Stolte Eye Center

Keith B. Stolte, M.D., F.A.C.S.
Board Certified Ophthalmologist

Welcome to Stolte Eye Center!

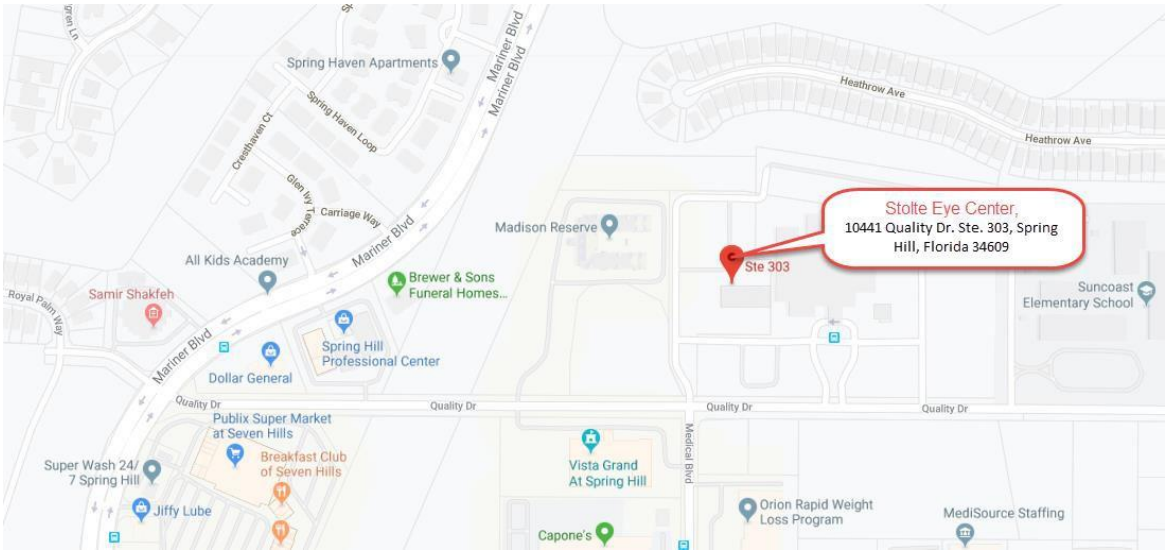
10441 Quality Dr. Ste.303, Spring Hill, Florida 34609
(352) 666-9990 Fax: (352) 666-1905

We want to thank you for the opportunity to become your Eye Care Specialist. We are committed to providing the highest level of eye care available. To accomplish our level of excellence, we would like to give you some information on what to expect during your exam;

Our technicians will perform extensive history taking, dilation (if needed), testing, and face-to-face time with the physician during this time.

Need new glasses? We have an on-site optical shop with everything from high-end designer frames such as Guess, Jordon, Harley Davidson, and much more.

We offer many different types of Natural Pharmaceutical grade vitamins. You can purchase them from our office directly or through our website. We offer multivitamins, fish oil, and many more that treat the whole body, not just the eyes. We can also provide nutritional testing to help detect vitamin deficiencies.



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WELCOME TO OUR OFFICE

Today's Date: _____ Soc. Sec # _____

Patient's Name: _____/_____

(First) (MI) (Last) (Preferred Name)

Marital Status: S M D W Date of Birth: ____/____/_____ Age: _____ Sex: F M

Address: _____

City, State, and Zip Code: _____

Home#: (_____) _____ Cell#: (_____) _____E-mail: _____

Spouse's Name: _____Phone#:(_____) _____

Employer: _____Work#: (_____) _____

Have you been seen by another eye doctor? Yes / No For this similar condition? Yes / No

Referred By: _____Phone#:(_____) _____

Family Physician Name: _____Phone#:(_____) _____

Insurance Information

Principal Insurance Name: _____

Insurance Policy Holder's Name: _____Date of Birth: ____/____/_____

Insurer's Social Security: _____Ins ID#: _____

Secondary Insurance Name: _____

Insurance Policy Holder's Name: _____Date of Birth: ____/____/_____

Insurer's Social Security: _____Ins ID#: _____

Emergency Contact

In case of emergency, please contact: _____Phone#:(_____) _____

Relationship to you: _____Address: _____

Name of family member NOT residing with you: _____Phone#:(_____) _____

Relationship to you: _____Address: _____

PLEASE NOTE: PAYMENT IS EXPECTED AT TIME OF SERVICE

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payments to Stolte Eye Center Inc. for any services rendered to me by any doctor of Stolte Eye Center Inc. I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, coinsurance, and referrals. I am responsible for obtaining any required referrals, and in the absence of such, I will be held responsible for the cost of the service provided.

