FLORIDA OCULAR PROSTHETICS INC
PATIENT INFORMATION FORM

Patient Name: ____ MALE (OR) FEMALE

(Guardian) ______________________ relationship ____________________________

Street Address ____

City ________________________ State ____________ zip code ______________________

Cell Phone _(_______)______________________ Additional # (_______)______________________

Email __________________________________ social security _______-________-_______

Date of Birth _____/______/______ Marital Status Married - Divorce - Single - legally separated

Allergies____

Have you been exposed or tested positive for HIV, AIDS or HEPATITIS? If YES date: ___/___/___

who referred you to our facility? ____

Eye Doctor name ___________________________________ NPI ______________________

Phone number (______)______________ fax number (_____)___________________________

Primary Doctor name ______________________________ NPI_________________________

Phone number (_____) ________________ fax number (______)_________________________

Cause of loss or Blind/Scarred eye ____

RIGHT LEFT OR BOTH

Has your eye been removed? If yes date ______/________/__________

MEDICAL RECORDS RELEASE AUTHORIZATION

FLORIDA OCULAR PROSTHETICS, INC
967 SE FEDERAL HIGHWAY
STUART FLORIDA 34994
OFFICE 772-221-0929
***FAX 772-221-0939**

Date on file ____/____/_____

Patient name: ______________________________

Date of Birth: ______________________________

Physician name – __________________________

Medical Record Department

Office # __(______)_________-__________

Fax number # __(________)_________-___________

Signature: ______________________________

Please fax the last **1** or **2** office visits (additional notes okay). Supporting the patient's **Prosthetic Eye(s)** or **Facial Piece** we are treating the patient for.

Thank you for your immediate response.

FLORIDA OCULAR PROSTHETICS INC

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ______________________________

PRIMARY INSURANCE _______ ______________________________

IDENTIFICATION # ______________________ GROUP# ______________

INSURANCE PHONE NUMBER #__(_______)______________________

PRIMARY INSURANCE COMPANY ADDRESS ______________________

____

SECONDARY INSURANCE (if applicable) ______________________

INDENTIFICATION # ______________________________________

INSURANCE PHONE NUMBER #_(________)______________________

SECONDARY INSURANCE COMPANY ADDRESS ____________________

____

I hereby authorize payment directly to **Florida Ocular Prosthetics, Inc**. of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. A copy of this authorization (signature) may be used in lieu of the original.

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health care financing administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I understand that I am financially responsible for the charges not covered by this authorization. I hereby agree that all the information on pages one and two are indeed correct without any uncertainty.

PATIENT (GUARDIAN) SIGNATURE ______________________ DATE___/___/_____

FLORIDA OCULAR PROSTHETIC INC

TOLL FREE (844) 254- 9098 OFFICE (772)-221-0929 FAX (772)-221-**0939**

TERMS AND CONDITIONS OF SERVICES

THIS IS A CONTRACT BETWEEN CUSTOMER "PATIENT" AND FLORIDA OCULAR PROSTHETICS SUBJECT TO THE TERMS AND CONDITIONS BELOW.

SALES ARE FINAL: All sales are final the "Durable Medical Equipment" is subject to a **90 DAY WARRANTY,** this warranty covers the structural integrity of the product but excludes any damage or destruction caused from the negligence of patient, including if the product is lost.

WARRANTY: Claims made against this warranty must be received in writing to our "Main Office" whose address is available online at www.floridaocularprosthetics.com within NINETY DAYS.

INDEMNIFICATION: Patient agrees to indemnify FLORIDA OCULAR PROSTHETICS INC and its employees for patient's own negligence while on the premises of any of the locations where prosthetics evaluations are conducted, including but not limited to those offices listed online and including reasonably foreseeable evaluations facilities. In no event shall Ocularist or Florida Ocular Prosthetics be liable for any indirect, special, or consequential loss or damage arising out of the performance of services.

WAIVER OF RIGHTS TO TRIAL BY JURY: Patient waives their right to jury trail and if any cause of action arising out of services received by patient must be sent to arbitration and this arbitration must be performed in Martin County, Florida.

PAYMENT: Patient agrees to pay for Durable Medical Equipment received and personally guarantees payment for medical equipment, including any balance left unpaid by insurance.

I HAVE BEEN:

- Offered a copy of the Medicare Supplier Standards
- Offered a copy of the Client Rights
- Offered a copy of the HIPAA LAW
- Informed of Florida Ocular Prosthetics (90) ninety-day warranty for all services and prostheses

______________________________ ______/________/________

Patient Name (Print) **Date**

____

Patient signature

FLORIDA OCULAR PROSTHETICS, INC

CONFIDENTIAL

HARDSHIP WAIVER

Patient Name:____
(Please print)

Due to my financial hardship, I am unable to pay your usual and customary charges.

In the event that my financial situation improves, I will make every attempt to reimburse the organization in full the balance owed on my account.

Patient Signature:______________________________ Date:______________

Patient Caregiver:______________________________ Date:______________
(Sign only if patient unable)

Florida Ocular Prosthetics, Inc.

CLIENT RIGHTS

Florida Ocular Prosthetics, Inc. is dedicated to providing the best care possible to our clients. As a part of our commitment to your care, we want you to be aware of your rights. You have the right to:

1. Considerate and respectful treatment without regard to sex, age, religion, ethnicity, or method of payment.
2. Know the professional who is primarily in charge of your fitting.
3. Receive as much information about any products or procedures as you want or need to make informed decisions about your fitting and care.
4. Participate actively in decisions regarding your fitting, including the right to refuse suggestions.
5. Expect reasonable personal safety and privacy insofar as company practice and environment are concerned.
6. To be advised of the reason for the presence of any person other than your primary fitter during your fitting.
7. Confidential treatment of all communications and records pertaining to you.
8. Reasonable responses to reasonable requests about the services you receive.
9. Examine and receive an explanation of your bill, regardless of the source of payment.

Patient Satisfaction Survey

1. Were you able to schedule a convenient appointment?

   Yes or No

2. Were you seen in a timely manner for your scheduled appointment?

   Yes or No

3. Did you and your Care Provider discuss your goals and objectives as you go about your daily activities?

   Yes or No

4. How would you rate the knowledge, care, and attention that the ocularist provided to you during your visit?

Excellent **Very Good** **Good** **Fair** **Poor** **Does not apply**

5. Would you recommend Florid Ocular Prosthetics Inc to a friend?

   Yes or No