Welcome to Stolte Eye Center!

Keith B. Stolte, M.D., F.A.C.S
120 Medical Blvd, Ste 100 Spring Hill, Fl 34609
(352) 666-9990 Fax: (352) 666-1905

_____has an appointment scheduled with our office on

_____@ _____

We are located at 120 Medical Blvd, Suite 100, Spring Hill, Florida 34609-0221. One quarter mile past Mariner Blvd. heading east. We are open from 8:30 – 5:00 pm Monday through Friday. We are closed from 12-1 for lunch. Please visit our website and learn about our *state of the art facility* and more about Dr. Keith Stolte and our many services.

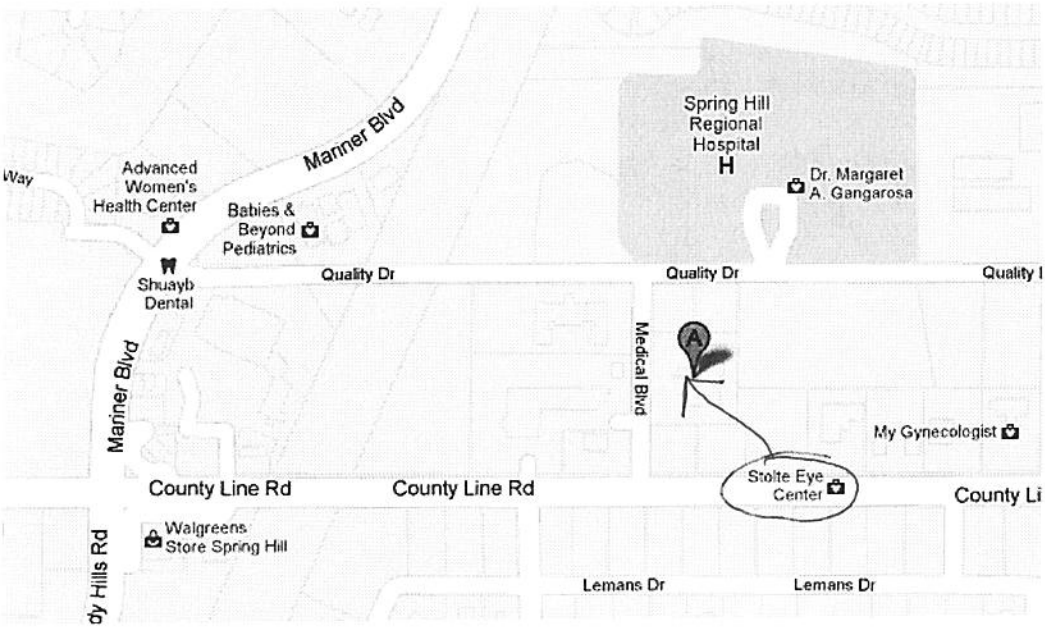
Do you have questions about a recent eye diagnosis? Go online to **Stolteeyecenter.com**

Come See the Difference…

-Need new glasses? We have an on-site optical shop with everything from high end designer frames such as Gucci, Saks 5 Ave, Dolce and Gabbana, and much more. As well as some cost effective alternatives and deals such as 2 pair of frames for only $99.00. We have very competitive pricing for frames and lenses.

-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.

We look forward to meeting you at your appointment. Thank you for choosing Stolte Eye Center for your medical services.





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PATIENT INFORMATION SHEET

Please Print Clearly Date: _____/_____/_____

Previous Patient: Yes_____ No_____ Social Security #: _____-_____-_____

Name: _____ Date of Birth: _____/_____/_____
Last First MI

Age: _____ Sex: _____ Marital Status: M S W D Home Telephone #: (____) _____

Local Address: _____ Cell phone #: (____) _____

City: _____ State: _____ Zip: _____ E-mail: _____

Mailing Address: _____
(if different than above)

Primary Physician: _____ Phone #: (_____) _____

Employed: Full Time: _____ Part Time: _____ Student: _____ Retired: _____ Not Employed: _____

Employer: _____ Phone #: (_____) _____

Spouse or Nearest Relative: _____

Relationship: _____ Phone #: (_____) _____

Please tell us how you came to choose our office.

Newspaper: _____ Phonebook: _____ Billboard: _____ Brochure: _____ Other- explain: _____

Word of Mouth: _____ Friend: _____ Doctor: _____ If so, which Doctor or Friend: _____

METHOD OF PAYMENT

Check: _____ Cash: _____ MC/Visa: _____ Am. Exp.: _____ Insurance: _____

Primary Insurance Company: _____

Policy Holder: _____ D.O.B.: _____/_____/_____ S.S. #: _____-_____-_____

Secondary Insurance Company: _____

Policy Holder: _____ D.O.B.: _____/_____/_____ S.S. #: _____-_____-_____

Patient Signature: _____
If patient is under 18, parent signature is required.

Please initial and date if information above is correct at each visit.

