

## COHN EYE CENTER PATIENT INFORMATION SHEET

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Maiden Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ P.O. Box (if applicable): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (     ) \_\_\_\_\_ Fax Number: (     ) \_\_\_\_\_  
Cellular phone :(     ) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_  
Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
General/Family Physican: \_\_\_\_\_ Phone: \_\_\_\_\_  
Your Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Friend/ Relative who we could call to reach you in case of emergency:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### INSURANCE INFORMATION

Do you have Medicare? Yes \_\_\_ No \_\_\_ Medicare#: \_\_\_\_\_ Is Medicare Primary? \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Policy Holder SSN: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship of Patient to Policy Holder: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ Group #: \_\_\_\_\_

### Authorizations and Assignment of Benefits

I hereby authorize the Physicians and staff of Cohn Eye Center to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to Cohn Eye Center. I understand that I am financially responsible for all charges arising from services rendered to me by Cohn Eye Center. I hereby authorize Cohn Eye Center to file on any and all insurance for any charges that I incur. I request that all payments from any of these insurance's be mailed directly to Cohn Eye Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any insurance company, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE READ AND FILL IT OUT CAREFULLY**

Who is your family physician? \_\_\_\_\_ Referring Doctor? \_\_\_\_\_

Have you ever been treated/informed you have any of the below? Please circle.

	Yes/No	When		Yes/No	When
Eye Injury	Y N	_____	High Blood Pressure	Y N	_____
Glaucoma	Y N	_____	Blood Transfusion	Y N	_____
Cataract	Y N	_____	Seasonal Allergies	Y N	_____
Retinal Detachment	Y N	_____	Diabetes	Y N	_____
Amblyopia	Y N	_____	Heart Problems	Y N	_____
Lazy/cross eye	Y N	_____	Asthma	Y N	_____
Glasses	Y N	_____	Emphysema	Y N	_____
Dry Eyes	Y N	_____	Arthritis	Y N	_____
Corneal Disease	Y N	_____	Kidney Problems	Y N	_____
Uveitis	Y N	_____	Tuberculosis	Y N	_____
Inflammation of the Eye	Y N	_____	Bruise Easily	Y N	_____
Shingles on your face	Y N	_____	Hepatitis or Liver Disease	Y N	_____
Herpes of the Eye	Y N	_____	Thyroid Disease	Y N	_____
Migraine Headaches	Y N	_____	Autoimmune Disease	Y N	_____
Brain Tumor	Y N	_____	(Lupus, Sjogrens, Rheumatoid)		_____

List other medical conditions that apply to you? \_\_\_\_\_

Has anyone in your immediate family ever been treated or informed they had any of the following? Please circle.

	Yes/No	Relative
Glaucoma	Y N	_____
Cataract	Y N	_____
Retinal Detachment	Y N	_____
Macular Degeneration	Y N	_____
Amblyopia	Y N	_____
Lazy/cross eye	Y N	_____
Migraine Headache	Y N	_____
Other eye problems	Y N	_____

List names and allergic reactions to medications. \_\_\_\_\_

List all eye surgeries and dates. \_\_\_\_\_

List any previous general surgeries. \_\_\_\_\_

List all eye medications you are taking and how often. \_\_\_\_\_

List current medications. \_\_\_\_\_

Approximate date of last eye exam. \_\_\_\_\_ Approximately how old are your glasses? \_\_\_\_\_

Have you ever worn contact lenses? \_\_\_\_\_ Type. \_\_\_\_\_

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

WHICH OF THE FOLLOWING EYE COMPLAINTS IS THE MAIN REASON FOR YOUR VISIT TODAY? CIRCLE IT! IF THERE IS MORE THAN ONE PROBLEM WHICH YOU NEED TO CIRCLE, PLEASE MARK AN "X" NEXT TO THE MOST IMPORTANT PROBLEM YOU WANT THE DOCTOR TO ADDRESS TODAY. WRITE HOW LONG YOU HAVE HAD EACH PROBLEM.

