



The Eye Associates

Sight for Life & So Much More

Thank you for choosing The Eye Associates as your eye care provider. We appreciate the opportunity to provide you with professional eye care.

Enclosed you will find a blank medications list that you will need to complete and bring with you to your appointment. When completing the medications list, please include all medications and vitamins, including any over-the-counter medications and drops.

In addition, please bring the following with you the day of your visit if applicable:

- Your insurance cards and photo ID
- Your current eyewear, including sunglasses and contact lenses.
- During your examination, you will likely be dilated. Please remember to bring your sunglasses and arrange for a driver if you feel it is necessary.

Please arrive 10-15 minutes prior to your appointment to allow us to gather additional data needed for our electronic medical records system.

If you have any questions, please do not hesitate to give us a call at **941-792-2020** or toll free 1-866-865-2020.

West Bradenton Office & Surgery Center
West Bradenton The Optical Gallery
East Bradenton Office & The Optical Gallery
Ellenton Office & The Optical Gallery
Sarasota Office & The Optical Gallery
Venice Office & The Optical Gallery
Sun City Office & The Optical Gallery

• 6002 Pointe West Blvd, Bradenton, FL 34209
• 2203 61st Street West, Bradenton, FL 34209
• 6807 53rd Avenue East, Bradenton, FL 34203
• 7915 US Hwy 301 N, Suite #101, Ellenton, FL 34222
• 2111 Bee Ridge Road, Sarasota, FL 34239
• 1550 East Venice Avenue, Venice FL 34292
• 3894 Sun City Center Blvd, Sun City Center, FL 33573

• 941-792-2020
• 941-792-2020
• 941-758-1916
• 941-729-2020
• 941-923-2020
• 941-493-3763
• 813-634-2020

sight4life.com

866.865.2020

Patient Name

Date of Birth



The Eye Associates

941-792-2020 | Sight4Life.com

We want you to know that we value your privacy. Your personal information will be kept confidential and will never be sold to third parties. Your information will only be used for communications related to the services provided by The Eye Associates.

At The Eye Associates, we are always looking for ways to better serve you. For your convenience, we now utilize email, text, and phone communications for appointment reminders, eyewear ready notifications, and other communications related to the services provided by The Eye Associates.

If, at any time, you do not wish to receive email or text communications, you can opt out of these communications by following the instructions on the communication.

E-mail Address @ _____

Cell Phone Number

Print Name

Date

Patient Signature

For office use:

Entered into NextGen

Chart # _____

Initials _____



The Eye Associates

941-792-2020 | Sight4Life.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES SUMMARY

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA).

I acknowledge that I have received the attached Privacy Practices Summary.

Patient's Name	Date of Birth	Chart #
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May we release information to anyone other than you (i.e. spouse, child, friend, etc.)? YES NO
(Please circle)

If YES, please list each person:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE.

Signature of Patient or Personal Rep	Print Name
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Signature of Witness	Witness Name
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Date

The Eye Associates' Lifetime Authorization

Patient's Name

Chart #

Date of Birth

Please read the following and initial the line beside each.

_____ To obtain a complete medical eye exam, The Eye Associates may want to dilate your eyes with drops. This is not injurious to the eye. Dilating the eyes may blur vision slightly for a few hours but is not dangerous. Driving a car or using heavy machinery during this period should be done with caution.

_____ I authorize The Eye Associates to treat the above-named person and agree to pay all fees and charges for such treatment.

_____ I understand that I will be personally responsible for charges on any services not covered by Medicare or other insurance, such as refractions, contact lenses fittings, etc.

Please read the following authorizations and sign the line below.

• **MEDICARE LIFETIME SIGNATURE AUTHORIZATION and CERTIFICATION FOR PAYMENT**

I certify that the information given by me in applying for payment under Title XVII 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 or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the group medical practice, furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I also request that this authorization apply to all other insurance.

• **OTHER INSURANCE AUTHORIZATION**

I request that payment of authorized benefits be made on my behalf to the physician or group medical practice for any services furnished to me by them. I authorize any holder of medical information about me to release to [see copy of card] any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing.

The undersigned certifies that (s)he has read the forgoing and is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accept it's terms.

Signature of Patient or Personal Rep

Date

Signature of Witness

Printed Name of Witness

=====

Consent for Treatment of a Minor

I hereby authorize The Eye Associates to administer treatment as they so deem necessary to my son/daughter.