Initials										
Date										

Stolte Eye Center

Patient Medical History

Patients Name: _____ 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 hospitilized?
   Yes ☐ No ☐ If YES, please provide date and reason: _____
5. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, list: _____
6. Do you take any medications?
   Yes ☐ No ☐ If YES, list: _____

_____

_____

_____

Review of systems

Do you currently have any of the following problems?	Yes	No	If YES, please 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: _____ Date: _____

STOLTE EYE CENTER

The following financial policies allow us to provide excellent service to our patients. We would like to thank you in advance for placing your trust in Stolte Eye Center and allowing us to participate in your care and that of your family and friends.

Accepted Forms of Payment:

Cash, Check, Credit/Debit cards (MasterCard, Visa, Discover, and American Express), Care Credit (Medical Credit Card) Financing available, approval in minutes!

Payment Policy:

Payment is due at the time of service for any patient responsible amounts of all applicable co-pays, unsatisfied deductible amounts, and/or any non-covered services at the time of service. Any balance not paid will be turned over to collections or small claims court.

Cancel/No Show Policy:

There is a $40.00 fee for any missed appointments or cancellations not cancelled within 24 hours of appointment time.

Medicare Assignment:

Stolte Eye Center is a contracted Medicare provider and does accept assignment as payment for 80% of Medicare's approved amount, less any unsatisfied deductible amounts.

Non-covered services are those services which Medicare has deemed to be NOT MEDICALLY NECESSARY and therefore not payable under Medicare policies. This may include but not be limited to refractions, premium implants for cataract surgery, LASIK, driver's license examination form, and any cosmetic procedures which are not Medicare Benefits.

Refunds:

If at any time your account should experience a credit balance, it will be referred to the patient accounts department for reconciliation. If a refund is due to the patient, we will contact you to determine whether you prefer to have the monies returned to you or carry the credit forward to apply to future services. If a refund is due to your insurance company as the result of an overpayment, it will be refunded directly to the insurance company.

Returned Check Policy:

Checks returned for Non-Sufficient Funds (NSF), must be paid within ten (5) business days in the form of cash, cashier's check or money order only for the amount of the check plus a processing fee of twenty-five dollars per transaction. If the balance is not paid timely, the matter will be referred for legal action.

I, _____, have read the Stolte Eye Center Financial Policies and by my signature below agree to all policies set therein. I understand that it is ultimately my responsibility to ensure the payment for any services rendered to me.

_____ _____

Patient Signature Date

STOLTE EYE CENTER

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance benefits be made either to me or on my behalf for any services by APPLE OPHTHALMIC (Stolte Eye Center). I authorize any holder of medical information to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize APPLE OPHTHALMIC (Stolte Eye Center) to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s)/Medicare to make payment directly to APPLE OPHTHALMIC for medical/diagnostic/surgical benefits payable for the services rendered. I understand that unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment, and healthcare operations) and in case of an emergency.

1. Name: _____ Relationship: _____
   Phone Number: _____ DOB: _____

   Name: _____ Relationship: _____
   Phone Number: _____ DOB: _____

2. Can we send any Appointment Reminders, Lab Results, and/or Correspondence from our office to the address you listed as your home address? YES: ____ NO: ____

3. Please indicate whether or not you would want to receive calls about your appointment reminders, follow ups, test results, etc. YES: ____ NO: ____

4. Can confidential messages (appointment reminders, test results, follow up needed, etc.) be left on your telephone answering machine or voice mail? YES: ____ NO: ____

   If other than home phone, please print phone number. (_____) _____

There is a copy of the Notice of Privacy Practices for Protected Health Information (HIPAA) posted in our waiting area; copies can be given upon request.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Patient Signature: _____
If patient is under 18, parent signature is required.

Patient Name: (Print) _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

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Refraction Policy

A "refraction" is a test that is performed to determine what prescription for glasses is needed to provide you with your best possible vision.

This test is not performed on every patient. It is only performed *and billed* when requested by the patient or when a patient presents with substandard vision that would disqualify them as a legal driver based on state requirements if they wish to be eligible for a valid license.

Although many people feel that this test should be included in a medical eye examination, the Agency for Health Care Financing Administration (HCFA) that governs Medicare and other insurance guidelines has determined this service to be NON-MEDICAL in nature and therefore has deemed that payment for this service is not included in a MEDICAL eye examination.

Medical eye examinations are to evaluate the ocular health of the eye as it relates to medical conditions or diseases. While "refractive errors" that result in poor vision without corrective lenses (glasses or contacts) may not be comfortable for the patient it will not cause any adverse health issues, damage to the eye or worse vision in most situations.

If this test is performed you will be responsible for a $38.00 refraction fee that is not covered by *medical* insurances of any kind and payment for this service will be due at the time it is rendered.

By your signature, you are indicating that you understand the office policy regarding refraction fees and that you agree to pay for this service on the day that it is performed.

This test is only performed when requested by you.

_____
Print Patient Name

_____ _____
Patient Signature Date