VASSALLO EYE
INSTITUTE, P.A
JOHN M. VASSALLO, M.D.

PATIENT INFORMATION FORM

APPOINTMENT DATE: _____ REASON FOR VISIT: _____

LAST NAME: _____ FIRST NAME _____ : MIDDLE NAME: _____

SOCIAL SECURITY#: _____ DATE OF BIRTH: _____ SEX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____ Email address: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

REFERRING PHYSICIAN NAME: _____ PHONE: _____ ADDRESS: _____
IF NOT REFERRED BY A PHYSICIAN, PLEASE CIRCLE AND PROVIDE SOURCE BELOW:

Insurance Company Friend/Relative Advertisement Word of Mouth

EMPLOYER INFORMATION:

EMPLOYER (IF RETIRED. PLEASE STATE RETIRED):

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ ID#: _____ GROUP #: _____

POLICY HOLDER: _____ DOB: _____ SS#: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ ID#: _____ GROUP#: _____

POLICY HOLDER: _____ DOB: _____ SS# _____ RELATIONSHIP TO PATIENT: _____

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN AND RELEASE -INFORMATION:

I request that payment of authorized Medicare/insurance benefits be made on my behalf to Vassallo Eye Institute, P.A, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Any service not covered or paid by your insurance plan will be my responsibility.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____ DATE: _____

CONSENT FOR TREATMENT:

I hereby authorize treatment/care from Dr. John M. Vassallo

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____ DATE: _____

Vassallo Eye Institute, P.A

John M. Vassallo, M.D.

PATIENT HISTORY: GENERAL MEDICAL BACKGROUND

NAME:_____DATE:_____

PLEASE CHECK ALL ANSWERS THAT APPLY:

1. DO YOU HAVE OR HAVE YOU EVER HAD:

_____Diabetes
_____Elevated Thyroid Levels
_____Low Thyroid Levels
_____Cancer of _____
_____Tumor of_____
_____Psych. Therapy
_____Heart Disease
_____Asthma
_____COPD
_____High blood pressure
_____Severe low blood pressure
_____Glaucoma
_____Retinal Detachment
_____Tuberculosis
_____Seizures or meningitis
_____Multiple sclerosis
_____Stroke
_____High Cholesterol
____Hepatitis
_____AIDS
_____Arthritis or skeletal problems

2. DO ANY BLOOD RELATIVES HAVE:

_____Diabetes
_____Hypoglycemia
_____Bleeding or clotting disorder
_____Cancer
_____Heart disease
_____Other major medical problems such as those above.
Please list:_____

3. MEDICATION ALLERGIES (Please specify if No Known Allergies): _____

4. LIST ALL CURRENT MEDICATIONS AND DOSES (INCLUDE BIRTH CONTROL PILLS AND VITAMINS):

_____

_____

_____

_____

_____

_____

5. DO YOU USE EYE DROPS?_____YES_____NO WHAT KIND?_____HOW OFTEN? _____

6. DO YOU WEAR GLASSES OR CONTACT LENSES?_____YES_____NO

7. DO YOU HAVE AN OPTOMETRIST? _____YES_____NO

8. ARE YOU CURRENTLY OR DO YOU FREQUENTLY SUFFER FROM THE FOLLOWING CONDITIONS?

_____ WATERY EYES
_____ RED EYES
_____ FILM OVER EYES
_____DRY OR SCRATCH EYES
_____EYE SWELLING OR ITCHING
_____GLARE OR HALOS FROM CAR LIGHTS OR SUNLIGHT
_____FLASHES OF LIGHT, FLOATERS OR SPOTS IN VISION? EXPLAIN _____
_____TROUBLE READING SMALL PRINT OR ROAD SIGNS

NAME:

9. LIST OPERATIONS (PLEASE INCLUDE ANY SURGERIES ON YOUR EYES AS WELL):

_____

_____

10. SMOKING HISTORY:

_____ Never.

_____ Quit. When?_____Smoked about_____per day for_____years.

_____ Smoke_____packs per day. Have smoked for_____years.

_____ Used to smoke_____packs per day.

11. ALCOHOL:

_____No (rarely) alcohol.

_____ Yes. How much of what per day?

12. LIST OTHER DRUGS YOU USE:

_____ Marijuana _____Cocaine _____Other
Please list:

13. ARE YOU CURRENTLY CONTEMPLATING OR INVOLVED IN LITIGATION (LEGAL ACTION) RELATED TO YOUR HEALTH?_____Yes_____No

I agree to arbitrate any disagreement, controversy, or claim, which cannot be otherwise resolved to my satisfaction, arising out of or relating to any services provided by Vassallo Eye Institute and to settle any dispute by arbitration in accordance with the rules of the American Arbitration Association, which provides dispute resolution services.

