PINNACLE EYE CENTER

REGINE PAPPAS, M.D.
BOARD CERTIFIED OPHTHALMOLOGIST
GLAUCOMA SPECIALIST & EYE SURGEON

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VIERA, FL 32940
FAX: 321-622-5895

Appointment Date: _____

Dear Patient,

We are looking forward to meeting you at your upcoming appointment. Prior to your arrival, please familiarize yourself with our office policies and complete the attached "New Patient Paperwork." We request it to be filled out **PRIOR** to your appointment. This can be done via this paper form, or **online** via our **PATIENT PORTAL**. This link will be sent to you via email if you provided one when scheduling, and the online paperwork can **save significant time** during your appointment. **IT IS IMPERATIVE** that you complete these forms in full. Please use the medication form to list **all** prescription medications, and over the counter, vitamins, or supplements, that you currently take. Any incomplete information can affect being called back on time.

Please arrive at least 15 minutes before your appointment. Also be sure to bring your insurance cards, a government issued photo ID, and if you did **not** fill out the online paperwork, bring a list of your medicines and any prior surgeries/procedures.

❖ All co-pays are due at the time of service, or the appointment will need to be rescheduled.

❖ Generally, operations or procedures won't take place on the first visit.

❖ **There will be a $25.00 charge if you do not cancel your appointment within 24 hours of your scheduled appointment time OR no show after your appointment has been confirmed. You will not be seen or rescheduled until the NO SHOW FEE is paid in full.**

❖ PATIENTS ARRIVING FIFTEEN MINUTES PAST THE APPOINTED TIME, MAY BE ASKED TO RESCHEDULE OR WAIT UNTIL THE SCHEDULE PRESENTS AN OPPORTUNITY FOR THEM TO BE SEEN**.**

❖ Please allow 24-48 hours for refills on prescriptions and have your pharmacy information readily available. The answering service will not forward refill requests.

❖ If you are experiencing any cold or flu like symptoms, please be kind enough to reschedule your appointment. If you present ill at the time of check in your appointment will be rescheduled.

❖ Please refrain from using strong perfumes/colognes or lotions. Many of our employees and other patients have allergies and/or asthma. You will be asked to reschedule your appointment if the fragrance you are wearing is too strong.

❖ We ask that you **DO NOT** use the speaker phone while in the building, and cell phone usage is not permitted in the clinic area.

❖ All patients with a "Power of Attorney (P.O.A)" will need to provide the office with all current paperwork. Failure to do so *will* result in the appointment being rescheduled.

If you have any questions or concerns, please feel free to contact our office. Again, we look forward to meeting you!

Regards,

Pinnacle Eye Center

PINNACLE EYE CENTER FINANCIAL POLICY

As your ophthalmic physicians, we are committed to providing you with the best possible medical care. To achieve this goal, we need your assistance, and your understanding of our payment policy.

COPAYMENTS ARE DUE UPON CHECK IN AT TIME OF SERVICE, or we will be forced to reschedule your appointment. All Surgical fees will also be due PRIOR to your procedure.
Other payments for service are also due at the time services are rendered. We accept cash, personal checks, Master Card, Visa, and CareCredit. We do not accept postdated checks. Returned checks are subject to a service charge of $50 and you will lose your privilege to write checks in our office.

Managed care plans: Co-payment and deductible must be paid at the time of service. Refraction (a prescription for glasses) is **NOT** covered by most medical insurance plans and payment is due when services are rendered. A valid authorization is required for all services performed. Failure to obtain this authorization, prior to your visit, will result in the patient being financially responsible for all charges incurred and payment will be due on the date services are rendered.

Medicare patients: Your deductible and 20% of the allowable charges are due at the time of service if you do not have a secondary insurance**. Secondary insurance will be filed for you as a courtesy but will be billed to the patient if not paid within sixty days**. If your secondary insurance has a co-pay, please be prepared to pay this at the time of service. Routine eye exams and refractions are not covered by Medicare and payment is due when services are rendered.

