THE EYE CENTER
MEDICAL & SURGICAL EYE CARE
LAURA T. MULLER, M.D.

Name: Last _____ First_____ Middle_____

Social Security #: _____ - _____ - _____ Birth Date: _____ / _____ / _____ Sex: __M __F

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: (_____) - _____ - _____ Cell Phone #: (_____) - _____ - _____

Email Address: _____

__ Single __ Married __Divorced __Separated __Widowed __ Long Term Partner

Listed below are categories required by the Federal Government

Race: ___ American Indian ___ Asian ___ African American ___Native Hawaiian ___ White

Ethnicity: __ Hispanic __Not Hispanic Preferred Language: __ English __ Other: _____

Are you employed? ___ Yes ___ No If yes, Name of Employer: _____

Referring Doctor: _____ Primary Care Doctor:_____

Reason for visit: _____

Date of your last eye exam? _____Who performed your last eye exam? _____

Please Circle or list any eye diseases that you have:

Narrow Angle Glaucoma, Open Angle Glaucoma, Cataract, Dry Eye, Retinal Detachment, Amblyopia, Diabetic Retinopathy

Other eye conditions:_____

_____

Do you use eye drops? YES / NO

Prescription eye drops: _____

Artificial Tears: _____

Have you had any eye surgery? Please list with dates and surgeon:

_____

_____

Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY: Please circle if you have any of the following conditions:

Diabetes Type 1, Diabetes Type 2, High Blood Pressure, Heart Disease, HIV, Lupus, Rheumatoid Arthritis Cancer type: _____

Other (Please list): _____

_____

Previous Surgery Excluding Eye (Please List):

_____

_____

_____

Medications / Supplements

If you have an updated medications list please attach a copy with your completed paperwork ☺

Name:	Dosage:	# Times a day	Name:	Dosage:	# Times a day

Drug Allergies (Please List):

_____

Family History: Do any of the following conditions run in the family? (Please circle and list who)

Diabetes _____ Macular Degeneration _____ Glaucoma _____ Cancer _____

Other conditions: _____

Smoking / Tobacco: YES / NO # of packs per day_____ Age when started? _____ Age when quit ____

Recreational Drug Use: YES / NO

For prescriptions we may write for you, what pharmacy do you prefer to use?

Pharmacy Name: _____Corner of: _____

Address: _____ City: _____ State: _____

Phone #: (_____) - _____ - _____ Fax #: (_____) - _____ - _____

Name: _____ **Date of Birth:** _____

Review of Systems: Do you currently have any of the following symptoms? Circle: Yes / No

Fevers	Yes / No	Rashes	Yes / No
Fatigue	Yes / No	Urinary Frequency	Yes / No
Night Sweats	Yes / No	Increased Thirst or Appetite	Yes / No
Headaches	Yes / No	Heat or Cold Intolerance	Yes / No
Hearing Loss	Yes / No	Dizziness	Yes / No
Cough	Yes / No	Emotional Distress	Yes / No
Chest Pain	Yes / No	Joint Pain	Yes / No
Vomiting	Yes / No	Weakness	Yes / No
Diarrhea	Yes / No	Difficulty Walking	Yes / No
Constipation	Yes / No	Easy Bruising	Yes / No
Painful Urination	Yes / No	Abnormal Bleeding	Yes / No
Blood in Urine	Yes / No	Food / Environmental Allergies	Yes / No

Is there anything else that you would like for us to know?

Thanks for filling out our paperwork!

The Eye Center
Medical & Surgical Eye Care

Laura Muller M.D. (727) 216-2020

The Eye Center has updated their Privacy Notice as of July 1, 2017. Please review, sign and return to the front desk or mail to: 3155 Curlew Road, Oldsmar, FL 34677.