I have read and fully understand this agreement.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

Acknowledge of Receipt of Privacy Notice for Vassallo Eye Institute, P.A

Patient Name:_____ Date of Birth: _____

Social Security Number: _____

We are required by law to make available to you a copy of our Notice of Privacy Practices. A copy is available for you at the reception window and you may take this copy with you if desired. Please sign below to acknowledge that a copy of our privacy practices was made available to you.

Signature of Patient_____ Date_____

You may authorize certain individuals to be involved in your care. This consent for disclosure includes both health and financial as it relates to your care. Below you may list those individuals for which our office is allowed to release your Protected Health Information.

Individual's Name (Please Print)	Relationship to Patient

_____ _____

Your Signature is needed for Permission Date

Welcome to Vassallo Eye Institute, P.A!

Our goal is to provide you with quality, state of the art patient care in a cost effective manner. In order to maintain that goal we have established the following policies to improve communication regarding appointments, medical records, and your financial responsibility at the time of service or prior to any scheduled surgery. If you have any questions, please feel free to ask a staff member.

YOUR INSURANCE POLICY:

Copay/Coinsurance and Deductibles: It is the policy of Vassallo Eye Institute to collect all applicable
Co-pays, coinsurances and/or deductibles prior to seeing the physician or prior to surgery. In the event you are unable to pay the co-pay, coinsurance and/or deductable, your appointment may be rescheduled. Please be aware that your insurance may require a higher co-payment for a specialist office visit.

Pre-Certification or authorization for a service is not a guarantee of benefits. Benefits are determined when your insurance company receives our claim. If no benefits are due, you will be responsible for any balance pertaining to denied services
HMO INSURANCES: It is the patients responsibility to get any authorizations for services prior to their appointments.

Federal Law prohibits our office from writing off any balance due after insurance. Patients that are experiencing financial difficulties should speak to the office manager prior to their office visit.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment and we reserve the right to charge $40 for missed or late cancelled appointments. This fee is not covered by your insurance company. Excessive abuse of scheduled appointments may result in discharge from the practice. Our office understands that emergencies do arise, but please call our office to discuss this with a staffmember.

MEDICAL RECORDS: Upon request we will provide you with copies of your medical records. However, this can be time consuming, so we charge $1 a page with a minimum of $5. Your insurance company does not cover this fee.

MEDICAL FORMS: A fee of $25 is charged for completion of a medical form. A charge of $40 will apply to forms consisting of more than one page or for narrative reports.

Your Account: You will be mailed a statement on a monthly basis for any balance due. We request that you pay upon receipt of the statement. Should you have any questions concerning your statement, please do not hesitate to contact our office. We will make an attempt to collect any prior balance at your office visit, as well as applicable copayment and deductible. Your account must be current prior to any scheduled appointments. If your account is past due, then future services may be postponed.

Seriously past due accounts - those older than 90 days or those failing to honor agreed upon payment terms - will be sent to a collection agency. Our office will forward your account balance plus any fees charged by the collection agency. Once the collection agency receives your information, your past due debt will be reported on your credit history. Additionally you may be dismissed from our practice and may need to enlist the care of a new health care provider. As a courtesy, we bill our patient's insurance companies, but any remaining insurance balances after 90 days become the patient's responsibility and are subject to collections as well.

PATIENT DISMISSAL: Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice.
I hereby understand and agree to the financial policies of Vassallo Eye Institute, P.A.

Patient Signature:_____ Date: _____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

_____
Name of person or organization

_____

_____
Address of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to

VASSALLO EYE INSTITUTE
3780 US HWY 1 S. PH#(904)797-7722
ST. AUGUSTINE, FL 32086 FAX #(904)797-5038

Expiration Date of Authorization
This authorization is effective through_____/_____/_____unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **THE VASSALLO EYE INSTITUTE, P.A.** You should contact the Privacy/Compliance Officer to terminate this authorization.

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____	_____
Name of Patient (Print)	Witness (Print)
_____	_____
Signature of Patient	Signature of Witness
_____	_____
Date	Date

_____
Signature of Patient Representative

_____
Relationship to Patient

_____
Date

REFRACTION: This is the test that we perform with you in order to get your glasses prescription

There is a $50 fee that is NOT covered by ANY insurance when a refraction is done.

By signing this page you are stating that you understand you will be responsible for that $50 fee at the time of service.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): DATE: