Miramar
EYE INSTITUTE

Surgery and Diseases of the Eye **Kenneth O. Karp, M.D.**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

NAME: _____

ADDRESS: _____

TELEPHONE: _____SOCIAL SECURITY: _____

SECTION B: To the patient – please read the following statements carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health care information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a Revised Notice to Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at any time by contacting the Miramar Eye Institute:

Miramar Eye Institute **Telephone: 954-437-4316**
1951 S.W. 172nd Ave. Suite 301
Miramar, FL 33029

Right to Revoke. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health care information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

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Consent for Disclosure of Medical Information
(Permiso para divulgar su condición médica)

I, _____, hereby allow and give consent for the following family members, friends, or health care surrogates to accompany me in the exam room during my visit or discuss my health information with the physician:

Yo, _____, autorizo a los siguientes familiars, amistades o personas a cargo de mi bienestar, a presenciar o discutir mi condición de salud durante mi visita con el médico:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

May we leave a message on your answering machine, cell phone, or with the person that answers the phone?
(Nos permite dejar un mensaje en su grabadora, cellular, o con la persona que conteste el teléfono?)

_____ YES (SI) _____ NO

_____ _____
Signature of Patient or Guardian Date/Fecha
(Firma del paciente o guardian)

_____
Signature of Witness/ (Firma del Testigo)

1951 S.W. 172nd Ave. # 301
Miramar, FL 33029

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Kenneth O. Karp, M.D

IMPORTANT NOTICE TO MY PATIENTS

Please be aware that your vision could be temporarily impaired following eye examinations at my office. Eye drops that dilate your pupils may be a necessary part of your exam to assure accurate results and to aid in the diagnosis and treatment of your eye disease. The use of dilating drops as well as other methods of examination and treatment may cause blurred vision, possibly interfering with your ability to drive safely. If your vision is blurred, please feel free to stay in my office until your vision returns to normal. If necessary, my staff can assist you in arranging for alternative transportation. If you have any questions, please ask my staff.

Patient Signature _____

Witness Signature _____

Date _____

NOTICE TO PARENTS AND LEGAL GUARDIANS

I understand that my child's eyes may be dilated which could temporarily impair vision. Climbing, bike riding and other activities could be potentially dangerous and should be avoided until vision returns to normal. If you have any questions, please ask my staff.

Parent's Signature _____

Witness Signature _____

Date _____

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PATIENT INFORMATION (información del paciente)

DATE: _____ (fecha) SOCIAL SECURITY #:_____-_____- _____ (no. seguro social) BIRTHDATE: _____-_____-_____ (fecha de nacimiento)

LAST NAME_____ (apellido) FIRST NAME:_____ (nombre) M.I._____ (inicial del 2do nombre)

ADDRESS:_____ (dirección) STREET NAME (calle) APT. (apto.) CITY (ciudad) STATE (estado) ZIP (código postal)

PHONE #: (_____)_____ - _____ (teléfono) AGE:_____ (edad) ❑ MALE (hombre) ❑ FEMALE (damas)

CELLULAR PHONE: _____ E-MAIL_____

IN CASE OF EMERGENCY, PLEASE CONTACT _____ (en caso de emergencia, Llame a) PHONE #_____ (número de teléfono)

OCCUPATION:_____ (ocupación) EMPLOYER PHONE #:_____ (telélono del empleador)

WHO IS YOUR EYE DOCTOR?_____ (quién es su oculista) WHO IS YOUR FAMILY DOCTOR? _____ (quién es su doctor general)

NAME OF INSURANCE COMPANY: (nombre de la compañía seguro) _____

HISTORY (historia)

DO YOU HAVE? (Usted tiene)

____HIGH BLOOD PRESSURE (presión alta)

____ DIABETES (diabetes)

____ ASTHMA/SHORTNESS OF BREATH (asma) (dificultad al respirar)

____ HEART DISEASE / ATTACK (problemas cardíacos)

____ STROKE (derrame cerebral)

____ STOMACH PROBLEMS (problemas estomacales)

____ARTHRITIS (artritis)

____ HIV (sida)

____ FEVER/ WEIGHT LOSS (fiebre - pérdida de peso)

____ CANCER (cáncer)

____ KIDNEY DISEASE (problemas de riñones)

____ GLAUCOMA

____ LIVER DISEASE (hepatitis)

____ OTHER/ OTRO

HAVE YOU EVER SMOKED? HOW MUCH?
(alguna vez ha fumado) (cuánto) _____

HAVE YOU EVER USED ILLICIT DRUGS? ___ YES (sí) ____ NO (no)
(alguna vez a usado narcóticos sin receta)

HAVE YOU HAD SURGERY ON THE **BODY/EYES**?
(ha tenido cirugía)

_____ YES (sí) _____ NO (no)

YES, WHAT TYPE (si la respuesta es sí, qué tipo)_____
_____
_____

LIST ALL MEDICINES YOU ARE TAKING: (Including eye drops)
(escriban todas las pastillas y colirios que esten tomando)

_____
_____
_____
_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? WHICH ONES? (Usted tiene alguna alergia a algún medicamento) (qué tipo)

_____ YES (sí) _____ NO (no)
_____
_____

IS THERE A FAMILY HISTORY OF: (historia de problemas en los ojos en la familia)

_____ GLAUCOMA? _____ RETINAL DISEASE? (enfermedad de la retina)_____BLINDNESS? (ceguera) REVIEWED by___,____,____

AUTHORIZATION TO PAY /FOR MEDICARE, LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to my insurance company, and, for Medicare/Blue Cross/Blue Shield to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of Blue Cross/Blue Shield of Florida, any information needed for this or a related insurance or claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/ or surgical insurance benefits, otherwise payable to me, to the party who accepts assignment. I understand that I am financially responsible for those charges not paid by my insurance.