Children of divorced parents: Payment is due at the time of service no matter who is responsible by order of divorce decree.

Financial agreement: You must realize that your insurance is a contract between you, your employer, and the insurance company. We are *not* a party to the contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services that they will not cover. We must emphasize that as a medical care provider, our relationship and concern is with you, **NOT** your insurance company. **All charges are your responsibility from the date services are rendered. Failure to pay any unpaid balances after 120 days will result in your account being sent to collections and dismissal from the practice.**

Please bring all **CURRENT** health insurance information with you and a picture ID. We will need to copy any insurance cards for our records**. If you are not able to provide this information, we will be glad to reschedule this appointment for you. If you do not provide us with the correct insurance information at EACH AND EVERY VISIT, you run the risk of being responsible for services rendered. By signing this form, you acknowledge responsibility for all incurred charges as long as you are a patient in this office.**

I have read and understand the above Financial Policy.

_____ _____
Patient name Date

_____ _____
Witness Date

Pinnacle Eye Center HIPAA Compliance Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The term of the notice may change, is so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Pinnacle Eye Center reserves the right to change the privacy policy as allowed by law.
- Pinnacle Eye Center has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Pinnacle Eye Center may condition receipt of treatment upon execution of this consent.

May we phone, or email you to confirm appointments? YES NO

May we leave a message on your answering machine at home or cellphone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please list name(s) and relationship to the patient:

_____

_____

_____

Print name: _____

Signature: _____Date: _____

Witness: _____Date: _____

Today's Date: _____ PINNACLE EYE CENTER

NEW PATIENT INFORMATION

Patient Name: _____ Gender: □ Male □ Female

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

(Month/Day/Year)

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

(This information will not be sold or shared with any third party and email address is needed to set up your patient portal)

Preferred method of contact: □ Cell □ Home □ Text □ Email

Is it ok to leave a voicemail and/or text messages for appointment reminders?

□ Yes □ No

Employer: _____ Occupation: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Spouse's Name: _____

Emergency Contact: Name: _____ Phone: _____

Relationship:_____

Primary Care Provider (PCP): _____

How were you referred to our office?

□ Internet/Google □ Social Media □ Facebook □ Word of Mouth

□ Hospital/Urgent Care □ Insurance □ Yes Magazine

□ Practice Website □ Previous Patient (Name:_____)

□ Referring Doctor:_____

□ Other _____

INSURANCE INFORMATION (Note: A copy of all insurance cards and photo ID is necessary for our records.*)

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Name of Policy Holder: _____

Primary Card Holder: □ Self □ Spouse □ Parent DOB of Policy Holder: _____

* Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Name of Policy Holder: _____

Primary Card Holder: □ Self □ Spouse □ Parent DOB of Policy Holder: _____

PINNACLE EYE CENTER MEDICAL HISTORY QUESTIONAIRE

Name: _____ **Preferred/Nickname**: _____ **Date of Birth**: _____

Primary Physician: _____ **Referring Physician**:_____

Primary Eye Doctor (if applicable): _____ **Gender:** □ Male □ Female

Pharmacy: _____ **Pharmacy Location** (City/Street):_____

Race: □ White □ Black □ Asian □ American Indian or Alaska Native
□ Native Hawaiian/Other Pacific Islander □ Decline to Specify

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ Spanish □ French □ Other: _____

Allergies to Medications: (List medication, type of reaction, and severity of reaction)

_____

Ocular History: (Mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataract(s)
□ Contact Lens Wear
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment
□ Trauma

Other_____

Ocular Surgeries: (Mark all that apply)

□ No ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Glaucoma Surgery
□ LASIK/PRK/SMILE
□ Punctal Plugs
□ Retinal Laser Surgery
□ RK
□ Strabismus/ Muscle Surgery
□ Trabeculectomy
□ Vitrectomy
□ YAG Capsulotomy

