PATIENT INFORMATION

DATE _____

Alejandro M. Tirado, OD PA
13119 Professional Drive, Suite 100
Jacksonville, FL 32225

PATIENT'S FULL NAME _____

ADDRESS _____ APT/LOT _____

CITY _____ STATE _____ ZIP _____ HOME PH# _____

CELL PH# _____

DATE OF BIRTH _____ AGE _____ SEX _____ SS# _____

MARITAL STATUS _____ EMAIL ADDRESS _____

SPOUSE'S NAME _____ **SPOUSE'S SS#** _____ **DOB** _____

PATIENT'S EMPLOYER _____ **WORK PH#** _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____ PHONE _____

REASON FOR VISIT _____

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT US?

DOCTOR REFERRAL? IF SO, WHOM? _____

PATIENT REFERRAL? IF SO, WHOM? _____

YELLOW PAGES AD? _____ NEWSPAPER AD? _____ INTERNET? _____

OTHER? PLEASE EXPLAIN _____

IF PATIENT IS A MINOR

STUDENT: FULL-TIME ☐ PART-TIME ☐ PARENT/GUARDIAN _____

PARENT/GUARDIAN EMPLOYER _____ PHONE _____

INSURANCE INFORMATION

Please check with our staff for names of insurance plans we will file for you. You are asked to pay for the visit at the time of the visit if we do not participate with your insurance plan or if insurance eligibility cannot be verified. Please understand that some carriers take up to three business days to get back with us for eligibility acceptance. If insurance cannot be verified we will still file your insurance and any moneys due you will be sent directly to you from the carrier. We will file one (1) Medicare supplement for our Medicare patients. We are not able to backdate claims for exams, glasses or contacts for insurances not provided at the time of service.

My insurance is in: My name _____ **Spouse's name** _____

Parent/Guardian name _____ Subscriber SS# _____ DOB _____

Please make available your driver's license/FL ID and health/vision insurance cards for copy and records.

Customer Eyewear Profile

Name _____ Occupation _____

How many pairs of eyeglasses do you currently own that you regularly use? _____
If you wear contacts the majority of the time do you have an up to date pair of glasses? _____ If not, how old is your most current pair? _____
If not, are any of your glasses over the counter or dime store readers? _____ Strength or Power?_____
Do you use a computer at work, school or home? _____ if so, how many hours a day? _____

Please check your hobbies, activities and sports:

Golf	☐	Dining Out	☐	Painting	☐
Running	☐	Theatre	☐	Reading	☐
Tennis	☐	Dancing	☐	Music	☐
Racquetball	☐	Travel	☐	Photography	☐
Aerobics	☐	Spectator Sports	☐	Sewing	☐
Swimming	☐	Scuba Diving	☐	Fashion	☐
Walking	☐	Snorkeling	☐	Cooking	☐
Snow Skiing	☐	Horse Riding	☐	Basketball	☐
Water Skiing	☐	Biking	☐	Woodcrafting	☐
Motorcycling	☐	Hiking	☐	Automotive	☐
Boating	☐	Surfing/Sup	☐	Gardening	☐
Spinning	☐	Yoga/Pilates	☐	Skateboarding	☐
Rollerblading	☐	Fishing	☐	Baseball	☐
Softball	☐	Skydiving	☐	Kayaking	☐
Hunting	☐	Soccer	☐	Football/Flag	☐
Lacrosse	☐	Cards/Bingo	☐	Martial Arts	☐
Volleyball	☐	Boxing	☐	Wrestling	☐
Hockey	☐	Pottery	☐	Gymnastics	☐

Other(s) _____

Please do not write below this line. Thank you. _____

Dr. Tirado/_____prescribes the following for you next pair of spectacle lenses:
IF YOU DO NOT PURCHASE *TRANSITIONS, SUNSENSORS, PHOTOGRAY OR PHOTOBROWN* PHOTOCHROMIC LENSES THEN WE ALWAYS RECOMMEND YOU PURCHASE A SEPARATE PAIR OF PRESCRIPTION SUNGLASSES WITH AT LEAST UV AND TINT TREATMENT TO FULLY PROTECT YOUR EYES EXTERNALLY AND INTERNALLY.

