PALM COAST EYE PHYSICIANS

PATIENT REGISTRATION

PLEASE FILL OUT COMPLETELY. Today's Date _____

Patient's Legal Name _____ Date of Birth ___/___/____
Last First MI

Sex: ____F ____ M Social Security # ____-____-____ Driver's License # _____

Home Address _____
Street City State Zip

Home Phone _____ Work/Cell Phone _____

If patient is a minor Mother's Name _____ Father's Name_____

Occupation _____ Employer_____

SPOUSE OR PARENT/GUARDIAN INFORMATION

Name _____ Relationship _____
Last First MI

Home Address _____
Street City State Zip

Home Phone _____ Work/Cell Phone _____

Occupation _____ Employer _____

REFERRING DOCTOR/PRIMARY CARE DOCTOR INFORMATION

Referring Physician _____ Phone # _____

Primary Care Physician _____ Phone # _____

PRIMARY INSURANCE

Primary Insurance _____ Phone #_____

Policy ID # _____ Group # _____

Name of Policy Holder _____ Relationship _____

Policy Holder SS# _____ Policy Holder DOB _____

Policy Holder Employer _____

SECONDARY INSURANCE

Secondary Insurance _____ Phone # _____

Policy #_____ Group # _____

Name of Policy Holder _____ Relationship _____

Policy Holder SS# _____ Policy Holder DOB _____

EMERGENCY INFORMATION

Please list a friend or relative (not of the same address) to contact in case of emergency.

Name _____ Relationship _____
Last First MI

Address _____
Street City State Zip

Phone # _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize **Palm Coast Eye Physicians** to release any medical information necessary to process health insurance claims.

ASSIGNMENT OF HEALTH INSURANCE BENEFITS

I authorize payment of medical benefits applicable to services cited on the claim form to **Palm Coast Eye Physicians.**

CONSENT FOR TREATMENT

This consent is valid during the entire term of my association with **Palm Coast Eye Physicians** and may be relied upon by **Palm Coast Eye Physicians,** unless, and until, revoked by patient or those acting for patient, in writing.

Knowing that I am suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician(s) in charge. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination or treatment in the hospital or office. If a biopsy is deemed necessary, I hereby authorize **Palm Coast Eye Physicians** to send a biopsy specimen to a suitable laboratory for a pathology report.

GUARANTEE OF ACCOUNT

I hereby authorize **Palm Coast Eye Physicians** to provide such information as may be required by state or federal agencies or my insurance company, and for and in consideration of the services rendered to patient, we, the undersigned, jointly or severally, promise to pay to **Palm Coast Eye Physicians** the full amount of charges and services, on demand, or by such future date as may be determined by **Palm Coast Eye Physicians.** I understand that my bill will be due and payable in full on or before such date. In the event of default, I agree to pay a reasonable attorney fee and costs.

Signature_____ Date _____

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name _____ Relationship _____

Palm Coast Eye Physicians, LLC

Financial Policy

We require payment in full, which is due at the time of service, unless we participate with your insurance company, or prior arrangements have been made. You are ultimately responsible for payment and knowing what is NOT covered by your insurance policy. If you have an HMO, you are responsible for confirming that we have authorization to see you prior to all of your appointments. We will file claims with non-participating and secondary insurance companies, as well. However, payment for all services will revert back to the patient if non-contractual insurance payments are not made to this office within 30 days of the claim being filed. We collect all co-payments, co-insurances, and deductibles at the time of service. We accept cash, checks, and major credit/debit cards. Please note that you may incur a $40 fee for any returned checks.

MISSED APPOINTMENTS:

You may be subject to a $50 charge for missed appointments if appointments are not cancelled at least 24 hours in advance. **Same day cancellation/no show charge is also $50.**

INSURANCE CHANGES:

Please notify us prior to your next visit if your insurance changes or you may be held responsible for payment.

FINANCIAL AGREEMENT:

The undersigned agrees that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the physician in accordance with the regular rates and term of the physician. Should the account be referred to an attorney for collection, the undersigned shall pay all attorney fees and all collection expenses.