I authorize the use of this form on all my insurance submissions. I understand **I am responsible** for my bill. I permit a copy of this authorization to be used in place of the original.

I understand **I will be charged a $40 (forty dollars) cancellation fee** for canceling my appointment without giving 24-hour Notice.

I understand **I will be charged $250 (one hundred and fifty dollars) for the same-day cancellation/no-show fee.**

NOTE: ANY UNPAID BALANCES FROM PREVIOUS VISITS OR NON-ALLOWED CHARGES/NON-COVERED SERVICES MUST BE PAID IN FULL TODAY. I request that authorized Medigap benefits (if applicable) be made on my behalf to Stolte Eye Center. I authorize Stolte Eye Center to contact the State Ins. Commissioner, on my behalf, in states where my insurance company domiciles to collect their payment. SIGNING THIS FORM CERTIFIES YOUR AGREEANCE WITH ALL THE STATEMENTS ABOVE. If you disagree with any statement, please discuss it before signing.

_____ _____

Signature of Patient or Legal Guardian (Signature on file for payment authorization) Date

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Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)
   Yes ☐ No ☐ If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ☐ No ☐ If YES, please explain: _____
3. Have you ever had any surgery?
   Yes ☐ No ☐ If YES, please provide the date and reason: _____
4. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, please provide the date and reason: _____
5. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, list: _____

List medications you are currently taking.

_____
_____
_____
_____

Do you currently have any of the following problems?	**YES**	**NO**	**If Yes Explain**
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/Nose/throat problems (hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (chest pain, irregular heart beat)	☐	☐	
Respiratory problems (shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinary Problems (pain or discomfort, blood in urine)	☐	☐	
Skin problems (rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (depression, anxiety)	☐	☐	

Family and Social History

Do any medical or eye diseases run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
Yes ☐ No ☐ If YES, please explain: _____
_____

Do you smoke? Yes ☐ No ☐ If YES, how much?
Do you drink alcohol? Yes ☐ No ☐ If YES, how much?

Other information: _____
_____
_____

Patient Signature: _____ Keith B. Stolte M.D. _____

Date: _____ Date: _____

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Advanced Notice of Patient Responsibility for Non-Covered Services

PLEASE NOTE: If a refraction test is needed to determine a prescription for your glasses, a fee of $65.00 is collected at the time of the visit. This test is covered by vision insurance only.

A refraction test is not covered by medical insurance.

_____ _____

Patient Date

****

DILATION

To perform a thorough evaluation of the health of your eyes, it is sometimes necessary to dilate the pupils with eye drops. Please be advised of the potential for a significant decrease in vision after dilating drops, and driving may be difficult.

_____ _____

Patient Date

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ASSIGNMENT OF MEDICAL/SURGICAL BENEFIT
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I,_____hereby, irrevocably assign and transfer payment of any and all medical benefits to which I may be entitled to for services provided by Keith B Stolte M.D. under the contract of health insurance, group health insurance, Medicare, Medicaid, no-fault automobile insurance, or any type or form of insurance whatsoever, and authorize payment of said benefits directly to the physician mentioned above and or supplier. This assignment shall be binding upon my heirs, executors, and administrators.

I understand that I am financially responsible for any unpaid balance reflecting insurance deductibles, coinsurances, and non-covered services.

I authorize to release, to my insurance company, any medical or other information that may be necessary to process claims for services provided to me by the physician named above and/or supplier.

I authorize the release of pertinent medical records to the physician who referred me and to my primary care physician upon request.

All photos taken are the property of Stolte Eye Center; they may be used for insurance authorizations, educational purposes, and medical publications. Original photos cannot be released. This authorization will certify that I give full consent to have a photograph(s) taken, whether still or in motion, and to have said photograph(s) or portions thereof published. Photograph(s) taken for a specific purpose may be used for multiple purposes, including publications and advertising.

A photocopy of this authorization shall serve in the place stead of this original.