Lenses (Primary Pair) Binocular PD ☐ or get Monocular PD ☐ DVO ☐ NVO ☐
CR39 ☐ Glass ☐ Hi Index 1.60 / 1.66 / 1.70 / 1.74 Trivex ☐ Polycarbonate ☐

SV ☐ FT28 ☐ FT35 ☐ Exec ☐ Trifocal 7x28 ☐ Trifocal 7x35 ☐
Progressive Premium ☐ Progressive ☐

Treatments:
UV ☐ RLX ☐ Tint ☐ color ☐ full ☐ or gradient ☐ % _____
AR ☐ brand: Carat blue or gold ☐ Crizal ☐ Alize ☐ Avance ☐ Ultra ☐ Other ☐

Specialties
Transitions/SunSensors ☐ color _____ Polaroid ☐ Safety ☐
Mirror coat ☐ Photogray (glass) ☐ Photobrown (glass) ☐

Extras: Aspheric Design ☐ Polish edges ☐ Roll & polish ☐ Prism ☐ Match BC's & CT's ☐
High Add ☐ High Sphere ☐ High Cylinder ☐

Alejandro M. Tirado, OD, PA
13119 Professional Drive, Suite 100
Jacksonville, FL 32225

Dear Patient:

The Florida Board of Optometry has adopted regulation 59V-3.010 that requires all patients to have dilation upon their initial eye examination. If you have not previously been dilated under our care, at this location, then we would be required to perform the procedure.

Dilation of the eye expands the pupil and allows a more thorough examination of the retina than would be possible without the procedure. Without dilation, the presence of holes, tears, or retinal degeneration could not be detected unless other symptoms existed. With dilation we can see stereoscopically (depth perception) which will render you eyes findings more accurate. *It's like opening the door to the room vs. trying to see through a keyhole.*

These are a few things we want you to be aware of concerning dilation:

- Dilation will enlarge your pupils, which could decrease your ability to see at reading distance and make lights seem much brighter.
- Dilation may make it difficult to see at a distance and some find sunlight to very uncomfortable.
- Driving a vehicle may be difficult after the dilation.
- Although dilations are <u>not</u> contraindicated for pregnant females the drops can still be absorbed systemically and could pass to the fetus. We usually opt for a milder dilation effect with the use of mydriacyl (tropicamide 0.5 or 1.0%) only. If you are pregnant or even just think you might be then please let us know beforehand. This is your responsibility.
- If you elect to have the dilation procedure, it will place an additional 15 minutes on the examination, due to the time it takes the drops to act upon the muscles of they eye.
- The effect of the dilation will last from 4 to 6 hours but could last longer if you are blue/green eyed and/or if you're taking certain medications such as anti-depressants, MAO inhibitors, or Dilantin for epilepsy.
- Please ask for filters at the front desk upon completion of your dilated exam. Dark sunglasses could suffice in lieu of these filters.

Please sign **one** of the following statements after checking the option you desire and after reading and understanding all aspects of the dilation procedure:

☐ 1. I understand the above paragraphs and elect to have my eyes dilated today.

_____
Signature Date

☐ 2. I understand the above paragraph and elect to have my eyes dilated within the next four weeks, but not today. If I don't return to have my eyes dilated within one month of this exam then the 3rd option below will supersede option 2.

_____
Signature Date

☐ 3. I understand the above paragraphs, but refuse to have my eyes dilated today or in the foreseeable future. If I later decide to have my eyes dilated I understand I will incur an office visit charge.

_____
Signature Date

_____
Parent/Guardian Date Associate

Alejandro M. Tirado, OD, PA
13119 Professional Drive, Suite 100
Jacksonville, FL 32225
904-683-8444

Dear Patient:

We are pleased to inform you that we have a Humphrey Matrix FDT Perimeter to enhance the diagnostic services we provide. It's like a "CAT SCAN" for they eyes and can often pick up many problems before symptoms appear. His sophisticated computerized instrument allows us to map the peripheral vision of each eye, which is valuable in assisting in the early detection of many eye diseases such as glaucoma, optic neuritis, retinal detachments, macular degeneration, brain tumors, bleeding in the retina and other neurological lesions that can affect your vision in ways that you many not notice until the condition has become severe. A visual field mapping may be the only effective way to detect problems in some cases. We also now have a Zeiss Visucam Fundus Camera that can take detailed pictures of the back of your eyes (retina) that can possibly show signs of diabetes, hypertension, cholesterol, multiple sclerosis, auto immune diseases, toxic medications and even some cancers. The latter will also give us photographic evidence that be researched in case you ever develop any of the above mentioned conditions or others later in life.

We strongly recommend all of our patients receive both evaluations. It's especially important if you have a history or suspicion of diabetes, headaches, migraines, flashes or floaters, stroke, recent changes in vision or a family member who has glaucoma or diabetes. Each state of the art procedure requires an additional 5 minutes of your time and there is a nominal fee of $25.00 for each or $45.00 for both.

If these screenings detect any potential problems we may require a more sophisticated diagnostic exam to more fully explore the levels of sensitivity in your field. This will help determine the extent of the field loss and the best course of treatment. The fee for this exam, if required is ~$89.00, which is sometimes covered by Medicare and some other major medical insurance programs. Retinal photography is ~$87.00. Please note while these tests are "optional" for some people, it represents preventative health care for others. It may be required to "rule out" certain eye diseases.

