COHEN LASER AND VISION CENTER

3020 N. Military Trail, Suite #150 Boca Raton, FL 33431
www.cohenlaser.com info@cohenlaser.com
Phone: 561-981-8400 Fax: 561-981-8460

New Patient Registration

Patient Information			
First Name:		Last Name:	
Address:	Date of birth:		Gender:
Phone:	Email:		Marital status:
How would you like to be contacted? ☐ Phone ☐ Text ☒ Email			May we leave voicemail? ☐Yes ☐No

Insurance Information		
Primary insurance:	Subscriber:	Effective Date:
Insurance ID number:	Group number:	
Secondary insurance:	Subscriber:	Effective Date:
Insurance ID number:	Group number:	

Emergency Contact Information			
Full Name:		Relationship:	
Email:	Phone:		Cell Phone:

Employment Information			
Name of Employer:		Retired? ☐Yes ☐No	
Telephone Number:		Occupation:	
Address:			
City:	State:	Zip:	Country:
Email:	Phone:		Cell:

Additional Services		
Primary language:		Medical interpreter needed? ☐Yes ☐No
Spiritual Affiliation	Ethnicity	Name of caretaker/interpreter

Pharmacy			
☐ CVS ☐ Walgreens ☐ Publix ☐ Costco ☐ Benzer ☐ Target ☐ Mail Order ☐ Other			
Address:			Phone:
City:	State:	Zip:	Fax:

Primary Care Doctor		
Name of physician:		
Phone:		Fax Number:
Address:		
City:	State:	Zip:

Referral Information

How did you hear about us?

☐ friend/relative ☐ online ad ☐ TLC ☐ Google ☐ Yelp ☐ Facebook ☐ Instagram

☐ Hospital/follow-up ☐ Physician referral ☐ Other _____

Whom may we thank for the referral? _____ Phone: _____

Please provide an official photo identification (license, passport, etc.)
Please provide a copy of all medical and vision insurance cards.

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Medical History

Patient Information		
First Name:	Last Name:	
Date Of Birth:	Age:	Gender:

Reason for Visit			
State eye problem:			
Which eye? ☐ Right ☐ Left ☐ Both ☐ Uncertain			
When did you first notice this problem?			
Have you been treated for this problem before?			
By whom?	When?	Do you have records? ☐ Yes ☐ No	

Ocular History			
Wear Rx glasses? ☐ Yes ☐ No ☐ only reading glasses		Wear contacts? ☐ Yes ☐ No	
Diagnoses? ☐ none ☐ dry eye ☐ glaucoma ☐ macular degeneration ☐ cataracts ☐ other			
Current eye drops? ☐ none ☐ glaucoma ☐ steroids ☐ artificial tears ☐ other			
Previous Eye Surgery ☐ None	Which Eye?	Date of surgery (DOS)?	
	☐ Right ☐ Left ☐ Both		
	☐ Right ☐ Left ☐ Both		
	☐ Right ☐ Left ☐ Both		
Previous eye doctor:	Clinic/Hospital:	Date of last exam:	
City / State	Zip	Country	
Phone / Fax	Records? ☐ Yes ☐ No		

Medical History ☐ none				
Cardiovascular	*Respiratory*	*Autoimmune*	*Neurological*	*General*
☐ hypertension	☐ sleep apnea	☐ rheumatoid arth.	☐ stroke/TIA	☐ diabetes
☐ high cholesterol	☐ COPD	☐ psoriatic arth.	☐ Parkinson's dis.	A1c_____BG_____
☐ heart attack (MI)	☐ asthma	☐ thyroid disease	☐ brain tumor	☐ kidney disease
☐ chest pain	☐ smoker (past/active)	☐ sarcoidosis	☐ seizures	☐ tuberculosis
☐ a. fib/arrhythmia	☐ chronic cough	☐ Sjogren's syndr.	☐ multiple sclerosis	☐ liver disease
☐ easy bleeding	☐ pneumonia	☐ lupus (SLE)	☐ migraines	☐ cancer
Please list any other conditions:				

Social History (confidential)	
Smoking/Tobacco	☐ Yes (current) ☐ Yes (desire to quit?) ☐ Former ☐ Never
Alcohol	*Please describe type, frequency, and amount*
Recreational drugs	*Please describe type, frequency, and amount*

Family Ocular History ☐ none/unknown	
Relative	*Problem(s) (e.g. glaucoma, macular degeneration, diabetes, etc.)*

Allergies ☐ no known allergies	
Allergy	*Reaction(s) (e.g. hives, anaphylaxis, itching, etc.)*

Medications ☐ no current meds		
Eye drops	*Dosage/units*	*Frequency*
Other medications	*Dosage/units*	*Frequency*