Assignment and Release

I, the undersigned, have insurance coverage with _____.
Name of Insurance Company

and assign directly to the Palm Coast Eye Physicians all medical benefits, if any, otherwise payable to me for the services rendered. *I understand that I am financially responsible for all charges whether or not paid by Insurance (within the practices and contractual agreement).* I hereby authorize the doctor to release all my information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submission.

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefit be made either to me or on my behalf to Dr. Pourkesali of Palm Coast Eye Physicians for any services furnished to me. I authorize any holder or medical information about me to release to Palm Coast Eye Physicians Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in the Item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance, and non-covered service. Co-Insurance and the deductible are based upon the charge determination of the Medicare Carrier.

PLEASE SIGN THIS ASSIGNMENT OF BENEFITS & FINANCIAL POLICY/AGREEMENT

_____ _____

Signature of Patient Date

PALM COAST EYE PHYSICIANS
Dr. Martin M. Pourkesali
391 Palm Coast Pkwy SW, Unit 2
Palm Coast, Florida 32137
(386)246-6289

ACKNOWLEDGMENT OF RECEIPT

Notice of Patient Privacy Practices

By signing this Written Acknowledgment of Receipt of Notice of Patient Privacy Practice ("Acknowledgment"), I hereby expressly acknowledge my receipt of Notice of Patient Privacy Practices.

_____

Patient, or Legal Representative, Signature

_____

Printed Patient, or Legal Representative, Name (or label)

_____

Date

Acknowledgment NOT obtained because:

_____ Patient, or legal representative, decline Notice of Patient Privacy Practices;

_____ Other (briefly describe) _____

_____

_____

Employee Signature

_____

Employee printed name

_____

Date

IMPORTANT NOTICE

PLEASE BE AWARE THAT REGARDLESS OF THE INSURANCE YOU MAY CARRY, YOU ARE ULTIMATELY RESPONSIBLE FOR THE ENTIRE CHARGE. IF YOUR INSURANCE DENIES ANY OF THE SERVICES RENDERED BY OUR DOCTOR AND FAILS TO PAY FOR SERVICES THAT YOU RECEIVED, YOU ARE ULTIMATELY RESPONSIBLE AND WILL BE BILLED DIRECTLY.

FAILURE TO PAY YOUR BALANCE IN A TIMELY MANNER WILL RESULT IN SUSPENDING YOUR PRIVILEGES AS A PATIENT AND WE WILL HAVE TO SEND YOUR ENTIRE INFORMATION TO A COLLECTION AGENCY. WE STRICTLY FOLLOW THIS POLICY AND THERE IS ABSOLUTELY NO EXCEPTION.

BY SIGNING BELOW YOU AGREE TO OUR TERMS OF SERVICE. FAILURE TO SIGN THIS SHEET WILL TERMINATE OUR RELATIONSHIP AND YOU WILL NO LONGER BE CONSIDERED A PATIENT WITH THIS OFFICE.

_____ _____

NAME OF PATIENT DATE

_____

SIGNATURE OF PATIENT

Palm Coast
Eye Physicians

Martin M. Pourkesali
D.O., F.A.O.C.O.
Eye Physician and Surgeon
Board Certified

NO SHOW FEE and 24-HOUR CANCELLATION POLICY

Dear Patient:

We strive to provide excellent medical care to you, your family, and all of our patients. In order to do so effectively, we have developed an appointment system that sets aside ample time for a patient.

"No Shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we must reiterate our Medical Appointment Cancellations Policy.

Our policy is as follows:

1. We request that you give our office at least a 24-hour notice in the event you need to reschedule your appointment. Our office number is 386-246-6289.

2. If you miss an appointment and DO NOT contact us with at least a 24-hour prior notice, we will consider this a missed appointment, and a fee will be assessed to you.

3. If you are 15 minutes late for an appointment, your appointment will be rescheduled.

4. Our office makes reminder calls prior to the appointment date, but it is ultimately the patient's responsibility to remember their scheduled appointment.

This fee will be billed to you directly and is not covered by insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and is subject to collections.

We thank you for trusting **Palm Coast Eye Physicians** with your medical care.

