PATIENT INFORMATION DATE:

SECTION 1

NAME: _____ DOB: _____ AGE: _____

CURRENT MAILING ADDRESS: _____

CITY/ STATE/ ZIP CODE: _____

HOME PHONE: ( )- _____ CELL: ( )- _____ WORK: ( )- _____

EMAIL ADDRESS: _____

MALE: ____ FEMALE: ____ OTHER: ____ SINGLE: __ MARRIED: __ OTHER: __

DRIVERS LICENSE: _____ SSN# _____

EMPLOYER: _____

SECTION 2

IF YOU ARE A MINOR: WHO IS THE RESPONSIBLE PARTY? _____

***REQUIRED INFO**FOR THE RESPONSIBLE PARTY

NAME: _____

RELATIONSHIP TO PATIENT: _____ YOUR DOB: _____

YOUR SSN#: _____ YOUR EMPLOYER: _____

YOUR WORK PHONE #: _____ YOUR EMAIL: _____

YOUR DRIVERS LICENSE: _____

SECTION 3

WHO CAN WE NOTIFY IN CASE OF AN EMERGENCY? : _____

PHONE: _____

RELATIONSHIP TO YOU: _____

HAVE YOU EVER BEEN SEEN BY DR KWITKO BEFORE? YES ___ NO ___

IF YES, WHEN? _____

LANGUAGE SPOKEN: ENGLISH ___ SPANISH ___ OTHER _____

INSURANCE INFORMATION

PRIMARY INSURANCE PROVIDER : _____

NAME OF PERSON THAT INSURANCE COVERAGE IS UNDER: _____

POLICY / CONTRACT NUMBER: _____

GROUP NUMBER: _____ EFFECTIVE DATE OF COVERAGE: _____

INSURED PERSONS DOB: _____ SSN#: _____ PH # _____

EMAIL: _____

RELATIONSHIP TO PATIENT: _____

**** IF YOU HAVE MEDICARE AS YOUR PRIMARY INSURANCE, DO YOU HAVE A SECONDARY SUPPLEMENTAL INSURANCE? YES: ____ NO: ____

**** IF YOU HAVE MEDICARE AS YOUR PRIMARY INSURANCE AND A SECONDARY INSURANCE, DOES YOUR SECONDARY 1) CROSS OVER FROM MEDICARE AUTOMATICALLY? YES: ___ NO: ___

2) HAVE ITS OWN DEDUCTIBLE? YES: ____ NO: ____

3) HAVE ITS OWN COPAYMENT? YES: ____ NO: ____

SECONDARY INSURANCE INFORMATION:

SECONDARY INSURANCE PROVIDER: _____

NAME OF PERSON THAT SECONDARY INSURANCE COVERAGE IS UNDER: _____

POLICY / CONTRACT NUMBER: _____

GROUP NUMBER: _____ EFFECTIVE DATE OF COVERAGE: _____

INSURED PERSONS DOB: _____ SSN# _____ PH# _____

IS THIS VISIT RELATED TO A WORKMANS COMPENSATION OR AUTO ACCIDENT?
YES: ____ NO: ____

IF AUTO RELATED:
WHAT IS THE DATE OF THE ACCIDENT?:

_____
WHAT IS THE PIP?: _____

OTHER INFORMATION NEEDED

1) NAME AND ADDRESS OF PHARMACY:
_____PHONE:_____
_

2) PRIMARY CARE PHYSICIAN:
_____ PHONE:
_____

3) Height:_____ Weight:_____

THE FEDERAL GOVERNMENT REQUIRES THAT WE COLLECT THIS INFORMATION ON RACE AND ETHNICITY.
PLEASE CHECK ALL THAT APPLIES:
RACE
_____ AMERICAN INDIAN OR ALASKAN NATIVE _____ WHITE/CAUCASIAN
_____ ASIAN _____ AFRICAN AMERICAN
_____ HISPANIC OR LATINO _____ DECLINED TO PROVIDE
_____ NATIVE HAWAIIAN/PACIFIC ISLANDER

ETHNICITY
_____ HISPANIC OR LATINO _____ NO ETHNICITY SELECTED
_____ NON-HISPANIC OR LATINO _____ DECLINED TO PROVIDE

PATIENT HISTORY

PATIENTS NAME: _____ TODAYS DATE: _____

DATE OF BIRTH: _____ REFERRING DOCTOR: _____

REFERRING DOCTORS OFFICE PHONE NUMBER: _____

PLEASE LIST ANY MEDICATIONS AND SUPPLEMENTS THAT YOU ARE TAKING, INCLUDING ANY EYE DROPS:

_____

_____

_____

Do you have any allergies to medication? Yes ___ No___
If YES, please explain: _____
Experiencing fever or weight loss? Yes ___ No ___
If YES, please explain: _____

Circle all that apply:

EYES: Glaucoma Cataract Lazy eye Retina problems Loss of vision

Pupils that are different sizes Tearing Pain Redness Sagging skin

Other: Please specify: _____

GENERAL HEALTH:

Hearing Loss Sinus Problems Sore Throat

Heart Problems Chest Pain Irregular Heart

Asthma Shortness of Breath Wheezing Coughing

Heartburn Acid Reflux Diarrhea Vomiting Abdominal Pain

Urinary problems Blood in your urine

Skin Rashes Excessively Dry Skin

Muscle aches Joint Pain Swollen Joints Arthritis

Numbness Weakness Headaches Paralysis Tingling in Hands or Feet

Leukemia Blood Disorders

Hay Fever Allergies

Thyroid Problems

Depression Anxiety

High Blood Pressure

Cancer - Please list what type of cancer(s) you have had or are being treated for

FAMILY HISTORY – CIRCLE ALL THAT APPLY

Glaucoma
Diabetes
High Blood Pressure
Macular Degeneration
Cancer
Heart Disease
Other

Do you smoke? Yes No How many per day?
Are you a former smoker? Yes No

Do you drink alcohol? Yes No
If YES, how many drinks per day? _____
If YES, how many days per week do you drink?_____

GEOFFREY M. KWITKO, M.D.
F.A.C.S., F.I.C.S., F.A.A.O., F.N.O.S.S., F.I.S.O.D.
COSMETIC & RECONSTRUCTIVE OCULOPLASTIC, ORBITAL, LACRIMAL & NEURO-OPHTHALMIC SURGERY

PLEASE READ CAREFULLY
DOCTOR-PATIENT ARBITRATION AGREEMENT

This agreement is made between Geoffrey M. Kwitko, M.D., their agents, employees or any of the foregoing, referred to herein after as "Doctor" and _____, referred to hereinafter as the "Patient". It is the intention of the parties to this agreement to bind not only themselves, but also the heirs, personal representatives, guardians, children, spouses, or any person deriving their claims through or on behalf of the patient.

It is understood by the patient that he or she is not required to use Geoffrey M. Kwitko, M.D. nor any of the foregoing referred to as "Doctor" for ophthalmologic services and that there are numerous other physicians in the Tampa Bay area who are qualified to perform ophthalmologic services.

For and in consideration of the mutual benefits flowing one to the other, it is understood and agreed that in the event of any controversy, dispute or claim which might arise between the doctor and patient, regardless or whether the dispute concerns medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided in the Florida Arbitration Code, Chapter 682, Laws of Florida. **IT IS UNDERSTOOD THAT THIS ARBITRATION SHALL BE IN LIEU OR INSTEAD OF ANY TRIAL BY JUDGE OR JURY.** Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The arbitrators shall be licensed physicians certified by the American Academy of Ophthalmology in the State of Florida. The panel of arbitrators shall hear and decide the controversy, dispute or claim, and the decision shall be binding on all parties.

It is further understood and agreed by the parties hereto that the arbitration of any controversy, dispute or claim pursuant to this agreement shall be commenced within the time prescribed by the applicable Florida Statute of Limitations. An action pursuant to this agreement shall be deemed to commence upon the receipt of a written claim notifying the Doctor or Patient, whichever the case may be, of the nature of the controversy, dispute or claim, and demanding that the parties proceed with arbitration in accordance with the terms of this agreement. The maximum recoverable damages under this agreement are limited to $250,000.00

In witness thereof, I (We) have set our hands this _____ day of _____, 20_____

"Doctor" "Patient"

By _____ By _____
Authorized Agent Patient

Witness: _____

Witness: _____

Dr. Geoffrey M. Kwitko, M.D., F.A.C.S.,F.I.C.S.,F.A.A.O.,F.N.O.S.S.,F.I.S.O.D.

CONSENT FOR TREATMENT, PAYMENT, AND OFFICE POLICIES

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I understand that diagnosis or treatment of myself may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed in order to carry out treatment, for payment of services provided, or within the health care operations of this practice. The above organization is not required to agree to the restrictions that I may request. However, if the above organization agrees to the restriction that I request, the restriction is binding between myself and the above organization.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health, or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the above Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the above organization. The Notice of Privacy and Practices are also provided at the above organization's website, if applicable. The Notice of Privacy and Practices also describes my rights and the above organization's duties with respect to my protected health information.

The above named organization reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ Signature of Patient or Personal Representative

_____ Printed Name of Patient or Personal Representative

_____ Relationship of Representative to Patient

Date:_____

GEOFFREY M. KWITKO, M.D.
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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent or uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and we will do all that 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 information, and information about the treatment, payment or health care operations, in order to provide health care that is in your best interests.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

TO OUR VALUED PATIENTS:

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "PRIVACY RULE". We strive to achieve the very highest of standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect. Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Geoffrey M. Kwitko, M.D.
F.A.C.S., F.I.C.S., F.A.A.O., F.N.O.S.S., F.I.S.O.D.