BLURRED VISION (with glasses)  
(sudden / gradual)

MATTERING OF EYES

PROBLEM DRIVING DAY / NIGHT

LID LESION OR GROWTH

CENTRAL VISION DISTORTION

BAGGY / DROOPY LIDS

DIFFICULTY READING / TV

LIGHT SENSITIVITY

DIFFICULTY WORK / HOBBIES

TEARS RUNNING DOWN CHEEKS

HALOS AROUND LIGHTS

ITCHY EYEBALLS

BURNING / STINGING EYES

ITCHY EYELIDS

RED EYES

LIGHT FLASHES

POOR DEPTH PERCEPTION

FLOATERS

EYE PAIN: STEADY / THROBBING

VEIL OR CURTAIN

GLAUCOMA

CATARACT

DRY EYES

OTHER \_\_\_\_\_

## **FINANCIAL POLICY: PLEASE READ AND SIGN**

All patients are considered Self Pay Patients and are expected to pay for their charges at the time services are rendered with the exception of MEDICARE, MEDICAID, CHAMPUS, HMO, PPO and ROUTINE VISION CONTRACTS with which Dr. Cohn participates. Self Pay Patients will be given itemized receipts that will be sufficient to submit to their insurance company for reimbursement. In the event of a hospital admission and/or surgery, the office will file the charges to your insurance company, as a courtesy. However, the financial responsibility remains with the patient. Any amount not covered by the insurance company is due from the patient. Accounts that have balances over 90days past due could possibly be turned over to a collection agency unless previous arrangements have been made.

### **To Our Patients For Whom We File Insurance As A Participating Physician, Please Note The Following:**

As a participating physician, we contract with your Insurance to file a claim for covered benefits in a timely manner. In order to do this, we verify all insurance coverage and benefits prior to your being seen. Therefore, providing us with a copy of your insurance card prior to the date of service, will speed up your initial visit.

#### **Dr. Richard A Cohn**

260 Lookout Place, Ste. 105  
Maitland, FL 32751

8000 Red Bug Lake Road, Ste. 250  
Oviedo, FL 32765

Fax: (407) 647-5744

We do collect all co-pays, deductibles and non-covered services at the time of the visit. The fact that Dr. Cohn is a participating physician does not guarantee payment of a claim or relieve you from your responsibility to pay our total fee. You are responsible and will be billed our total fee if a claim is denied because:

- *You provided us with incorrect insurance information.*
- *You did not provide a needed referral from your PCP at the time of your visit.*
- *Your insurance provides only medical coverage and after an exam, no ophthalmic medical diagnosis is found. This can occur even if your visit is recommended by another physician.*

### **MEDICARE PATIENTS**

The office will file charges to Medicare. We do collect all non-covered services (a refraction fee of \$30.00 applies when reimbursed), deductibles and the 20% approved but not paid by Medicare at the time of service unless you have a secondary medigap insurance plan.

## **HMO AND PPO PATIENTS**

The office will file charges for participating plans. Co-payments and non-covered charges are due at the time services are rendered. Almost all HMO and a few PPO plans require a referral from your Primary Care Physician before seeing Dr. Cohn. If you do not have or we have not received the required referral at the time of your visit, you will need to reschedule or be responsible for our total fee at the time of the service.

## **ROUTINE VISION CONTRACTS**

Some employers provide for routine eye coverage. This is generally different from your medical health insurance and requires preauthorization. If we participate with Vision Plan, the office will file the charges to the plan and collect all co-pays and non-covered services at the time of the visit. Your routine vision insurance must be provided, prior to being seen. We will not file after the fact.

## **YOUR SIGNATURE WILL SERVE FOR ANY OR ALL OF THE FOLLOWING:**

I hereby give consent to The Cohn Eye Center, PA (Practice Name) to provide the necessary treatment Dr. Cohn and I have discussed.

I am aware that payment is expected at the time service is rendered as explained above.

Authorization of Medical Release: I authorize Dr. Cohn to release to any third party (acting as an insurance company or government agency) any medical information requested for use in determining claim payment. I request payment benefits either to myself or to the party who accepts assignment.

Lifetime Signature Authorization for Medicare: I authorize the release of any medical information necessary to process my claim. I also request payment benefits either to myself or to the party that takes assignment.

Insurance Authorization (applies only as stated above): I authorize payment of medical benefits to the attending physician.

I permit a copy of these authorizations and assignments to be used in place of this original, which is on file at the Physician's office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA ACKNOWLEDGEMENT FORM

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

By signing this, I acknowledge that I have received a copy of the Cohn Eye Center Notice of Privacy Practices.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If the signature above is not the patient's, please state your relationship to the patient:

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

## COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT:	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific Instructions or Limitations: \_\_\_\_\_

Validation Code: \_\_\_\_\_ Please provide this code to any individual who may be involved in coordinating your care or payment for care. They will be asked for this code before information will be released over the phone.

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/  
Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_