_____ _____
PATIENT SIGNATURE DATE OTHER SIGNATURE/REASON, IF PATIENT IS UNABLE TO SIGN DATE

Miramar

EYE INSTITUTE

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES	INITIAL

ASSIGMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE MIRAMAR EYE INSTITUTE OF ANY AND ALL MEDICAL BENEFITS APPLICABLE AND OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE MIRAMAR EYE INSTITUTE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE MIRAMAR EYE INSTITUTE TO FURNISH MY INSURANCE COMPANY OR COMPANIES, OR THEIR REPRESENTATIVES WITH ANY AND ALL INFORMATION THAT MAY BE CONTAINED IN THEIR MEDICAL RECORDS.

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMIDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THE MIRAMAR EYE INSTITUTE ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE MADE TO THE HOLDER OF THIS ASSIGMENT ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH DEDUCTIBLES AND COINSURANCE.

MEDIGAP: I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE ON MY BEHALF TO THE MIRAMAR EYE INSTITUTE FOR ANY SERVICES FURNISHED TO ME BY THEM. I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO _____ ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I DO NOT NEED TO PROVIDE MY SUPPLEMENTAL INSURER WITH INFORMATION CONCERNING THIS MEDICARE CLAIM, BECAUSE MY SIGNING THIS AUTHORIZATION WILL CAUSE MEDICARE PAYMENT INFORMATION TO CROSS OVER AUTOMATICALLY.

LIABILITY/INSURANCE WAIVER: I HEREBY STATE THAT I WISH THE MIRAMAR EYE INSTITUTE TO SUBMIT MY CLAIM FOR MEDICAL SERVICES TO _____ FOR SERVICES RENDERED FOR THE ACCIDENT DATE OF _____. I AM NOT FILING THIS CLAIM WITH ANY OTHER LIABILITY INSURANCE AND WILL NOT BE MAKING ANY CLAIM TO ANY OTHER GENERAL LIABILITY INSURANCE OR COMPANY. I ALSO UNDERSTAND THAT IF I DO SUBMIT THIS TO ANY OTHER GENERAL LIABILITY INSURANCE OR COMPANY THAT _____ WILL HAVE TO BE REFUNDED IMMEDIATELY AND THE TOTAL AMOUNT ORIGINALLY CHARGED FOR THE SERVICES RENDERED WILL BECOME DUE AND PAYABLE BY ME. FILING YOUR LIABILITY INSURANCE DOES NOT CONSTITUTE AN ASSIGMENT. IF THIS IS A LEGAL,WE DO NOT ACCEPT ASSIGNMENT PENDING THE OUTCOME OF YOUR CASE. YOU ARE RESPONSIBLE FOR YOUR BILL IN ITS ENTIRETY.

IF THE PATIENT IS UNDER 18: I HEREBY GIVE MY PERMISION FOR _____ _____TO BE TREATED BY DR. KENNETH O. KARP.

_____ _____ _____

SIGNATURE/TELEPHONE VERIFICATION WITNESS DATE

PLEASE READ: THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. ALL CHARGES ARE DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYS AND NON-COVERED SERVICES NOT PAID BY MY INSURANCE COMPANY. IF A CHECK IS RETURNED, THERE WILL BE A $15 SERVICE CHARGE. IF MY ACCOUNT BECOMES DELINQUENT IN PAYMENT, I AGREE TO PAY ALL COSTS OF COLLECTION INCLUDING A REASONABLE ATTORNEY'S FEE.

METHOD OF PAYMENT: ☐ **CASH** ☐ **VISA** ☐ **M/C** ☐ **DISCOVER**

_____ _____ _____

DATE PATIENT/ GUARDIAN SIGNATURE WITNESS

THESE AUTHORIZATION MUST BE SIGNED IN ORDER TO EXPEDITE THE FILING OF YOUR INSURANCE CLAIM

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Dear Patient:

If you are here for a new pair of glasses to improve your vision, then a test called "REFRACTION" must be done. In the past, this test was included in your complete eye exam at no additional charge. However, most insurance plans no longer cover the cost of refractions. Please check with your insurance plan. They may offer the refraction and eyewear to you at no charge at a participating Optometrist's office. Our fee for the refraction is $60.00.

Si usted viene para mejorar su vision por medio de espejuelos, o sea, para saber si necesita una prescripción, entonces necesita una REFRACCION. En el pasado, este exámen estaba incluído en la visita y no se cobraban gastos adicionales. Sin embargo, este ya no es el caso. La mayoria de las compañias de seguro no cubre refracciones. Por favor llame a su compañia de seguro. Es posible que le ofrezcan la refracción o los espejuelos gratis a un precio bajo si fuera a uno de los optometristas que pertenecen a su plan. El costo de la refracción es $60.00.

I acknowledge I have read the above information.
Hago constar haber leido la informacion anteriormente descrita.

Signature/ Firma: _____ Date/Fecha: _____