MALOUF EYE

6912 West Linebaugh Ave,
Suite102, Tampa, FL 33625
Phone 813-798-2020
Fax 813-798-3390
maloufeye.com

Patient Information

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Please Fill out completely and clearly.

Today's Date ____/____/____

Name: _____ Sex: Male or Female
Last First M.I.

Date of Birth: ____/____/_____ Marital Status: Single Married Divorced Widowed

Patient/ Guardian's name if patient is under 18 yrs old: _____

Address _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Primary Care Physician: _____ Phone Number: _____

Pharmacy: _____ Address: _____ Zip code: _____

Occupation: _____

How did you hear about us? _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (EMERGENCY CONTACT)

Name _____ Relationship to patient: _____
Home Phone: _____ Work Phone: _____

PRIMARY CARE PROVIDER

Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

PREFFERED PHARMACY

Name: _____

Address: _____ Phone Number: _____

History and Intake Form

Past Medical History (please circle all that apply)

NONE

Anxiety	Coronary artery disease	Thyroid Problems
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End renal stage	Lymphoma
Bone marrow	GERD	Prostate Cancer
Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High blood pressure	Stroke
COPD	HIV/Aids	High Cholesterol

Other _____

Past Surgical History (please circle all that apply and indicate Right, Left, Bilateral)

NONE

Cataracts	Joint Replacement within last 2 years	Bladder removed
Kidney Biopsy	Mastectomy	Kidney removed
Heart stents	Kidney stone removal	Kidney Transplant
Breast biopsy	Breast reduction	Ovaries removed
Breast implants	Prostate Removed	Colectomy
Prostate Biopsy	Gallbladder removed	Coronary Artery
Spleen removed	Mechanical Valve Replacement	Heart Transplant
Biological valve replacement	Testicles removed	Hysterectomy
Joint Replacement (hip)	Joint replacement (knee)	

Other_____

Eye Disease and Surgical History

Cataracts	Pressure	Dry Eyes / Tearing
Glaucoma	Light Sensitivity	Red Eye / Itching / Pain
Diabetic Retinopathy	Droopy Eyelids	Injury
Double Vision	Blurry Vision	Glare
Retinal Detachment	Burning	Flashes / Floaters
Blindness		

Other _____

Medications: (please enter all current medications)

_____

_____

_____

Allergies: (please enter all allergies)

_____

_____

Family History

Do you have a family history of Glaucoma? Y / N Relative: _____

Do you have a family history of Macular Degeneration? Y / N Relative: _____

Do you have a family Diabetes? Y / N Relative: _____

Do you wear Glasses? Y / N If yes, how old are they? _____ Do you wear contacts? Y / N If yes, how long?____

Distance Only Reading Only Bifocal Progressive Trifocal

Social History

Cigarette smoking:

Has smoked in the past

Currently smokes

Never smoked

Former smoker

Alcohol use:

EtOH- None

EtOH- less than one drink per day

EtOH- 1-2 drinks per day

EtOH- 3 or more drinks per day

Please describe the reason for visiting the office today: (Right or Left Eye or both)

_____

_____

_____

_____

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PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing Malouf Eye as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or the patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan
- Co-pays are due at the time of service.
- Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

- Charge for returned checks $30.00

Patient Acknowledgement and Authorization

- We respect patient confidentiality and only release personal health information about you in accordance with State and federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy notice provided by Malouf Eye. I hereby authorize Malouf Eye to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Patient Name _____

Patient/Guardian Signature _____ Date _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my health information to MALOUF EYE. Please forward a full and complete copy of my medical records and all health information about me to Dr. Jorge Malouf via

Fax: to 813-798-3390

OR

Mail: 6912 W. Linebaugh Ave. Suite 102, Tampa, FL 33625.

The purpose for the use or disclosure is to initiate and/or follow-up on care with Dr. Jorge Malouf at Malouf Eye.

Name of Patient_____

Address _____

Phone Number _____

Date of Birth _____ **Social Security** _____

Name of Patient or Guardian _____

Signature of Patient/Guardian _____ **Date** _____

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HIPAA NOTICE OF PRIVACY PRACTICES

We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information in reference to your treatment, payment, or health operations, in order to provide health care that is in your best interests in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. My signature confirms that I am aware of my rights to privacy regarding my protected information.

Malouf Eye will be using an electronic prescribing method to enable you to get your medications filled at your pharmacy or through your RX mail order process. This will also assist Malouf Eye health care providers in understanding what other medications may have been prescribed for you by other providers.

We may use your information to contact you. For example: we may send you yearly appointment reminders, we may also want to call and remind you about your appointments. If you are not at home, we may leave this information on your answering machine/voice mail, or with a person who answers the phone.

Here at Malouf Eye, we are committed to treating and using protected health information (PHI) about you responsibly. This notice of Privacy Practices Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This notice has been updated in accordance with the HIPAA Omnibus Rule and is effective September 23rd, 2013.

I hereby affirm that the information submitted (and any addendums) is true to the best of my knowledge and is provided here in good faith.

I have read this notice [X] I prefer not to read & No Copy needed [ ] I understand notice [ ] Copy Needed & given [ ]

The below signature applies to the following sections of the above document.

X_____

Patient/Parent/Legal Guardian's Printed Name

X_____ _____

Signature **Date**

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Patient Consent for Use and Disclosure

of Protected Health Information

I hereby give my consent for Malouf Eye to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

The below signature applies to the following sections of the above document.

X_____

Patient/Parent/Legal Guardian's Printed Name

X_____ _____

Signature **Date**

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No-show/late cancellation policy

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling [813.798.2020], emailing {info@maloufeye.com, or using the patient portal.

If you do not show up for your appointment, or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. No-show appointments may be **subject to a $50 fee**. No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. If the no-show fee might prevent you from receiving necessary care, please contact us.

We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

If our office must cancel your appointment with less than 24 hours notice, on the same day, to reschedule, or to cancel. In these circumstances, we will not charge you a cancellation fee.

Signature of Patient / Legal Representative Witness _____

Patient Name _____ Date _____