NEW VISION EYE CENTER PATIENT INFORMATION SHEET

Patient Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Is This Address: ○ Private residence ○ Assisted living facility ○ Skilled nursing facility

Primary Phone: _____ Cell Phone: _____

Email Address: _____

How would you like us to contact you? ○ Phone ○ Text ○ Email

Patient Employer: _____ Employer Phone: _____

Marital Status: _____ Sex : (M) (F) Date of Birth: ___/___/___

Social Security Number: _____

Emergency Contact Name: _____ Relationship to Contact: _____

Emergency Contact Number: _____

Responsible Party Name: _____ Phone: _____

Address: _____ City: _____ State: ___ Zip: _____

The information below is required for Electronic Medical Records:

Pharmacy Name & Location: _____

Preferred Language: _____

Ethnicity: ○ Non-Hispanic or Latino ○ Hispanic or Latino

Race: ○ Asian ○ Black | African American ○ White ○ Other
○ American Indian or Alaska Native ○ Native Hawaiian or Pacific Islander

Which Doctor are you here to see?:
○ O'Brien ○ Tate ○ Reinauer ○ Seery

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Primary Cardholder Name and DOB: _____ ___/___/___

How did you hear about us? Please check all that apply

○ Internet Search ○ Website ○ Social Media ○ Radio/Television ○ Print

○ Referred by: _____
(Doctor, Family or Friend Name)

○ Other: _____

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER: _____

DATE REGISTERED: _____ REGISTERED BY: _____

NEW VISION EYE CENTER

105537th Place | Vero Beach, FL 32960
T: 772.257.8700 | F: 772.257.8705
NewVisionEyeCenter.com |

PATIENT CONSENT FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. Protected health information is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Policy provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of the Notice of Privacy Policies may change. If we change our Notice, you may obtain a revised copy by contacting our information privacy official, Administrator James Hughes at 772-257-8700, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound to our agreement. If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent Form, we have the right to refuse your treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information for purposes of requesting your revocation, or you may simply send us a letter in writing. By signing this consent, you acknowledge that you have received a copy of the “Notice of Privacy Policies.”

Please list the names of additional people we may disclose your protected health information to, either by phone or documentation:

NAME: _____ RELATIONSHIP TO PATIENT: _____
NAME: _____ RELATIONSHIP TO PATIENT: _____
NAME: _____ RELATIONSHIP TO PATIENT: _____

_____ _____

Patient’s Signature Date

NEW VISION EYE CENTER
1055 37th Place | Vero Beach, FL 32960
T: 772.257.8700 | F: 772.257.8705
NewVisionEyeCenter.com |

PAYMENT POLICIES

Please read the following Payment Policies before your appointment. Our office files your insurance as a courtesy.

If your doctor is an in-network provider for your insurance:
ALL COPAYS/DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE

Please note – each insurance policy is different. It is **your responsibility** to know your policy. If pre-authorization is needed, then it is **your responsibility** to notify our staff so that we may obtain authorization. If authorization is not obtained, it is **your responsibility** to pay for all charges incurred.

Remember – your insurance policy is a contract between you and your insurance company. It is not a contract between you and our doctors. **In order for us to process your insurance, we must have a copy of your card.** It is also your responsibility to let us know if there is a change in your insurance information, including a new card. Failure to provide a copy of your card/updated information may result in increased out-of-pocket expenses, for which New Vision Eye Center is not liable.

If you are, or the patient you legally represent is, currently enrolled in a skilled nursing facility (SNF), hospice care, or a rehabilitation facility - it is your responsibility to inform us of this prior to your visit. Prior authorization is required from such facilities which may affect your appointment or our ability to provide you care.

If you have any questions or are not prepared to pay for your appointment, please notify one of our office staff prior to your appointment. If you are not being seen for an emergency, and are unable to pay for prior balances from previous dates of service, you may be asked to reschedule your appointment.

Please note – Fees may be charged in the event of returned checks and/or unpaid balances that would result in your account being placed into collections/ pre-collections status. The amounts of these fees are listed below, and represent New Vision Eye Center's associated costs.

- Credit card transaction surcharge: **3%** (which is not more than our cost of acceptance)
- Checks returned for non-sufficient funds (NSF): **$25.00 Fee**
- Placement of account into pre-collections status: **$12.36 Fee**
- Placement of account into collections status: **$12.36 Fee**

Effective 6/1/2023, a $175 per eye fee will be applied for corneal abberometry testing prior to cataract surgery.
Effective 6/1/2023, a $45 refraction fee will be applied for a non-diagnostic refraction.
Effective 6/1/2023, a reasonable fee will be charged for completion of certain forms.

***Self-Pay patients are expected to pay in full at the time of service.**
We do not participate in auto injury claims or Worker's Compensation claims.

