Do you wear contacts ? Yes or No

Do you need a separate contact exam ? Yes or No

Bedotto Wallace Clewner & Kelly

Lawrence M. Clewner, M.D. • William J. Kelly, M.D.

EYE PHYSICIANS AND SURGEONS — FELLOWS OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

WELCOME TO OUR PRACTICE

Thank you for choosing us as your eye care professional. We will be giving you the most thorough eye examination possible. In order to prepare your important medical record, we need the following information from you. Please print clearly and fill out this form completely.

Date of Birth_____Sex_____ ss number_____

Name_____
last first middle

Street Address _____ Apt # _____

City_____ State_____Zip _____

Home phone # _____ work phone # _____

Occupation_____ Employer _____
if retired what was your occupation

Spouse's name _____or next of Kin _____

Their address _____phone #_____

Other address if your Florida address is not your permanent one

Street_____ Apt# _____

City_____ State ____Zip _____Phone# _____

How were you referred to our practice?_____

Present Physician_____ Phone # _____

Their Address_____

INSURANCE INFORMATION: Please provide complete information for proper insurance filing and reimbursement. We will need to photocopy your insurance cards and a photo ID for your medical record.

Primary Insurance Carrier_____

Secondary Insurance Carrier_____

Marital Status_____Next of Kin_____

Relationship_____ Phone Number_____

Financially responsible party_____

Have you been referred to our office by an attorney___ YES___NO

If so please give us their name and address_____

_____

(IF YOU HAVE BEEN REFERRED BY AN ATTORNEY, YOU ARE NOTIFIED THAT WE EXPECT PAYMENT OF ALL FEES TODAY. WE DO NOT DEFER FEES UNTIL RECOVERY BY YOUR ATTORNEY.)

IS THIS A WORKERS COMPENSATION CLAIM_____ YES _____NO

IF SO HAVE YOU NOTIFIED YOUR EMPLOYER_____ YES _____NO

I AUTHORIZED DRS. BEDOTTO, WALLACE, CLEWNER, OR KELLY TO RENDER MEDICAL TREATMENT FOR THE ABOVE MENTIONED PATIENT.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE INCLUDING DEDUCTIBLES AND CO-PAYMENTS.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND I CONSENT TO THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED FOR INSURANCE CLAIM PROCESSING.

I AUTHORIZE PAYMENT TO MEDICAL CHARGES TO DRS. BEDOTTO, WALLACE, CLEWNER, OR KELLY.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES DENIED BY INSURANCE.

IF THIS ACCOUNT IS REFERRED OVER FOR COLLECTION TO AN AGENCY, ATTORNEY, OR SMALL CLAIMS COURT, THE PATIENT IS LIABLE FOR ALL FEES AND COURT COSTS INVOLVED.

I UNDERSTAND IF MY INSURANCE REQUIRES A PRE-AUTHORIZATION TO BE SEEN IN THIS OFFICE AND I DID NOT BRING IT WITH ME THAT I WILL BE RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED.

A PHOTOCOPY OF THIS AUTHORIZATION MAY BE HONORED.

SIGNATURE:_____ DATE: _____

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

I,_____

Name Date Of Birth

Hereby authorize the release of all medical documentation, including PHI that I could personally obtain upon request from any healthcare provider, medical care facility, insurer or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 to:

_____

Name Address, City, State, Zip Code

_____

Name Address, City, State, Zip Code

The person(s) named above is/are hereby designated as my "personal Representative(s)" as that term is used within HIPAA.

Upon presentation of this authorization, you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal law.
This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164)

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical provider.

Signature of person authorizing disclosure:

_____ _____

Date

Witnessed on the above date by: _____

(Witness should not be any of the persons listed above)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION FORM

Bedotto Wallace Clewner & Kelly

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your physician, office staff and others outside of the office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and related services. This includes coordination or management of your health care with a third party. For example: We would disclose your PHI to a home health agency that provides care to you or to a physician to whom you have been referred to or from whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used as needed to obtain payment for your health care services.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of your physician's practice. We may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may call you by name from the waiting room. We may use your PHI to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These include as Required by law, Public Health issues as required by law, Communicable Diseases, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation.

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Previous Name/s(aka):_____

I Authorize: _____

Phone # _____

To release my health care information to: Bedotto, Wallace, Clewner & Kelly MD., P.A.
1701 N Federal Hwy Ste #1
Boca Raton, FL 33432

For the purpose of reviewing my records.

Information to be released:

___ **All Medical Records**
___ **All Medical Billing Records**
___ **X-Ray and imaging reports**
Other: _____

Dates of Treatment:

_____ **All Dates**
_____ **Specific Dates**

I understand that my express consent is required to release any health care information relating to testing/diagnosis and/or treatment of HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and or/ alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/ or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization diagnosis, prognosis, treatment medication and pharmacy records, correspondence, consults statement of charges or expenses. Any and all reports of any type or character.

I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the Facility/Provider or write a letter to the Facility/Provider.

I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or Enrollment).

This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and as an original.

Signature of Patient or Legal Representative_____ **Date:** _____

If signed by Legal Representative, relationship to Patient: _____

Signature of Attorney or Witness: _____

Bedotto Wallace Clewner & Kelly

EYE PHYSICIANS
AND SURGEONS
FELLOWS OF THE AMERICAN
ACADEMY OF OPHTHALMOLOGY

1701 N. FEDERAL HWY.
BOCA RATON, FLORIDA 33432
TELEPHONE: (561) 395-5666
FAX: (561) 368-0883

LAWRENCE M. CLEWNER, M.D.
WILLIAM J. KELLY, M.D.

Patient Name: _____

Pharmacy Name: _____

_____

Pharmacy Phone Number: _____

Pharmacy Address: _____

_____

_____

_____

_____

Dear Valued Patient

Our current refraction fee is $75.00

What is a Refraction?

A Refraction is the testing to discover a patients best possible visual acuity. Testing is performed to determine the need for glasses and the most up-to-date prescription needed to provide you with clear vision. This testing is also necessary to determine if your vision complaint is originating from a need for glasses verses other pathology within your eye. This is considered an extremely important part of your examination and should be performed at least once a year.

Does my insurance cover a Refraction?

Medicare and majority of private insurances, while recognizing the importance of this test, does not cover the payment for these services, and we therefore require payment for this testing at the time of service.

We thank you for your patronage and understanding

X_____ _____

Patient Signature Date