Please check the appropriate box below and sign:

- ☐ I would like a General Eye Exam with Visual Field Screening and Retinal Photography
- ☐ I would like a General Eye Exam with Visual Field Screening
- ☐ I would like a General Eye Exam with Retinal Photography
- ☐ I understand the importance of the Visual Field Screening + Retinal Photography and understand this exam would be in my best interest, but I prefer the General Eye Exam without the Visual Field Screening or Retinal Photography at this time.

Signature: _____ Date: _____

Sincerely,

Alejandro M. Tirado, OD

SERVICES AVAILABLE IN OUR OFFICE

- ☐ Non-surgical vision improvement (Corneal Refractive Therapy) for nearsightedness or farsightedness
- ☐ Dry eye management
- ☐ Contact lens fitting for astigmatism or bifocals
- ☐ Medical Contact lens fitting for ocular disease
- ☐ Diagnosis and treatment of eye disease
- ☐ Routine eye exams for 2 years of age and up (Children's Vision)
- ☐ Diabetic eye exams and screening
- ☐ Rehabilitative Vision Services (Low Vision)
- ☐ Post Refractive (LASIK) or customized contact lens fitting
- ☐ Nutritional supplementation for maintenance and prevention of ocular disease
- ☐ Theatrical contact lens fitting and dispensing
- ☐ Vision Screening
- ☐ Frame styling for prescription sunglasses
- ☐ Exams for high-risk medications (Example: plaquenil, ethambutol, prednisone, amiodarone, etc.)

Alejandro M Tirado, OD, PA
Eye Care For You
Specializing in corneal refractive therapy & customized contact lenses
Harbour Place Professional Park
13119 Professional Drive, Suite 100
Jacksonville, FL 32225
Eyecareforyou.net

NOTICE OF PRIVACY PRACTICES

Alejandro M Tirado OD PA

Eye Care for You

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.

This notice takes effect on January 1, 2011 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the heath information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for personal fundraising purposes. We will limit our uses and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a proposal and establish protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than your treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement or disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us immediately. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Alejandro M Tirado OD PA
13119 Professional Drive
Jacksonville, FL 32225
Attn: Administrator

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

ASSIGNMENT OF MEDICAL/MEDICARE BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I request that payment of authorized medical/Medicare benefits be made on my behalf to Alejandro M. Tirado, OD, PA for any services furnished to me by that physician/supplier. I further understand that I will be solely responsible for any deductibles, co-insurance, and/or any "non-covered" services, including medical, not payable by my insurance plan. This assignment will remain in effect until revoked by me in writing. _____(initial here)

I further understand that most insurance companies will not pay for any examination for glasses or for change of lenses. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine the benefits or the benefits payable for related service. A photocopy of this assignment is to be considered as valid as an original. _____(initial here)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related medical/Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. Please also read and sign our new Privacy Policy based on HIPAA. _____(initial here)

I further understand; regardless of insurance coverage, I am wholly responsible for any charges incurred while being treated by this physician/supplier and if it should be turned over to a collection agency/attorney then I am responsible for all costs of collection and attorney's fees. If this account is assigned to a collection company an additional fee of **50%** of the owed amount will be added to the balance along with any late fees and interest. _____ (initial here)

Professional fees are not refundable, however, merchandise purchased can be returned within 30 days for an <u>in store credit only</u> if the item is exchangeable per manufacturer and otherwise undamaged. We do not give charge card credits or cash refunds. _____(initial here)

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

<u>I will not file insurance for services furnished me by physician/supplier. I understand I am wholly responsible for all charges incurred during the course of my treatment with this physician/supplier. *If the bill for our services is not paid within 60 days by the insurance carrier, the patient will be responsible for the balance atop late fees on the 61st day.* **If insurance is to be filed this must be signed.**</u>

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

I INTEND TO PAY MY MEDICAL EXPENSES AS FOLLOWS: (CHECK ONE OR MORE)

☐ Cash/Check ☐ MC/Visa/Discover/AmEx ☐ Debit ☐ Medicare ☐ PPO/HMO Insurance

Interest accrues at 21% per annum (1 ¾ % per month) on bills over one month unpaid.

Eye Care for You

Alejandro Tirado OD PA
13119 Professional Drive, Suite 100
Jacksonville, Fl 32225
Ph: 904-683-8444 Fax: 904-683-5148
www.eyecareforyou.net

- Dry Eye Management
- Rehabilitative Vision Services
- Pediatric Exams
- Corneal Refractive Therapy
- Customized Contact Lenses
- Ocular Disease

Authorization to Release Medical Information

Name: _____ **DOB:** _____

In accordance with the Health Information Privacy and Portability Act (HIPPA), clinical information cannot be discussed with spouses, family members or friends without written authorization. I authorize the following person(s) to obtain clinical information on my behalf.

_____ _____

_____ _____

_____ _____

_____ _____

This authorization may be amended at my discretion with written directive from me.

_____
Signature

_____
Date