Ram Eye Care and Retina Center
PERSONAL INFORMATION FORM

************PLEASE PRINT************

Name_____M/F_____Date_____

Date of Birth_____Age_____Social Security# _____

Address_____City_____State_____

Zip Code_____Phone#_____Cell#_____Married___Single_

Employer_____Work Phone#_____

Primary Care Physician_____Phone#_____

Email Address_____

Spouse's Name_____Spouse's Employer_____

Emergency Contact Name_____Relation_____Phone# _____

INSURANCE INFORMATION (We only file two insurances per person)

Primary Insurance_____

Secondary Insurance_____

Policy Holder's Name_____Relation_____

Policy Holder's Date of Birth_____Policy Holder's Social Security#_____

Pharmacy Name/Location/Phone#_____

WAIVER OF LIABILITY: DR. RAMCHANDER'S STAFF HAS INFORMED ME THAT A REFRACTION (EYEGLASSES TEST) IS NOT COVERED BY MEDICARE OR MOST OTHER INSURANCE COMPANIES, AND IS NOT CONSIDERED A MEDICAL PROCEDURE. I UNDERSTAND THAT IF THE INSURANCE COMPANY DENIES THIS PROCEDURE, I WILL BE FINANCIALLY RESPONSIBLE FOR THIS $45 CHARGE.

SIGNATURE_____DATE_____

RAM EYE CARE CENTER
OFFICE BILLING POLICY

FINANCIAL ASSIGNMENT AND AGREEMENT:

PAYMENT IS DUE UPON RECEIPT. PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED IF YOUR DEDUCTIBLE HAS NOT BEEN MET & IF YOU HAVE A COPAY.

PLEASE NOTE THAT YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY OF THIS CONTRACT. SO, YOU ARE THE ULTIMATE RESPONSIBLE PARTY FOR THE PAYMENT OF YOUR EYE CARE. THE PATIENT/LEGAL GUARDIAN WILL BE RESPONSIBLE FOR THE SERVICES RENDERED. IF YOUR INSURANCE COMPANY REQUIRES AN AUTHORIZATION, IT IS YOUR RESPONSIBILITY TO OBTAIN THE AUTHORIZATION PRIOR TO YOUR APPOINTMENT FROM YOUR PCP.

IF YOU WISH TO CANCEL OR RESCHEDULE YOUR APPOINTMENT PLEASE CALL US ATLEAST 24 HOURS IN ADVANCE OR YOU MAY BE CHARGED A FEE OF $30.00.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND OR INSURANCE BENEFITS BE MADE ON MY BEHALF FOR ANY SERVICES FURNISHED BY ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION, ITS AGENTS, OR ANY INSURANCE CARRIER I MAY HAVE, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY NECESSARY TO SECURE THE PAYMENT.

SIGNATURE_____**DATE**_____

INFORMED CONSENT FOR DILATING DROPS

Dilating drops are used to dilate the pupils of the eye to allow Dr. Ramchander to get a better view of the inside of the eye. Dilating drops blur vision for a length of time which varies from person to person and will make bright light bothersome. It is not possible to predict how much your vision will be affected. Because driving may be difficult immediately after your examination it is best that you do not drive yourself. I hereby authorize RAM EYE CARE CENTER to administer dilating drops. The eye drops are necessary to diagnose my condition.

SIGNATURE_____**DATE**_____

RAM EYE CARE AND RETINA CENTER

NAME:_____ **DATE:**_____

Referred by Physician? **YES** **NO** Name of referring Physician:_____

Thank you for choosing **RAM EYE CARE AND RETINA CENTER** for your eye care. To better serve you, please answer the following questions:

1. **Are you CURRENTLY experiencing any eye symptoms? Circle all that apply:**

eye pain	**blurred vision**	**eyelid crusting**
discharge	**light sensitivity**	**double vision**
halos	**reading problems**	**decreased vision**
floaters	**flashing lights**	**other:**_____

2. **Have you ever been treated for any eye disease? YES NO**
   If yes, please explain:_____

3. **Have you ever had eye surgery (Cataract or Retinal) or any type of eye lasers? Please list type, which eye and approximate dates:**

   _____ **R/L**_____

   _____ **R/L**_____

4. **Are you currently using any eye medications? List name and how often used:**

   _____

5. **Are you taking or being treated for any medical conditions? Please circle all that apply:**

   diabetes **heart disease** **high blood pressure** **lung disease**
   high cholesterol **arthritis** **thyroid disease** **stroke**
   other:_____

6. **What medications are you taking? Please list: (Exclude eye medications)**

   _____

   _____

7. **Are you allergic to any medications? Please list:** _____

   _____

8. Do you have any family history of eye problems?

	Family Relationship:
_____Glaucoma	_____
_____Macular Degeneration	_____
_____Retinal Detachment	_____
_____Other	_____

Please tell us how you learned about RAM EYE CARE AND RETINA CENTER! Fill out all that apply and the name associated with the referral. Thank You!

Physician Referral_____ Patient_____
Friend_____ Yellow Pages_____
Newspaper Ad_____ Former Lake Eye Patient_____
Other_____

REVIEW OF SYSTEMS:	YES	NO	If yes, please explain
Do you <u>currently</u> have any of the following problems?			
Chronic fever, unexpected weight loss/gain	____	____	_____
Ear/Nose/Throat problems	____	____	_____
Heart problems	____	____	_____
Respiratory problems	____	____	_____
Gastrointestinal problems	____	____	_____
Urinal problems	____	____	_____
Skin problems	____	____	_____
Musculoskeletal problems	____	____	_____
Neurological problems	____	____	_____
Psychiatric problems	____	____	_____
Other	____	____	_____

SOCIAL HISTORY: Do you smoke? If yes, how much?_____
Do you drink alcohol? YES NO Socially Other

_____
Signature of Patient (Parent/Guardian for minor patient) Date

Ram Eye Care Center MD, PA
1131 E North Blvd.
Leesburg, FL 34748
(352)365-2333

I have read and understand these rights set forth under HIPAA

PRINT NAME: _____ (Patient's name)

SIGN NAME: _____ (Please sign parent/guardian's name if minor)

DATE: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate