BRADFORD COUNTY EYE CENTER

1105 S. Walnut St. Starke, FL 32091

P: 904-964-8076 F: 904-964-8107

Authorization For Release of Medical Information

Permission to get records:

I,_____, with a date of birth, _____ give my

(Patients DOB)

permission for _____ to give my medical records to

(doctor's or hospital name who has records)

Bradford County Eye Center so that he/she can better understand my condition.

I understand that:

- I do not have to give my permission to share these records.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or staff person and sign a paper.
- This form is only good for 3 months.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION.

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date _____

Relationship of Authorized Representative_____

Consent of release of medical records for (patient name) _____

Records within the following dates:

- All records for this patient
- Records dated between _____ and _____

Please fax records back ASAP to 904-964-8107. Thanks

BRADFORD COUNTY EYE CENTER

In Office Use Only		
OCT	☐ Y	☐ N
Retinal Photos	☐ Y	☐ N
Add Refraction	☐ Y	☐ N

Patient Registration Form:

Name (First) _____ (MI) ____ (Last)_____ Gender: M F

Address _____ City _____ State _____ Zip _____

Telephone (H) _____ (Cell/Work) _____ DOB ___/___/____ SS# _____-___-_____

Occupation_____Employer _____Email _____ Single ☐ Married ☐

Health Insurance Carrier_____ Vision Insurance Carrier_____

Have You ever been to this office before? ☐ **YES** ☐ **NO** When was your last Eye Examination? _____

Eye Health / History : (Please check all that apply)

What Problems are you currently having?

☐ Blurred Vision
☐ Halos/ Glare
☐ Flashes/ Floating spots
☐ Redness
☐ Burning
☐ Itching
☐ Dryness
☐ Double Vision
☐ Discharge
☐ Headaches
☐ Watering
☐ Foreign Body sensation
☐ Pain/Soreness
☐ Contact Lens Problems
☐ Peripheral Vision Loss
Other _____

Have you ever been told you have any of these or have any family history of these? (Please check all that apply)

☐ Cataracts
☐ Dry Eye
☐ Lazy eye
☐ Glaucoma
☐ Macular Degeneration
☐ Crossed eyes
☐ Retinal Detachment
☐ Retinitis Pigmentosa
☐ Blindness
☐ Melanoma of Eye
☐ Corneal Dystrophy
Other _____

Do you now wear contact lenses? ☐ **YES** ☐ **NO** If no, have you worn them in the past? ☐ **YES** ☐ **NO**

Are you Interested in Contact lenses even for occasional use? ☐ **YES** ☐ **NO** Are you Interested in LASIK ☐ **YES** ☐ **NO**

Have You ever had an Eye injury, surgery or bad infection? ☐ **YES** ☐ **NO** Explain _____

Medical History (Please Check all that apply to you, circle if Family History only)

Approximate Height _____
Approximate Weight _____
☐ Sinus Congestion
☐ Hearing Loss
☐ Multiple Sclerosis
☐ Cerebral palsy
☐ Parkinson's
☐ Migraines
☐ Stroke
☐ Depression
☐ Anxiety
☐ Bipolar Disorder
☐ Heart disease
☐ Artery disease
☐ Hypertension
☐ High Cholesterol
☐ Asthma
☐ COPD
☐ Colitis
☐ Crohn's Disease
☐ Ulcers
☐ Currently Pregnant
☐ Degenerative Disk
☐ Muscular Dystrophy
☐ Fibromyalgia
☐ Osteoporosis
☐ Rosacea
☐ Shingles
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Thyroid disease
☐ Rheumatoid arthritis
☐ Lupus
☐ Sjogren's disease
☐ HIV/AIDS
☐ Smoker
☐ Consume Alcohol
Other _____

Medications (Please list any current Medications you take, if you do not know the name- then what you take it for)

1. 2. 3. 4.

5. 6. 7. 8.

Are allergic to any medications? Yes ☐ No ☐ Please List _____

Are there any other conditions we should Know about? Yes ☐ No ☐ Explain _____

Bradford County Eye Center

Financial Policy

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing cost than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in the practice regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. We also ask that materials be paid for before they are odered.
_____(Initials)

Provider Claims

I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for related services. Payment from my insurance company is to be paid directly to Dr. Schlofman. I understand that the insurance I provide will be billed as my primary insurance. I understand billing any second insurance is my responsibility. I understand all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.
_____(Initials)

Privacy Policy

I acknowledge that I received a copy of Dr. Schlofman's revised notice of privacy practices as of 10/04/2013_____(Initials)

Cancellation Fee

A $25 fee is charged for failure to give a 24-hour notice to reschedule or cancel your appointment_____(Initials)

Refraction Fee

Our office fee for a refraction (spectacle evaluation) is a $25 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.
_____(Initials)

Notice of Polycarbonate for Minors

We strongly recommend that all patients 19 and under get polycarbonate lenses with their glasses. Polycarbonate is an impact resistant material that is needed for safety reasons for minors._____(Initials)

_____Patient's Name _____Date

_____Patient/Parent or Guardian if under 18 Signature