NOTICE OF PRIVACY PRACTICES

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

At The Eye Center, we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective July 1, 2017. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit The Eye Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your health information.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of The Eye Center, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. We maintain an electronic medical record ("EMR"), you have the right to access your EMR in a machine readable electronic format and to direct us to send a machine readable copy directly to a third party. The Eye Center will charge you a reasonable cost-based fee for the cost of supplies and labor of copying.
- Amend your health record which you believe is not correct or complete. The Eye Center is not required to agree to the amendment if The Eye Center did not create the information or if it is correct or complete.
- Obtain an accounting of disclosures of your health information.
- Communications of your health information by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases The Eye Center is not required to agree to these additional restrictions, but if The Eye Center does, The Eye Center will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). The Eye Center must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a copy of your health care information in paper or a machine readable electronic format.

Our Responsibilities

The Eye Center is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect.
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the The Eye Center, P.A.'s Privacy Officer at: (727) 216-2020 or the address listed at the top of this Notice.

If you believe your privacy rights have been violated, you can file a written complaint with The Eye Center's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, The Eye Center operates an EMR. This is an electronic system that keeps health information about you. The Eye Center may also provide a subsequent healthcare provider with health information about you (e.g., copies of various reports) that should assist him or her in treating you in the future. The Eye Center may also disclose health information about you to, and obtain your health information from, electronic health information networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

The Eye Center may use a prescription hub which provides electronic access to your medication history. This will assist The Eye Center health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to provide services on our behalf and disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

The Eye Center

Medical & Surgical Eye Care

Laura Muller M.D. (727) 216-2020

Financial Policy *updated 6-8-17*

As a courtesy to you, our patient, our office will file your insurance(s) for you. However, since the coverage is a contract between you and the insurance company, it is ultimately the patient's responsibility to ensure that services are paid in a timely manner. If your procedure is a non-covered benefit, according to your insurance policy, it becomes an expense billable to you.

If you are a member of an **HMO policy**, which requires an authorization from the primary care physician, **IT IS THE PATIENT'S RESPONSIBILITY** to obtain any and all authorizations *prior to your visit*. If the authorization is not in our office at the time of service, it may be necessary to reschedule your visit.

All **Co-Payments** are due at the time of service and will be collected at the front desk when you sign in. All **Coinsurances and/or Deductibles** are also due at the time of service. Payments can be made by check, cash or credit card. If a check is returned by your bank for any reason, you will be charged a $39.00 **Returned Check Fee,** which will be added to your account. This charge along with the amount that was returned from your bank must be paid in full by cash, credit card, or money order prior to any follow up visits.

If you are a **PRIVATE PAY PATIENT** (with no insurance coverage) all fees are due and payable at the time services are rendered, unless prior arrangements have been made with our billing department.

If you are a **PARENT/LEGAL GUARDIAN OF A MINOR,** it is your responsibility who is seeking treatment for the child to ensure that payment is rendered accordingly. Minors MUST be accompanied by a Parent/Legal Guardian at all visits.

For all **MEDICAL RECORDS REQUESTS,** the applicable form will need to be completed and signed by the patient. To cover the costs of copying and mailing, there may be a fee for medical records requests that are furnished to you. No charge will be assessed for a request to another physician. Our office will only release medical records pertaining to services performed by The Eye Center. Please provide our office 24-48 hour advanced notice when requesting records.

Cancellation of an appointment will require a 24 hour notice prior to the scheduled appointment time for cancellations. A fee of $100 may be billed to the patient if the office does not receive proper notification of cancellation.

By signing, I acknowledge that I understand that **I AM RESPONSIBLE FOR PAYMENT OF SERVICES PROVIDED.** If for any reason I am delinquent in my payments, I will be responsible for the Collection Fee of 30% plus the outstanding balance on my account, plus any attorney's fees.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THIS FINANCIAL POLICY AND A COPY SHALL REMAIN IN MY CHART.

RELEASE OF INFORMATION. By signing, I authorize Laura T. Muller, M.D. and The Eye Center to release any information with regard to my treatment, for insurance purposes. I also authorize the above physician to release my information to other physicians or institutions as necessary for my treatment. I understand that any information given with regard to my treatment shall remain CONFIDENTIAL and will be released only as necessary to my care or treatment.