_____ _____

DATE PATIENT's or AUTHORIZED PERSON's SIGNATURE

WITNESSED BY: _____

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PATIENT INFORMATION DISCLOSURE AUTHORIZATION

Please list below the names of persons authorized to receive information from Stolte Eye Center concerning your diagnoses, treatment, and prognosis for purposes other than treatment and payment. When authorized persons request healthcare information about you, they must present a photo I.D. When authorized persons inquire via telephone, your name, date of birth, and social security number will be verified. Authorized names shall remain on file until you request removal.

NAME	**RELATIONSHIP TO PATIENT**

Patient Signature _____ **Date** _____

Patient Name _____ **Acct#:** _____

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INSURANCE TERMINOLOGY FOR PATIENTS

PARTICIPATING PROVIDER:	Any doctor who agrees to accept the Medicare allowable (not the Medicare payment) as payment in full.
MEDICARE ALLOWABLE:	The amount Medicare allows for a separate charge that may be equal to or less than the doctors.
MEDICARE PAYMENT:	Medicare pays 80% of the allowable amount after the deductible has been met.
MEDICARE DEDUCTIBLE:	Medicare requires that you pay the first they have allowed for charges submitted on an annual basis.
MEDICARE CO-PAYMENT:	What's left after Medicare pays 80% of the allowable? You are responsible for the 20% balance due under co-payments.
OUT-OF-POCKET EXPENSES:	Medicare requires that you pay the deductible plus 20% of the allowable amount.
SUPPLEMENTAL INSURANCE:	You may purchase a separate insurance policy that may pay your out-pocket expense (Medicare deductible and co-payment) in part or in full, depending on the terms of your policy.

_____ _____

Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

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 summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patients, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this Notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

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NOTICE OF PRIVACY PRACTICES

Updated 10/1/2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means obtaining service reimbursement, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage before surgery.

- Health Care Operations include business aspects of running our Practice, such as conducting quality assessments and improving activities, auditing functions, cost-management analysis, and customer service. An example of this would be new patient survey cards.

- The Practice may also disclose your PHI for law enforcement and other legitimate reasons, although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you by phone or in writing to provide appointment reminders, information about treatment alternatives, other health-related benefits and services, and other fundraising communications that may interest you. You do have the right to "opt out" concerning receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to our receiving written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures are not described in this Notice.

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You may revoke such authorization in writing, and we are required to honor and abide by that written request, except that we have already taken actions relying on your authorization. You may have the following rights concerning your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances, which we shall explain if you ask. If we agree to the restriction, we must abide by it unless you agree to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this Notice from us upon request.
- The right to be advised if you're unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket" in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the Notice of our legal duties and our privacy practice concerning PHI.

This Notice is effective as of, and we intend to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and make the new notice provision effective for all PHI we maintain. We will post, and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Signed: _____ Date: _____

Witness: _____ Date: _____

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INFORMED CONSENT OF TREATMENT

Patient's Name/I.D. #:_____ DATE:_____

I, _____(name of patient), agree and consent to health care services offered and provided by Stolte Eye Center, a health care provider. I understand that I am consenting and agreeing only to the services the provider named above is qualified to perform.

Suppose the patient is under the age of eighteen or unable to consent to treatment. In that case, I attest that I have legal custody of those named above the individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I understand and consent to the possible presence of authorized medical personnel for observation, research, and/or instructional purposes during my visits to Stolte Eye Center.

I understand my personal health information, in compliance with HIPAA, will be held in the same confidential manner and cannot be shared with any other person or entity except as specifically authorized by the facility or as required by law, as all my other records and/or procedures concerning my care.

Signature: _____ Date: _____

Relationship to Patient (if applicable):_____

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Dear patient,

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and the convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescription to mail-order pharmacies.

To implement this new program, we need to collect information from you on the pharmacies of your choice. We will define one pharmacy as your main pharmacy. However, you may also provide the information for additional pharmacies to be used as an alternative. Also, if you have a mail-order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, and fax), as any information provided will be helpful.

Patient Name: _____ Date of Birth: _____

MAIN PHARMACY

Name (i.e., CVS, Walgreens, etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

ADDITIONAL PHARMACIES YOU WOULD LIKE TO KEEP ON FILE

Name (i.e., CVS, Walgreens, etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

Name (i.e., CVS, Walgreens, etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

☐ Medco ☐ CareMark ☐ Express Scripts ☐ Pharmacare ☐ Other

Please list your allergies: _____