



239 W Redstone Ave. Crestview, FL 32536
Office: (850)331-3937 Fax: (850)634-6136

www.alabataeye.com

alabataeye@gmail.com
www.facebook.com/alabataeyecenter

PATIENT MEDICAL HISTORY

Patient Name: _____ DOB _____		Referring Provider: _____
Preferred Pharmacy: _____		Primary Care Provider: _____
1. List all Medical Conditions for which you are currently being treated (high blood pressure, high cholesterol, diabetes, heart disease, cancer, autoimmune disease, immune deficiency and organ transplant)	<input type="checkbox"/> None	
2. List all Medical Conditions for which you have been treated in the past (high blood pressure, high cholesterol, diabetes, heart disease, cancer, autoimmune disease, immune deficiency and organ transplant)	<input type="checkbox"/> None	
3. List all Current Medications AND EYE DROPS, with Dosage and Directions	<input type="checkbox"/> None	
4. List all EYE PROBLEMS (past/present)	<input type="checkbox"/> None	



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5. List all SURGERIES including EYE Surgery	<input type="checkbox"/> None
6. List all DRUG and FOOD ALLERGIES	<input type="checkbox"/> None
7. List all EYE DISEASES that run in your FAMILY and WHICH FAMILY MEMBER such as glaucoma, macular degeneration, cataract, diabetic retinopathy	<input type="checkbox"/> None
8. List any HEALTH PROBLEMS that run in your FAMILY and WHICH FAMILY MEMBER, such as diabetes, cancer, auto-immune disease	<input type="checkbox"/> None
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a pneumonia and/or flu shot? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Check the BOX if you are CURRENTLY experiencing any of the following:</u>	
<input type="checkbox"/> Chronic Fever <input type="checkbox"/> Elevated Blood Sugar <input type="checkbox"/> Scalp Tenderness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Allergies <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <input type="checkbox"/> Elevated Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Arthritis
<input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Thyroid Abnormalities <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Rash <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Dialysis <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Coughing
Patient Signature:	
Date:	

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Patient Identification

First Name _____ Initial _____

Last Name _____

Gender Male () Female () Age _____

Date of Birth _____

SSN _____

Married () Single () Other ()

Ethnicity Hispanic Origin ()

Non Hispanic Origin ()

Preferred Language _____

Emergency Contact

First Name _____

Last Name _____

Relationship _____

Phone _____

Patient Employment

Employed () Retired () Other ()

Employer _____

Street Address _____

City, State, Zip Code _____

Address

Street Address _____

City, State, Zip Code _____

Contact Information

Ok to Leave Msg

Home Phone _____ Yes () No ()

Mobile Phone _____ Yes () No () Text ()

Work Phone _____ Yes () No ()

Other Phone _____ Yes () No ()

Email _____

Primary Contact: Home () Mobile () Other () Email ()

Backup Contact: Home () Mobile () Other () Email ()

Automated appt reminders Yes () No ()

Referral Source

Referred By _____

Previous Patient () Word of Mouth () Provider ()

Referring Provider _____

Primary Care Provider _____

Insurance Information

Primary Insurance _____

Primary Ins Member ID _____

Secondary Insurance _____

Secondary Ins Member ID _____

Signature of Patient or Guardian of Minor

Date

Print Name of Patient

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ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my DEPENDENT) have insurance coverage with the carrier(s) given to the front desk staff and assign directly to Alabata Eye Center, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. If your insurance requires that your primary care doctor provide a referral to the physician who is providing your ophthalmology care, it is your responsibility to obtain authorization in advance of your appointment (at least 24 hours). Your doctor may mail/fax it to our office or you may bring it to your visit. Please contact us if you require any assistance in obtaining the authorization. We will be happy to assist you in obtaining your authorization. If an authorization is NOT obtained from your insurance prior to the delivery of care/services, we will expect you to accept financial responsibility for any/all charges. You will receive a bill for physician services provided to you. Our panel is closed to HMOs, Medicaid, TriWest, VA, Tricare East and Workman's Compensation.

I have read the statement above and that I understand that I will be billed and am responsible for payment for the professional and facility fees for services provided to me in the event that my insurance provider does not authorize these services.

Signature of Patient or Guardian of Minor

Date

Print Name of Patient

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Refraction Service and Fees

A refraction is an important part of your complete eye examination. It is a vital part that helps Dr. Alabata determine the best possible visual acuity or central function of your eyes. It is essential medical information for Dr. Alabata to have as he completes the proper assessment of your eyes. It helps determine if you have a visual impairment that may need to be addressed in a timely fashion. This is important even if you do not desire an eyeglass prescription.

A refraction is **NOT** a covered service by Medicare or most medical insurance plans. These plans consider a refraction a “vision” service and not a “medical” service.

Our office fee for a refraction is \$25.00. This fee is collected at the time of service in addition to any co-payment or deductible your plan may require. Your co-pay or deductible is for the medical portion of your exam and is separate from and not included in the refraction fee. Medicare does not cover a refraction and most insurance companies follow Medicare’s policies as a guideline.

The technician will advise the patient at the time of the appointment.