COSMETIC & RECONSTRUCTIVE OCULOPLASTIC, ORBITAL, LACRIMAL & NEURO-OPHTHALMIC SURGEON

CLINICAL ASSISTANT PROFESSOR, UNIVERSITY OF SOUTH FLORIDA

CONSENT TO OBTAIN MEDICATION HISTORY

DATE: _____ PATIENT NAME (PLEASE PRINT): _____

As a user of electronic medical records, we would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and health insurance company.

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions. By signing this consent form you are giving us permission to collect this medication history, and your pharmacy and health insurance company to provide us with information about your prescriptions that have been filled at any pharmacy or were covered by your health insurance plan. This includes prescription medicines to treat HIV/AIDS and medicines to treat mental health conditions, such as depression. This information will become part of your electronic medical record, should your provider feel that it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make a persons' drug history available to us, and the drug history might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything that you are taking, and for you to tell us about any errors in your medication history.

____ I give permission for Dr. Geoffrey M. Kwitko to obtain my medication history from my pharmacy, my health insurance company and my other health care providers.

____ I DO NOT give permission for Dr. Geoffrey M. Kwitko to obtain my medication history from my pharmacy, my health insurance company and my other healthcare providers.

_____ _____

Print Patient Name/ Guardians Name **Patients Date of Birth**

_____ _____

Signature of Patient or Guardian **Relationship to Patient**

GEOFFREY M. KWITKO, M.D.
F.A.C.S., F.I.C.S., F.A.A.O., F.N.O.S.S., F.I.S.O.D.

CURRENT OFFICE POLICY

1. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO, OFFICE VISIT COPAYMENTS, DEDUCTIBLES, SURGICAL COPAYMENTS, AND COLLECTION FEES.**
2. If we cannot verify your insurance coverage on your first office visit, you are responsible for the payment in full at the time of the visit.
3. If you are covered by an HMO you must have prior authorization for your visit or you must reschedule your appointment. If you do not want to reschedule, you must pay the doctors fee in full at the time of your visit.
4. Any insurance copayments and deductibles must be paid at the time of your office visit. Self-pay patients must pay in full at the time of their visit.
5. If you have Medicare coverage and no supplemental insurance, you must pay the Medicare 20% coinsurance at the time of your visit.
6. If your insurance company requests any information such as additional insurance policies, injury reports, prior medical history etc., you must cooperate and comply with the insurance company within a timely manner. Failure to do this will ensure that you will be fully responsible for this bill.
7. There is a $50.00 for returned checks.
8. We do not give out medical information over the phone, as required by law, nor do we email or mail medical records. We are HIPAA compliant.
9. Minor children must have a guardian or parent present during an office visit.
10. We will file your secondary insurance for you as a courtesy. If after filing twice, your insurance company does not issue payment, you will be billed for any remaining balances and you will be responsible for the payment of these charges.
11. We do not file third insurances for patients.
12. **IF SURGICAL PROCEDURES ARE AUTHORIZED BY YOUR INSURANCE COMPANY AND THEY THEN DENY PAYMENT OF YOUR CLAIMS, YOU ARE RESPONSIBLE FOR THE PAYMENT OF THESE CLAIMS.**
13. If you receive a bill from our office, you will only receive that ONE bill. You will have 30 days from the date of the invoice to pay your bill in full. Any

remaining balances after this time will be turned over to our collection agency.

14 There may be a medical student present during the office visit examination unless you refuse it.

I _____ hereby have read and fully understand these policies and I will abide by them.

_____

Patient / Parent or Guardian Signature (if patient is a minor) Date

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make any payable benefits to Dr. Geoffrey M. Kwitko, M.D., and a copy of this assignment shall be considered as valid as the original. I authorize the doctor to initiate any complaints to the Insurance Commissioner for any reason on my behalf.

_____

Patient / Parent or Guardian Signature Date

RELEASE OF MEDICAL RECORDS

I agree to allow Dr. Geoffrey M. Kwitko, M.D., to release a copy of my medical records, if so requested by me either now or in the future, to another party to be designated by me at the time of my request. I authorize any physician who has examined and/or treated me, to release any and all medical information and records concerning diagnosis and treatment to Dr. Geoffrey M. Kwitko, M.D.

_____

Patient / Parent or Guardian Signature Date

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

I consent to be photographed and authorize the use or disclosure of such photos, which will be cropped to the eye area only, in order to assist scientific treatment, educations, public relations, marketing and I hereby waive any right to compensation for such used by reason of the foregoing authorization. I may refuse to sign this authorization. I have a right to receive a copy of this authorization.

Patient Signature & Date: _____