



LaserVue

G. Brock Magruder Jr., M.D.

Thank you for choosing LaserVue/Eye Foundation for your eye care needs. As the patient, it is your responsibility to know your particular insurance policy and its obligations. This includes your obligations to see a participating physician, know your coverage and its limitations, and **be prepared to pay any out-of-pocket expenses at the time of your visit.**

Health care regulations require us to collect all co-payments, deductibles, balances and non-covered service fees or face charges of fraud.

Refraction is a non-covered service of Medicare. Medicare pays for medical eye exams that determine if there is an eye disease. Medicare does not consider wearing glasses a medical reason; therefore, Medicare does not pay for this service. According to Medicare law, when you are examined for glasses or any other non-covered service, the patient must pay out of pocket and will not be reimbursed. Payment must be made at the time of service. This may apply to other insurance carriers as well. Please be familiar with your benefits regarding refractions.

I have read the above, and understand my responsibilities regarding my insurance coverage and voluntarily give my authorization for evaluation and/or treatment by LaserVue/Eye Foundation. It has been determined that I will be responsible for partial or all of my visit for the following reason (s):

- I do not have insurance.
- I do not have a secondary insurance.
- My insurance may not cover the service provided.
- Eye Foundation is not a provider of my insurance.

Signature of Patient/Insured

Date



Dr. Mr. Mrs. Ms. _____
 Address _____
 City _____ Zip _____
 Spouses name _____

Date _____
 Soc. Sec.# _____
 Date of Birth _____ Age _____
 Home Phone _____
 Cell Phone _____
 Work Phone _____
 Occupation _____

Referred by Dr: _____

LIST ALL INSURANCES

	Name of Company	Name of Insured
Primary	_____	_____
Second	_____	_____
Third	_____	_____

Please bring your insurance identification card(s) to the receptionist at the window.

Emergency Contact

Name _____ Relationship _____ Phone _____
 Address _____

Do you have cataracts, glaucoma or other eye problems? _____

Have you had any eye surgery? If so, give type and date. _____

Family Physician (name/number) _____

Do you have any of the following? How Long?

Heart Trouble _____
 High Blood Pressure _____
 Diabetes _____
 Kidney Trouble _____
 Migraine Headaches _____
 Surgery (type/date) _____
 Other Illnesses _____

Does anyone in your family have any of the following?

Specify which relative

Glaucoma _____
 Cataracts _____
 Crossed Eyes _____
 Retinal Disease _____
 Diabetes _____

List any ALLERGIES to Medication _____

List any MEDICATIONS _____

LIFETIME AUTHORIZATION

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf for any services furnished to me by the Doctors affiliated with The Eye Foundation. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its agents, or other insurance carriers, any information needed to determine these benefits for related services.

 Date

 Signature

LaserVue / Eye Foundation ** Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review carefully.

At LaserVue / Eye Foundation, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above.

We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S. W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Bill Meyers at (407) 843-5665.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of the **LaserVue / Eye Foundation** Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

**LASERVUE / EYE FOUNDATION
HEALTH & MEDICAL PHYSICAL**

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY QUESTIONNAIRE

PATIENT: _____ **DATE:** _____
 AGE: _____ SEX: M F HEIGHT: _____ WEIGHT: _____

	PATIENT		RELATIVE			PATIENT		RELATIVE	
	YES	NO	YES	NO		YES	NO	YES	NO
Cough or cold in the past week					Tuberculosis				
Infections or contagious diseases					Shortness of Breath				
Chest Pain/Angina					Asthma				
Heart Attack					Emphysema/Bronchitis				
Heart Surgery					Convulsions/Seizures/Stroke/TIA				
Pacemaker					Fainting/Blackout Spells				
Heart Irregularity/Murmur/Fast Beat					Diabetes/Low Blood Sugar				
High Blood Pressure					Thyroid Problems				
Ankle Swelling					Liver Trouble/Jaundice/Hepatitis				
Rheumatic Fever					Kidney Problems/Dialysis				
Anemia/Sickle Cell Anemia					Cancer				
Bleeding Problems/Blood Clots					Polio/Paralysis/Meningitis				
Back Pain/Sciatica/Slipped Disc					Other Diseases Not Listed				
Weakness/numbness in arms/legs					Unusual Reaction to Anesthesia				

Do You Smoke? NO YES - Packs per day? _____
 Amount of Alcohol You Consume Each Week? _____

List all ALLERGIES:(Include: Tape, Latex, IV Dye, and Medications) _____

List all PREVIOUS SURGERIES: _____

List all MEDICATIONS that you take; include *amounts* and *how often you take each* (or attach a list).