Review of Systems ☐ all negative	
Symptoms	*Present?*
Sudden loss of vision?	☐ Yes ☐ No
Sensitivity to light/glare?	☐ Yes ☐ No
Blurry vision despite glasses?	☐ Yes ☐ No
Itchy/red eyes?	☐ Yes ☐ No
Eye pain?	☐ Yes ☐ No
Dizziness?	☐ Yes ☐ No
Headaches?	☐ Yes ☐ No
Weight loss or gain?	☐ Yes ☐ No
Change in appetite?	☐ Yes ☐ No
Night sweats?	☐ Yes ☐ No
Fatigue?	☐ Yes ☐ No
Difficulty sleeping?	☐ Yes ☐ No
Feel hotter than others?	☐ Yes ☐ No
Feel colder than others?	☐ Yes ☐ No
Non-healing skin/foot ulcers?	☐ Yes ☐ No
Dry skin?	☐ Yes ☐ No
Hair changes/thinning?	☐ Yes ☐ No
Easy bruising or bleeding?	☐ Yes ☐ No
Seasonal allergies/hives?	☐ Yes ☐ No
Neck pain?	☐ Yes ☐ No
Neck lumps or goiter?	☐ Yes ☐ No
Difficulty swallowing?	☐ Yes ☐ No
Change in hearing?	☐ Yes ☐ No
Shortness of breath?	☐ Yes ☐ No
Frequent coughs/wheezing?	☐ Yes ☐ No
Voice changes?	☐ Yes ☐ No
Chest pain?	☐ Yes ☐ No
Palpitations?	☐ Yes ☐ No
Nausea?	☐ Yes ☐ No
Heartburn/reflux?	☐ Yes ☐ No
Abdominal pain?	☐ Yes ☐ No
Other?	

CLVC
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PAYMENT POLICY

At CLVC, we are committed to providing you with the best possible care. We always strive to serve the best interest of the patient, and that means helping you take full advantage of any medical or vision insurance benefits you may have. We will always discuss your proposed treatment, cost, and payment options in advance so you are fully aware of the scope and value of all services offered.

Payment for all services is due at the time of service. We accept cash, checks, Visa, MasterCard, and American Express credit cards. We will also assist in processing your insurance claim for reimbursement. When Medicare is the primary payer, we may accept assignment of insurance benefits. Any returned checks of outstanding balances older than 30 days may be subject to additional collection fees and interest charges.

Please review the following details regarding insurance contracts:

1. Your insurance status is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range for most insurance companies and are therefore covered up to a designated maximum allowance that varies by each carrier (e.g. 50% or 80% of U.C.R). "U.C.R" is defined as usual, customary, and reasonable fees for this region. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. For example, Medicare does NOT reimburse for refraction testing, which is often a necessary component of a medical eye exam. Therefore, you may be responsible for payment at the time of service for this and other charges.
4. "Medicare assignment" does not mean Medicare pays in-full for all services rendered. Medicare will pay 80% of only approved services, so patient is responsible for any outstanding balance, usually 20%. Please understand that our professional relationship is between you and Dr. Cohen, not the insurance company. Therefore, all charges for services rendered are ultimately your responsibility to be paid when due.
5. We recognize that there are financial problems which may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. Ultimately, payment issues will never interfere with the quality of your care.

If you have any questions about the above information or concerns about payment, please do not hesitate to contact us. We are here to help. Thank you for your understanding.

Kindly acknowledge acceptance of this policy by signing below:

Patient name: _____ DOB:_____

Patient signature: _____ Date:_____

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IMPORTANT INFORMATION REGARDING COMPLETE EYE EXAMS WITH DILATION

At CLVC, we strive to provide every new patient with a thorough diagnostic exam, which includes dilation. Dilation is necessary to properly assessing and evaluating all aspects of the eye, including tissues that are otherwise not accessible. While we understand that dilation can be a temporary impairment, it is generally required for all new patients desiring to establish care with us. Dilation takes time, so please allow 1-2 hours for a complete exam.

Dilation and other diagnostic measures may render your vision temporally blurry – for this reason it is recommended that all new patients come with a driver. While it may be safe to and work after dilation, sensitivity to light and decreased near vision are reasons many do not feel safe operating a motor vehicle. Please use your discretion and do not attempt to drive if you do not feel comfortable. Sunglasses or shades will be provided for the 2-4 hours your vision may be sensitive to light. Other rare complications that may result from pharmacologic dilation include acute glaucoma, arrhythmia, dizziness, elevated blood pressure, and others which may occur despite appropriate precautions. Any drastic change in vision, redness, or pain requires immediate medical attention. The risks and benefits of dilation will be discussed at the time of your visit, and exceptions will be made in consultation with the physician. Keep in mind any adverse reaction to dilation is extremely rare.

I hereby authorize my eye doctor and/or such assistant he/she may designate to administer dilating eye drops if recommended.

Patient Signature: _____ Date: _____

Important Notice to Parents and Legal Guardians I understand that my child's eyes may be dilated, this could impair his or her vision such that climbing, bike riding, and other activities could be potentially dangerous and should be avoided until vision returns to normal. Additionally, I hereby give consent to any additional examinations and/or treatment necessary for my child's condition.

Parent's signature: _____ Date: _____

Relationship: _____

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FEE SCHEDULE FOR REFRACTION

Refraction:

Refraction is the technical term for the process of determining the amount of corrective eyeglass power required to obtain your best vision. The physician believes this is an important component of your medical exam and recommends this test be performed.

