PATIENT INFORMATION DATE:

SECTION 1

NAME: ____________________________________ OOB:____________E:________

CURRENT MAILING ADDRESS: ____

CITY/ STATE/ ZIP CODE: ____

HOME PHONE: ( )- _______________CELL: ( )- _______________WORK: ( )- ______________

EMAIL ADDRESS: ______________________________

MALE: FEMALE: OTHER: SINGLE: MARRIED: OTHER:

DRIVERS LICENSE: ______________________________ SSN#I_________________________

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 ff: ____________________________ YOUREMAIL:_ ___________________

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: _________SSNI#: _____________PHI#_______________

RELATIONSHIP TO PATIENT: _____________________ MALE ___ FEMALE_

• • •1F YOU HAVE MEDICARE AS YOUR PRIMARYINSURANCE, DO YOU HAVE A SECONDARY SUPPLEMENTAL INSURANCE' YES: NO:

1) DOES IT 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 THE SECONDARY INSURANCE COVERAGE IS UNDER: _ _ _ _ _ _

POLICY/CONTRACT NUMBER ____ __

GROUP NUMBER: _____________EFFECTIVE DATE OF COVERAGE: ____________

INSURED PERSONS DOB: _________________SSN#:_______________PH#· ____________

RELATIONSHIP TO PATIENT: ___________________ MALE. ___ FEMALE:___ _

INSURANCE APPEALS: Please sign so if there are any problems with the insurance paying the claim we can appeal it to their highest level to resolve it

___________________ *give* permission to act on my behalf for services rendered on ______________

PRINT NAME LEAVE BLANK

By Dr. Geoffrey Kwitko, M.D to appeal this claim.

____

Patient Signature

Patient Name: _______________ __ Date· ____________

I SSMIS VISIT RELATED TO A WORKMANS COMPENSATION OR AUTO ACCIDENT?

YES: NO:

IF AUTO RELATED:

WHAT ISTHE 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 ETHNIC1TY.

PLEASE CHECK ALL THAT APPLIES:

_ AMERICAN INDIAN OR ALASKAN NATIVE

ASIAN

____ HISPANICOR LATINO

_ NATIVE HAWAIIAN/PACIFIC ISLANDER

__ WHITE/CAUCASIAN

AFRICAN AMERICAN

DECLINEDTO PROVIDE

ETHNICITY

HISPANIC OR LATINO

NON-HISPANIC OR LATINO

NO ETHNICITYSELECTED

DECLINEDTO PROVIDE

PLEASE ANSWER THE FOLLOWING- THIS IS REQUIRED SY OUR GOVERNMENT

1) Have you had two or more falls within the last year or any falls with injllry in the last year? _________Date of Fall/injury (if known): ______________ __
2) Have you received a flu shot within the last flu season (Oct-Mar)? ___ _
3) Have you ever received a pneumonia vaccination? ___________________ __

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. l<WITKO, M.D.

F.A.C.S., F.t.C.S., F.A.A.O., F.N.O.S.S., F.I.S.O.O.

COSMETIC & RECONSTRUCTIVE OCULOPIASTIC, 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 ________________________ _r,eferred to hereinafter as the "Patienr. 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 SHAU 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, dlspute 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 actlon 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 S2SO,OOO.OO

In witness thereof, I (We) have set our hands this __________ day of ______________, 20 ___ _

"Doctor"	"Patient"
By ______________________________________	By ___________________________
Authorized Agent	

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.0.0.

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.
F.A.C.S., F.1.C.S., F.A.A.O., F.N.O.S.S., F.I.S.O.D.
COSMETIC & RECONSTRUCTIVE OCULOPLASTIC, ORBITAL, LACRIMAL & NEURO-OPHTHALMIC SURGERY

PATIENT CONSENT FORM

The Department of Health and Human Services has established a *Privacy RuleN 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 wtll 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: ______________

COMPLIANCEASSURANCE 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 uPRIVACY RULE". we strive to achieve the very highest of standards of ethics and integrity in performing services for our patients.

It 1s our policy to properly determine appropriate uses of PHI in accordance with government rules, laws and regulations. We want to ensure that our practoce 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 penaliiation 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.l.C.S., F.A.A.0., F.N.O.S.S., F.1.S.0.0.

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 elPctronir mPdical record, t-iould 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 Indude *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 Or. Geoffrey M. Kwltko to obtain my medication history from my pharmacy, my health insurance company and my other health care providers.

___ I DO NOT give permission for Or. Geoffrey M. Kwltko 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 INSURANCECOMPANY, 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.

______________________________ 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. Kwrtko, 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.O.

____

Patient/ Parent or Guardian Signature Date

CONSENT TO PHOTOGRAPH ANO 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: ____ __

GEOFFREY M. l(WITKO 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 OCULOPLAST1C, ORBITAL, LACRIMAL& NEUR0-OPHTHALM1C SURGEON

CLINICAL AsSISTANT PROFESSOR, UNIVERSITY OF SOUTH FLORIDA

Acknowledgement of Potential Release
for Failure to Follow Treatment Plan

Geoffrey M. Kwitko, M.D. greatly appreciates having you as a patient and the opportunity to participate in your treatment. Communication is critical to the physician - patient relationship. In that regard, please feel free to communicate any concerns regarding your current condition and the prescribed treatment plan. It is also critical that you adhere to the treatment plan, including but not limited to following physician orders, taking medications as prescribed and attending scheduled appointments. By executing this provision, you acknowledge the imp01iance of following physician orders, taking medications as prescribed and attending scheduled appointments. Dr. Kwitko may, at his own discretion, release you as a patient for your failure to adhere to the treatment plan prescribed for you. Failure to adhere to the treatment plan shall be deemed a release and termination of the doctor - patient relationship. If you are released as a patient, your medical records will be provided to you as prescribed by Florida Statutes. Additionally, if you are released as a patient, you waive any claim that may arise against Geoffrey Kwitko, M.D. based on your release.

____

Patient Signature Date

____

Printed Patient Name
#18732109vl

GEOFFREY M. l(WITKO, M.D.

F.A.C.S., F.J.C.S., F.A.A.O., F.N.O.S.S., F.I.S.O.O.

COSMETIC & R.ECONSTRUCTIVE OCULOPLASTIC, ORBITAL, LACRIMAL & NEUR0-OPHTHALMIC SURGEON

CU:SIGIL A5 1S°L',Nl PROFE <;OR, U:--1\ERSITY OF Sotrrn fLORIDA

Patient name:-- Date:_________ __

Please check the following symptoms if it applies to you

___ Tired eyes ___ Red eyes ___ Trouble reading

____ Trouble watching TV ___ Difficulty driving ___ Watery eye/tearing

___ Dry eyes ____ Tilting head backwards to see forward

___ Irritated/burning eyes Other:____________________________________

311SOUTHMACDILLAYENUE • TAMPA.FLORIDA33609-3I4I • 813-877-8665 • WATS800-303-1113• FAX813-877-9479

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