Signature of Parent or Guardian

Date

Printed Name of Parent or Guardian

Signature of Witness

Printed Name of Witness

SUMMARY OF PRIVACY PRACTICES FOR THE EYE ASSOCIATES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. For more information about these rights, please see the detailed Notice of Privacy Manual at Reception Desk.

Date of Last Revision 09/10/2013

Effective Date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of Personal Health Information. We are required to provide this Notice of Privacy Practices to you by the privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

How We May Use and Disclose Personal Health Information about You

- For medical treatment
- For Payment
- For Healthcare Operation
- For Treatment Alternatives
- For Health-related Benefits and Services
- Other Purposes For Which The Law Requires Us To Use Or Disclose Personal Health Medical Information Without Your Written Authorization

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You Have Certain Rights Regarding The Information We Maintain About You

These rights include:

- Your Right to Request Restrictions on Certain Uses and Disclosures of Personal Health Information
- Your Right to Receive Confidential Communications of Personal Health Information
- Your Right to Inspect and to Copy Personal Health Information
- Your Right to Amend Personal Health Information We Maintain About You
- Your Right to Receive an Accounting of Our Disclosures of Your Personal Health Information
- Your Right to Receive a Paper Copy of This Notice
- Your Right to File a Complaint

Omnibus Final Rule

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information technology for Economic and Clinical Health (HITECH) Act, are as follows:

- You have the right to opt out of fundraising communications from TEA and TEA cannot sell your health information without your permission
- Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in this notice will be made only with your authorization.
- If you pay in cash in full (out of pocket) for your treatment, you can instruct TEA not to share information about your treatment with your health plan
- You have the right to be notified of a data breach

Due to government regulations, we will be unable to release your Private Health or Financial Information to anyone without your permission. If you want a family member, advisor, friend, etc. to be given your Private Health or Financial Information, you must provide their name and phone number to us in writing. When someone calls inquiring about your bill, examination or surgery and they are NOT on your list, we will be unable to release any information.

For further information about matters covered by this notice, you may contact the Privacy Officer at 941-259-0903.

Name _____ DOB _____ Acct# _____ Date _____

List ALL medications that you currently take in the sections below:

Do you take any eye medications? YES NO

EYE MEDICATIONS

Strength
(mg, tablet,
drop etc.)

Directions
(times per day or week,
as needed, etc)

Medication is taken
(oral, injection,
topical, etc.)

Do you take any prescription medications? YES NO

OTHER MEDICATIONS

Strength
(mg, tablet,
drop etc.)

Directions
(times per day or week,
as needed, etc)

Medication is taken
(oral, injection,
topical, etc.)

Do you take any OTC medications? YES NO

**OVER THE COUNTER
MEDICATIONS (herbals, vitamins, etc.)**

Strength
(mg, tablet,
drop etc.)

Directions
(times per day or week,
as needed, etc)

Medication is taken
(oral, injection,
topical, etc.)

Please list any allergies to medications: _____



Patient Name _____ Chart _____ Date _____

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

Yes No When? _____

1. Do you have any of the following symptoms?

- Redness
- Burning
- Light sensitivity
- Tired eyes, eye fatigue
- Foreign body sensation
- Fluctuating vision
- Scratchy feeling of sand or grit in the eye
- Itching
- Excess tearing / watering eyes
- Stringy mucus in or around the eyes
- Contact lens discomfort

Report the FREQUENCY of symptoms you are experiencing by using the numbering system below:

1 = Sometimes 2 = Often 3 = Constant

SYMPTOMS	1	2	3
Dryness, Grittiness or Scratchiness			
Soreness or Irritation			
Burning or Watering			
Eye Fatigue			

2. Are your symptoms related to or made worse by any of the following factors?

- Windy conditions
- Places with low humidity (e.g., airplanes / hospitals)
- Areas that are air conditioned / heated
- More than 2 hours of computer / PDA use per day

3. Are you being treated for any of the following conditions?

- Diabetes
- Arthritis
- Lupus
- Dry Eye
- Thyroid Condition
- Sjögren's Syndrome
- Rosacea
- Blepharitis

** For Technician Use Only**

Attending Clinician Signature: _____ Date: _____

Technician: _____

Tear Osmolarity: OD: _____ OS: _____