Do you take ASPIRIN: YES NO BLOOD THINNERS: YES NO

List your Primary Care Physician: _____ Phone: _____

Address: _____ Date of last visit: _____

Person to contact in case of Emergency? _____

WHO WILL BE TAKING YOU HOME AFTER SURGERY? _____ Phone: _____

To the best of my knowledge, the above information is accurate and inclusive of my past and present medical history.

Patient's signature: _____ **Date:** _____

Medical Clearance Required? YES NO

Medical History Information Reviewed With The Patient and Agreed Correct.

SEE PHYSICAL EXAM DONE AT THE AMBULATORY SURGICAL CENTER.

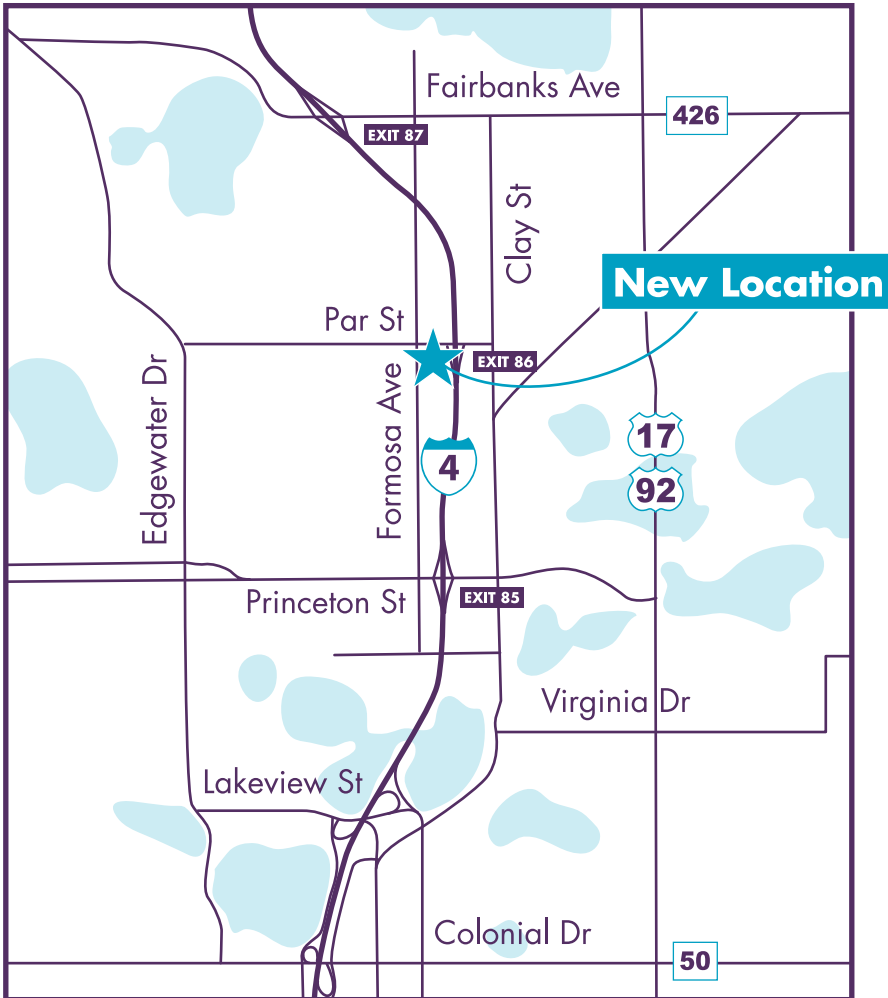
Comments: _____

SURGEON'S SIGNATURE: _____ DATE: _____



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120 E Par Street, Suite 2000 • Orlando, FL 32804

Going West on I-4:

Exit 85, Princeton Street. Turn right. Take your next right onto Formosa. Go approximately 1 miles to the next light, turn right on Par Street. Building is on the right.

Going East on I-4:

Exit 86, Par Street. Turn left and go under the overpass. Building is immediately on the left.

Coming From East/West (408):

Exit I-4 East, got to Exit 86, Par Street. Turn left and go under the overpass. Building is immediately on the left.