It is customary in the field of ophthalmology to perform a refraction if indicated and to charge for the service, as often insurance does not reimburse the practice for this type of testing. The cost of glasses, frames, contact lenses

Fee Schedule:

• Refraction for glasses	$60.00
• New contact lens fit (never worn contacts)	$150.00
• Contact lens change (update)	$75.00

Contact lens fittings include a short trial of lenses that may need to be shipped in certain circumstances. This fee does NOT include the cost of lenses themselves, which are ordered when the refraction is finalized through the patient's preferred vendor.

Insurance:

These fees will be collected at the conclusion of your visit. As a courtesy, we will bill your insurance if applicable for this service. If your insurance company indeed does pay for the refraction, a prompt refund or future credit will be reimbursed.

Thank you for your cooperation and understanding in this matter.

Patient signature: _____ Date:_____

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TO ENSURE THE PRIVACY OF OUR PATIENTS, PLEASE COMPLETE THE FOLLOWING:

Print Name: _____ DOB: _____

1. CLVC may leave **scheduling** and appointment reminders on my answering machine or mobile voicemail.
   ☐ Yes ☐ No
2. CLVC may leave **medical information** (test results, diagnostic information, post-operative information, etc.) on my voicemail.
   ☐ Yes ☐ No
3. CLVC may **email or text** my mobile device with appointment reminders (standard texting rates apply).
   ☐ Yes ☐ No
   Cell phone number: _____
4. CLVC may email **promotional materials** and event invitations.
   ☐ Yes ☐ No
   Email: _____
5. CLVC (Dr. Cohen) may **discuss my medical history** or conditions with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned by my signature. This authorization shall be in effect until I revoke such disclosures.

Patient signature: _____ Date: _____

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RECORDS RELEASE AUTHORIZATION

I, _____, authorize that my medical records be released

☐ To: ☐ From:

Office/Provider:_____

Address: _____

City:_____ State: _____ Zip:_____

Phone: _____ Fax: _____

For the period of _____ to _____

For the purpose of: ☐ continuing care ☐ insurance purposes ☐ other

(explain)_____

☐ To: ☐ From:

☐ Dr. G. Richard Cohen ☐ Dr. Joshua D. Cohen

Cohen Laser and Vision Center
3020 N. Military Trail – Suite 150
Boca Raton, FL 33431

Patient name: _____ DOB: _____

Patient ID # _____ Social Security # _____

Patient signature: _____ Date:_____

Witness signature: _____ Date:_____

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INTRODUCTION TO PATIENT-PHYSICIAN AGREEMENT

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize that there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country – claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU

We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field, and adhere to a solid code of ethics.

WHAT WE ASK OF YOU

We are asking you or any representative to commit to this process also by using only board-certified expert medical witness(es) if you are dissatisfied with your medical care and decide to pursue legal action.

We hope, and believe, you will never have to consider this again, but if you do, we will honor this commitment to you as demonstrated by our signature below.

Dr. G. Richard Cohen, MD

Joshua D. Cohen, MD

Please keep a copy for your records.

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AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____ (*insert name of patient or guardian*)

"Physician" shall be understood to mean ☐ G. Richard Cohen, MD or ☐ Joshua D. Cohen, MD, and Cohen Laser and Vision Center.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, and meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the _American Academy of Ophthalmology.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the _American Academy of Ophthalmology_ and that the expert(s) will be obligated to fully consent to formal review of conduct by such society as its members.

I agree to require my attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

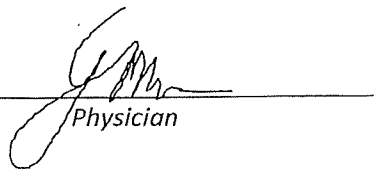
In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence as frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery, or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and ask questions about it.



_____ _____

Physician *Patient/Guardian*

_____ _____

Effective from Date of Treatment *Date of signature*

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NOTICE OF PRIVACY PRACTICES (H2.6C) EFFECTIVE 01/01/2020

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present, or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

Howe we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. **Example**: *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may communicate with each other to discuss your care.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. **Example**: *Your payer may require copies of your PHI during the course of a medical record request, chart audit, or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. **Example**: *We may share PHI with third parties that perform various business activities (e.g. Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples:

- Required by Law, such as mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be

disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding you PHI.

You have the following rights regarding your PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication**. You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to Copy of This Notice**. You have the right to a copy of this notice.

Website Privacy:

Any personal information you provide us with via our website, including your email address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal email address simply because you visit our site. In some instances, we may partner with a third party to provide services such has newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness, or timeliness, of the information available on our site or affiliated websites. We are not liable to anyone for any loss, claim, or damages caused in whole or in part, by any of the information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches: You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints: If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Cohen Laser and Vision Center. If you have questions and would like additional information, you may contact us at 561-981-8400.

Patient Name :_____ Signature:_____

Date: _____