Other_____

Current Ocular Medications: (Eye Drops, Eye Ointments, Ocular Vitamins, etc)

_____

Medical History:

□ Overall Healthy
□ AIDS
□ Anemia
□ Aneurysm
□ Ankylosing Spondylitis
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Crohn's Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes (Type 1 or 2)
□ Dementia
□ Eczema
□ Fibromyalgia
□ Graves' Disease
□ Headache
□ Hearing Loss
□ Heart Attack
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Lung Disease
□ Liver Disease
□ Migraine
□ Multiple Sclerosis
□ Polymyalgia
□ Psychiatric Disorder
□ Rheumatoid Arthritis
□ Sjogren's Syndrome
□ Stroke
□ Thyroid Disease
□ Ulcerative Colitis

Other:_____

Infection History:

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphilis
□ Toxoplasmosis
□ Wound Infection

Other:_____

Height: _____ **Weight:** _____ **Hemoglobin A1c** (If diabetic)**:**_____

Previous General Surgeries:

_____

_____

Current Systemic Medications: (Please list on attached medication sheet or bring a copy of pharmacy list)

Have you ever had problems with Anesthesia? □ No □ Yes, reaction:_____

Have you ever taken prostate medications or Alpha Blockers? □ No □ Yes, circle or list below

Flomax, Tamsulosin, Hytrin, Cardura, Saw-Palmetto, Doxazosin, Terazosin, Uroxatral, Rapaflo, Other:_____

Family History: (Applies to gene or "blood" relation only)

□ Unknown Family History

□ Arthritis	Relation:_____	□ Heart Disease	Relation:_____
□ Blindness	Relation:_____	□ High Blood Pressure	Relation:_____
□ Cancer	Relation:_____	□ Keratoconus	Relation:_____
□ Diabetes	Relation:_____	□ Macular Degeneration	Relation:_____
□ Glaucoma	Relation:_____	□ Thyroid Disease	Relation:_____

Social History: (Mark all that apply)

Smoking: □ everyday smoker □ occasional smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes, list how much and how often?_____

Recreational Drug Use: □ No □ Yes, list type and how often?_____

Occupation: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Review of Systems: (Mark all that apply)

Eyes
□ Previous Surgery
□ Contact Lens
□ Pain
□ Double Vision
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Dry Eyes
□ Flashes
□ Floaters

Ear, Nose, and Throat
□ Hard of Hearing
□ Ringing in Ears
□ Vertigo

Cardiovascular
□ Chest Pain
□ Dizziness
□ Fainting Spells
□ Shortness of Breath
□ Irregular Heart Beat
□ Difficulty Lying Flat

Constitutional
□ Fatigue / Weakness
□ Fever
□ Weight Gain / Loss

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma

Gastrointestinal
□ Heartburn
□ Nausea / Vomiting
□ Jaundice / Hepatitis

Genito-Urinary
□ Pain / Difficulty
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

Psychiatric
□ Anxiety / Depression
□ Mood Swings
□ Difficulty Sleeping

Endocrine
□ Increased Thirst
□ Increased Hunger
□ Increased Urination
□ Increased Sweating
□ Fingernail Changes

Blood / Lymph nodes
□ Easy Bruising
□ Gums Bleed Easy
□ Prolonged Bleeding
□ Heavy Aspirin Use

Musculoskeletal
□ Stiffness
□ Arthritis
□ Joint Pain / Swelling

Skin
□ Rash / Sores
□ Lesions
□ Hives / Eczema

Neurological
□ Seizures
□ Weakness / Paralysis
□ Numbness
□ Tremors

Immunologic
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure

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Current Medication List

Name:_____

Date of Birth: _____

Please list all medications, vitamins, or supplements that you are taking currently.

Medication	Dosage Strength	Frequency	Condition Medication Treats