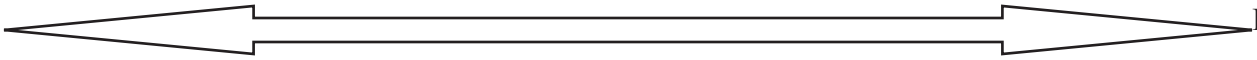
The term "cataract" refers to a cloudy lens within the eye. When a cataract is removed, an artificial lens is placed inside the eye to take the place of the human lens that has become the cataract. Occasionally, clear lenses that have not yet developed cataracts are also removed to reduce or eliminate the need for glasses or contacts. This questionnaire will help us to provide you with the lens that is best suited for your needs. Many patients still need to wear glasses for some activities after surgery. Please fill this form out completely and return it to our staff when you have finished. If you have questions, please let us know and we will assist you with this form.

1. How important is it to you to be able to see well **at distance** without glasses after surgery?
___Prefer no distance glasses ___Not important to me. I wouldn't mind wearing distance glasses.

2. How important is it to you to be able to see well **at near** without glasses after surgery?
___Prefer no reading glasses ___Not important to me. I wouldn't mind wearing reading glasses

3. Zones of Vision.

We divide vision into 5 "Zones of Vision"

Near  **Far**

Zone 1 (12-20 in)	**Zone 2 (2-4 ft.)**	**Zone 3 (6-20 ft.)**	**Zone 4 (20-100 ft.)**	**Zone 5 (100 ft.+)**
Newsprint	Shelves	Indoors	Day-far	Night-far
Phone book	Computer	TV	Driving	Night driving
Maps	Dash board	Cooking	Road signs	Movies
Sewing			Cleaning	Landscapes

**Golfing applies to All Zones.

Which group of "Zones of Vision" is the **most** important group to you? Please choose **only one** of the following three options of Group A, B or C:

____Group A: Zones 1, 2 and 3. ____Group B: Zones 2, 3 and 4. ____Group C: Zones 3, 4 and 5.

4. If you **had** to wear glasses after surgery for one type of activity, for which activity would you be **most** willing to use glasses? **____Reading fine print ____Computer ____Driving**

5. If you could have good **distance vision during the day** without glasses, and good **near** vision for reading without glasses, but the compromise was that you **might** see some **halos** around lights at night, would you like that option? **____Yes ____No**

6. If you could have good **distance vision during the day and night** without glasses, and good **computer-distance (Zone 2)** vision without glasses, but the compromise was that you might need glasses for reading the finest print at near, would you like that option? **____Yes ____No**

7. Please place an "X" on the following scale to describe your personality as best you can:

[----------I----------]
Easy going Perfectionist

Please Sign Here: _____

PATIENT RIGHTS:

The patient has the right to:

- Be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Know of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of source of payment.
- Receive upon request, full information and necessary counseling on the availability of known financial resources for his /her care, including information regarding facilities discount and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
- The patient has the right to be advised as to the reason for the presence of any individual involved in his /her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility.
- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.

The patient's written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.

- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trails. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided it subjects will be contained in the medial record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate, thereof, of the continuing healthcare requirements following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

PATIENT RESPONSIBILITIES:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders
- The patient is responsible for reporting to the health care provider any unexpected changes in his/her condition.
- The patient is responsible of providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.

- The patient is responsible for his/her actions should he/she refuse treatment or not follow their physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient's advance directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

ADVANCE DIRECTIVE NOTIFICATION:

In the state of Florida, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. SightTrust Eye Institute upholds those rights.

However, unlike in an acute care hospital setting, the Surgery Center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney. Your agreement with this facility's policy will not suspend any current health care directive or health care power of attorney while at this facility.

If you wish to complete an Advance Directive, copies of the official state forms are available at our facility or you may obtain a copy via the website:

http://ahca.myflorida.com/mchq/health_facility_regulation/HC_Advance_Directives/index.shtml

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the states laws, the rights of the patient are exercised by the person appointed and /or the legal representative designated by the patient under Florida law to act on the patient's behalf. The center will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

PATIENT COMPLAINT OR GRIEVANCE:

If you have a problem or complaint, please speak to the receptionist or your care giver. We will address your concern(s) promptly.
If necessary, your problem or complaint will be advanced to the Manager for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.

If you are not satisfied with the response of the facility, you may contact:

Clinical Director
Sight Trust Institute
1601 Sawgrass Corporate Parkway
Sunrise, FL 33323
(954) 653-0100

Patient complaints or grievances may be filed through the State of Florida Consumer Services Unit at 1-888-419-3456 or write to the addresses below:

If you have a complaint against a health care professional and want to receive a complaint form:

Department Of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

You may also contact AAAHC by mail at:
Accreditation Association for Ambulatory Health Care,
5250 Old Orchard Road, Suite 200
Skokie, Illinois 60077

By signing this document, I acknowledge that I have read and understand its contents:

By:

_____

(Patient/Patient Representative Signature) Date:

SightTrust Eye Institute

Notice of Health Information Practices

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices SightTrust.

I understand that SightTrust is committed to treating and using protected health information about me responsibly.

I understand my rights as they relate to my records at SightTrust and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of SightTrust, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that SightTrust is required to maintain the privacy of my health information. SightTrust will require my authorization to release my health information to outside sources with the exception of disclosures for the purposes of Treatment, Payment and Healthcare operations. These may include: access to my health information by SightTrust staff and physicians: billing to myself or to a third-party payer; in addition, business associates of SightTrust, may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgement, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.

SightTrust may call me with appointment reminders, cancellations and may leave voice messages at my home or place of employment.

I have read and understand the Health Information Practices of SightTrust.

HIPAA Contact List

SightTrust and its associates and staff have my permission to speak to the following family members/friends in reference to my medical care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

SightTrust; its associates and staff have my permission to leave a message on my home answering machine: yes _____no _____and/or call me at my place of work: yes _____no_____

Patient Signature: _____ Date: _____