Patient's Signature _____ Print Name _____ Date _____

(By signing this document, I am attesting that I have read and understand the above information)

New Vision Eye Center
[1055 37th Place, Vero Beach, FL, 32960 | (772) 257-8700 | www.newvisioneyecenter.com]

Patient Appointment, Procedure & Surgery Cancellation Policy

Dear Patient,

At New Vision Eye Center and New Vision Surgery Center, our goal is to provide timely, high-quality eye care to every patient. Office visits, diagnostic testing, in-office procedures, and operating room surgery times are reserved specifically for you. When an appointment is missed or cancelled without adequate notice, that time cannot be offered to another patient who may be waiting for care — including patients needing urgent evaluation.

To help us keep our schedule available and fair to all patients, we ask that you review and acknowledge the policy below.

Cancellation Notice Required

- Office visits and in-office testing/procedures: please cancel or reschedule at least 24 hours in advance.
- Laser procedures and injections: please cancel or reschedule at least 48 hours in advance, as these appointments require dedicated equipment and staff preparation.
- Surgery center (NVSC) procedures: please cancel or reschedule at least 5 business days in advance whenever possible. Surgical time is reserved exclusively for you, and OR staffing, anesthesia, and supplies are committed in advance and generally cannot be reassigned on short notice.
- Repeated cancellations, regardless of notice given, may affect your ability to schedule future appointments or surgery dates.

No-Show / Late Cancellation Fees

If you do not show up for a scheduled appointment or procedure, or fail to cancel within the notice period above, the following fees apply. These fees are not covered by insurance (including Medicare) and are the patient's responsibility.

Appointment / Service Type	Fee
Office visit / intravitreal injection / H&P	**$40**
Procedures (OR or Clinic Based)	**$50**

We Understand Emergencies Happen

Illness, family emergencies, and unavoidable situations happen, and we do not want fees to be a barrier to your care. Please call our office as soon as possible if an emergency prevents you from keeping your appointment or surgery date. Fees may be waived at the practice's discretion for documented emergencies.

Repeated Missed Appointments

- After two (2) no-shows or late cancellations within a 12-month period, your account may be flagged for review.
- For surgical patients: a missed or very late-cancelled surgery date may require a new pre-operative evaluation and clearance before a new date can be scheduled.
- Continued missed appointments may result in a requirement to pre-pay applicable fees before future visits are scheduled, or in discharge from the practice for chronic no-shows, consistent with our patient care policies.

Acknowledgment

I have read and understand the above Cancellation, No-Show, and Surgery Rescheduling Policy. I agree to comply with these terms and understand that applicable fees will be my responsibility.

Patient Name: _____

Signature: _____

Date: _____

NEW VISION EYE CENTER MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

Primary Physician (Local Preferred): _____

City State

Allergies (Please list any prior drug / substance allergy): ◯ None ◯ List Attached

DRUG / SUBSTANCE NAME	TYPE OF REACTION
	Mild / Moderate / Severe
	Mild / Moderate / Severe
	Mild / Moderate / Severe
	Mild / Moderate / Severe
	Mild / Moderate / Severe

Past Ocular Surgery (please check all that apply):

Please identify which eye surgery you have had, if any: (Please check all that apply and give the date and doctor)

- ☐ Cataract surgery (Left Eye): Date_____ Doctor _____
- ☐ Cataract surgery (Right Eye): Date_____ Doctor _____
- ☐ Glaucoma surgery (Left Eye) Date_____ Doctor _____
- ☐ Glaucoma surgery (Right Eye) Date_____ Doctor _____
- ☐ Retinal surgery (Left Eye) Date_____ Doctor _____
- ☐ Retinal surgery (Right Eye) Date_____ Doctor _____
- ☐ Vision correction surgery (Left Eye) Date_____ Doctor _____
- ☐ Vision correction surgery (Right Eye) Date_____ Doctor _____
- ☐ Other (Left Eye) Date_____ Doctor _____
- ☐ Other (Right Eye) Date_____ Doctor _____
- ☐ **Other prior eye conditions or concerns:** _____

Eye Drops:

◯ None ◯ List Attached

Left Eye: _____ Right Eye: _____

Past Medical History (please check all that apply):

- ☐ Alzheimer
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (Type I)
- ☐ Diabetes (Type II)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Pacemaker
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

Past Surgical History:

Please specify type of surgeries and dates:

Current Medication List (including dosage):

◯ None ◯ List Attached

Family History (other than yourself):

☐ Unknown Family History

Please circle applicable family members:

☐ Glaucoma	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Macular Degeneration	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Blindness	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Diabetes	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Cancer	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Heart Disease	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ High Blood Pressure	Parent	Sibling	Maternal Grandparent	Paternal Grandparent

Social History (please check all that apply):

Smoking: ☐ every day smoker ☐ social smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes, how much and how often? _____

Drug Use: ☐ Yes ☐ No If yes, how much and how often? _____

Other (please check all that apply):

Have you had a flu vaccine? ☐ Yes ☐ No

Have you had a pneumonia vaccine? ☐ Yes ☐ No

Have you had a COVID-19 vaccine? ☐ Yes ☐ No

Have you fallen in the last 2 years? ☐ Yes ☐ No

Are you currently in a wheelchair? ☐ Yes ☐ No

If yes, can you transfer without assistance? ☐ Yes ☐ No

Name: _____ Date of Birth: _____ Today's Date: _____