

Welcome to Stolte Eye Center!

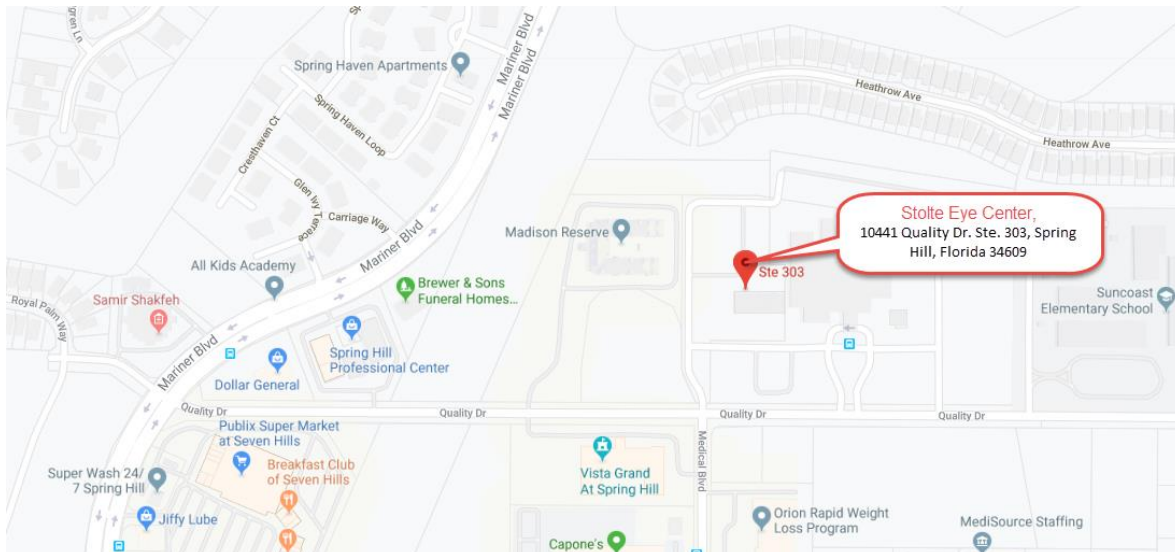
10441 Quality Dr. Ste.303, Spring Hill, Florida 34609
(352) 666-9990 Fax: (352) 666-1905

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

During this time, our technicians will be performing extensive history taking, dilation (if needed), testing and face to face time with the physician.

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.



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 payment of medical payments to Stolte Eye Center Inc. for any services rendered to me by any doctor of the 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 am subject to be charged a \$40 (twenty-five dollars) cancellation fee** for canceling my appointment without giving 24-hour notice.

I understand **I am subject to be charged a \$150 (one-hundred and fifty dollars) for 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 which state 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 with us before signing.

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

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 date and reason: _____
4. Have you ever been hospitalized?
 Yes No If YES, please provide date and reason: _____
5. Do you have any drug or food allergies?
 Yes No If YES, list: _____

List medications you are currently taking.

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

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: _____

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

In order 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

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. pursuant to contact 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 aforementioned physician 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, of any medical or other information which may be necessary to process claims for services provided to me by the above-named physician and/or supplier.

I authorize the release of pertinent medical records to the physician who referred me, as well as 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 and stead of this original.

DATE

PATIENT's or AUTHORIZED PERSONS SIGNATURE

WITNESSED BY: _____

PATIENT INFORMATION DISCLOSURE AUTHORIZATION

Please list below the names of persons who are 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 pertaining to you, they will be required to 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#:**

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 particular charge which may be equal to or less than the doctor's charge.
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 their 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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSES 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 your patient, 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 with 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.

NOTICE OF PRIVACY PRACTICES

Updated 10/1/2021

**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 are to 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 each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, 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 reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to 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 us receiving a 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



NOTICE OF PRIVACY PRACTICES

Updated 10/1/2021

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

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent 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 do agree to the restriction, we must abide by it unless you agree in writing 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 to make the new notice provision effective for all PHI that 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 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 writing.

Signed: _____

Date: _____

Witness: _____

Date: _____

INFORMED CONSENT OF TREATMENT

Patient's Name/ID#: _____

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 those services that the above-named provider is qualified to perform.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above-named 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): _____

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 some 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: _____