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing **Alabata Eye Center LLC**. We are committed to the treatment, preservation and advancement of your Ophthalmic care. Please understand that payment of your bill is considered part of Ophthalmic care. The following is a statement of our **Policy**, which we require that you read and sign before being seen by one of our physicians. **You are responsible for letting our office know of any changes in your demographics and insurance plans.**

Your Responsibility:

You are financially responsible for the services we provide to you. As such, we require that the patient or legal guardian to either pay or arrange for payment at time of service. As a courtesy to you, we will file a claim to your insurance plan(s). Please remember that your insurance benefits are a contract between you and your insurance carrier. You are required to make your co-payment and/ or pay any deductible and co-insurance at the time of your service. If there is a discrepancy with payment of our claims, we may look to you for assistance in expediting our claims in a timely manner. If your insurance company does not pay the practice within 90 days, you will be responsible for payment in full. If the practice later receives payment from your insurance, we will refund any overpayment to you. If you provide incorrect or false information, you will be responsible for any unpaid claims and /or all charges for services provided.

Non-covered Service Condition:

Since we are a specialty practice, some procedures that may be performed in your treatment plan could be deemed non-covered by your insurance plan. In the event that these services are determined non-covered, it is your responsibility to pay for the services rendered. Our patient financial counselors are available to review these out-of-pocket expenses with you prior to services being rendered. If we do not participate with your insurance carrier, you will be responsible for paying your charges at the time of service.

Prior Balance:

Patients with a balance from prior dates of service will be required to pay that balance in full before being seen by our physician. If the prior balance can not be paid in full, you will be asked to speak with our financial counselors to make payment arrangements based on our payment policy prior to being seen by our physician.

Self-pay Patients:

Patients who have no insurance or who elect to pay fee-for-service, will be extended a discount from charges. You will be expected to pay for the balance in full at time of service.

Returned Checks:

We will assess a fee on all checks that have been returned by our bank for "non-sufficient funds" per applicable state laws. Payment of this fee must be made prior to your next appointment.

Collection Agency:

Prompt payment of patient's balances is expected per the terms of this agreement. We will use an outside collection agency for outstanding patient's balances as we deem necessary. Failure to resolve outstanding balances may result in discharge from care by our physician. Prior balances must be resolved before the practice will provide new services.

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No Show /Cancellation Policy:

We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call within 24 hours of your **office appointment** if you are unable to attend. There will be an automatic \$25 fee for a no show appointment. If **two** appointments are cancelled without 24 hour notice, you will be charged a \$25.00 fee. If **three** appointments are missed without proper notification, you will be dismissed from the practice for non-compliance. **For surgery cancellations**, we need a 72 hour notice. There will be a \$75 charge if you cancel less than 72 hours or if you are a no show for your procedure.

Arrival Time:

We ask that all new patients arrive 30 minutes early for paperwork and check-in. For all established patients, please arrive 15 minutes early for updates and check-in. Please also be aware that for efficiency reasons arriving 10 minutes late to a scheduled appointment is subject to cancellation or having to be rescheduled. Please understand that this is a sub-specialty ophthalmology practice. **At times, please be prepared to spend two hours or more per visit.**

Restructuring:

As of June 18, 2020 we have restructured our clinic in order to properly care for our current as well as upcoming patients in need of specialist and surgical care. We have now changed our role to the community to strictly a Glaucoma, Laser and Cataract Surgical Specialty Center, to include LASIK, SMILE and PRK. We will no longer be accepting referrals for routine eye care.

Please initial each line

- _____ Immediately notify our office of any change of demographics and/ or insurance.
- _____ Payment is due at the time of service.
- _____ You are responsible for any non-covered charges.
- _____ If there are any prior balances, these will need to be paid in full before your appointment.
- _____ There will be a \$25 Fee for a no show appointment and for **two** cancellations within 24 hrs of appt.

I have read and understand the financial policy of Alabata Eye Center LLC. I agree and understand the terms and conditions of this policy, and agree that any questions I have, have been answered by the patient financial counselors to the best of my understanding. Policies and fees are subject to change.

Signature of Patient or Guardian of Minor

Date

Print Name of Patient



Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a **Notice of Health Information Privacy Practices**, which provide a complete description of health information usage and disclosures. I understand that I have the following rights and privileges.

1. The right to review the Notice prior to signing this consent
2. The right to object to the use of my health information for directory purposes
3. The right to request restrictions as to how my health information may be use or disclose to carry out treatment, payment or health care operations

I understand that I may revoke my consent for the use of my health information in writing at any time. I also understand that if I revoke my permission, **Alabata Eye Center LLC** will no longer use or disclose medical information about me for the reasons covered by my written authorization. I understand that **Alabata Eye Center LLC** is able to take back any disclosures already made with my permission, and that they are required to retain the records of care provided to me.

I further understand that if I chose to revoke my consent, **Alabata Eye Center LLC** may refuse to treat me as permitted by **Section 164.506 of the Code of Federal Regulations**.

By signing this document, I **acknowledge** that I have been provided with a copy of this office's **Notice of Privacy Practices**.

Print Name

Signature

Date

With your permission, **Alabata Eye Center LLC** may release your protected health information to a family member or another involved in your care or payment for your care.

Please identify the person/persons who are involved in your care or the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

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

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

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