I have read and understand the NO SHOW FEE and 24-Hour Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature Date

West Point Plaza
391 Palm Coast Pkwy SW
Unit 2
Palm Coast, Florida 32137

Tel: (386) 246-6289
Fax: (386) 246-6389

Palm Coast Eye Physicians

Martin M. Pourkesali, DO

Medical History Questionnaire **Date** _____

PLEASE FILL OUT COMPLETELY.

Patient's Name _____ DOB_____
If Minor, Parent's Names _____
Reason for visit_____

List **ALL** medications and dosage you currently take (both prescription and over the counter)

_____
_____
_____
_____

Do you have any allergies or reactions to medications? NO YES (explain)

_____
_____

Please list all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, eye injuries, etc.) _____
_____
_____
_____

Please list any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) _____
_____
_____
_____

Do you currently have any problems in the following areas:
Eye conditions or injuries

Loss of vision	Yes	No
Blurred vision	Yes	No
Distorted vision	Yes	No
Loss of side vision	Yes	No
Double vision	Yes	No
Dryness/sandy gritty feeling	Yes	No
Mucous/discharge	Yes	No
Redness	Yes	No
Itching/burning	Yes	No
Foreign body sensation	Yes	No
Excess tearing/watering	Yes	No
Glare/light sensitivity	Yes	No
Eye pain or soreness	Yes	No
Infection of eye or eyelid	Yes	No

General/Constitutional conditions

Ears, Nose, Throat (Sinus, ear infection, cough, dry mouth, etc.)	Yes No
Cardiovascular (heart, vessels, etc.)	Yes No
Respiratory (asthma, emphysema, etc.)	Yes No
Gastrointestinal (stomach ulcers, bowel disease, etc.)	Yes No
Genital, Kidney, Bladder	Yes No
Muscle, Bones, Joints (arthritis, etc.)	Yes No
Neurological (multiple sclerosis	Yes No
Psychiatric (anxiety, depression, insomnia, etc.)	Yes No
Endocrine (diabetes, thyroid, etc.)	Yes No
Blood/Lymph (cholesterol, anemia, etc.)	Yes No
Allergic/Immunologic (hay fever, lupus, etc.)	Yes No

Family History M = mother F = father S = sibling GP = grandparent

PLEASE CIRCLE

Condition			Relationship to patient			
Blindness	Yes	No	M	F	S	GP
Amblyopia (lazy eye)	Yes	No	M	F	S	GP
Strabismus (eye turning in or out)	Yes	No	M	F	S	GP
Glaucoma	Yes	No	M	F	S	GP
Arthritis	Yes	No	M	F	S	GP
Cancer	Yes	No	M	F	S	GP
Diabetes	Yes	No	M	F	S	GP
Heart Disease or High Blood Pressure	Yes	No	M	F	S	GP
Kidney Disease	Yes	No	M	F	S	GP
Lupus	Yes	No	M	F	S	GP
Stroke	Yes	No	M	F	S	GP
Thyroid Disease	Yes	No	M	F	S	GP
Other	Yes	No	M	F	S	GP

Social History

Marital status (married, divorced, single, widowed)			
Do you drive:	Yes	No	
Do you have visual difficulty driving?	Yes	No	
Do you have problems with night vision?	Yes	No	
Have you ever tried to wear contact lenses?	Yes	No	How long?
Do you currently wear glasses?	Yes	No	How old are these glasses?
Do you drink alcohol?	Yes	No	How many drinks per day?
Do you smoke?	Yes	No	How many packs per day?
Have you ever had a blood transfusion?	Yes	No	

_____

Signature of patient or guardian Date

History reviewed

_____

Martin M. Pourkesali, D.O. Date

Palm Coast Eye Physicians

Informed Consent:

COVID-19

I understand that I am consenting to an elective treatment/procedure/surgery that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. After my elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this elective procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the treatment/procedure/surgery listed below.

I have been given the choice to have my treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Name of patient:

Patient date of birth:

Name of provider: Martin Pourkesali DO, FAOCO

Signatures:

Patient:

Date:

Provider: Martin Pourkesali DO, FAOCO

Date: