ORLANDO NORTH EYE CLINIC

Dr Aly Reza Sheraly, MD

Board Certified and Glaucoma Fellowship Trained Ophthalmologist

Please keep this page for your future reference.

Welcome to Orlando North Eye Clinic, we are pleased that you have chosen us for your eyecare. Your Vision is Our Focus. Please read the entire form as it contains important information to better serve you before, during and after your visit to the clinic.

Below are some of the many ways you can connect and contact us:

(321) 234-7424

info@OrlandoNorthEyeClinic.com

@OrlandoNorthEyeClinic

Orlando North Eye Clinic

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3300 W Lake Mary Blvd, Suite 210, Lake Mary, FL 32746

(on the 2nd floor, above the Nemours Walk-in Clinic)

For communication regarding private and medical information, please utilize our:

ORLANDO NORTH EYE CLINIC Patient Portal at www.OrlandoNorthEyeClinic.com

Please review and complete the following forms.

Before your Appointment

1. Please review and complete this new patient forms.
2. Please contact your insurance company to verify your medical and/or vision coverage. Your appointment may be billed as a "vision" or "medical" visit depending on the reason for your exam, along with any tests and/or procedures.
3. If your primary care Doctor is listed on your insurance card, you may be required to have a referral. **Please contact your primary care Doctor to confirm if a referral is required.**

Day of your Appointment

1. Medications – please either bring a current list of all medications you are taking or provide your pharmacy information and permission to acquire this information electronically (see forms below). Please also include all over the counter medications and/or herbal medication you may be taking

2. Eyeglasses – please bring your best or most recent eyeglasses and/or contact lens box, even if they no longer improve your vision. The glasses will provide important information about the past condition of your eyes.

3. Insurance Cards – please bring all current insurance cards with you to the appointment.

4. Photo ID – We are required to obtain a copy of your photo ID. This is to protect you from someone else using your medical insurance (a type of identity theft).

5. Form of Payment: Your insurance plan may require you to pay a co-pay or pay out of pocket if you haven't met your deductible. As a service provider to your insurance company, we are obligated to collect the amount you are responsible for during the encounter. For your convenience we accept Cash, Credit Card and checks.

6. Optional: bring a driver or someone with you if you'd like as you may be dilated at the exam. Also, some find it helpful to have a second set of ears in the room while discussing your exam findings and treatment plan.

After Your Appointment

1. If any medications were prescribed, please go to the pharmacy to pick up those medications and begin using as directed. If you are unsure of the directions or are experiencing any side effects, please contact our Clinic at (321) 234-7424.

2. If any Lab tests were ordered, please go to the lab and have the labs draw as soon as possible. If there are any concerns or confusion, please contact our Clinic at (321) 324-7424

3. Please access your patient summary report on your Patient Portal by visiting www.OrlandoNorthEyeClinic.com

4. If you received a follow-up appointment, it is very important to keep that appointment. Your Doctor has made that appointment for you. Please put that time and date into your calendar so you don't forget it. If you are unable to make it for any reason, please contact our Clinic as soon as possible at (321) 234-7424

PATIENT INFORMATION

Welcome to Orlando North Eye Clinic, we are pleased that you have chosen us for your eyecare. Your vision is our focus. Please complete this form and bring it with you to the appointment.

Full Name: _____

Last *First* *M.I.*

Date of Birth: _____ Email Address: _____

MM/DD/YYYY

Social Security Number:_____

Address 1: _____

Street Apt/Unit

Address 2: _____

City *State* *Zip Code*

Cell Phone: _____ Home Phone: _____

Emergency Contact: _____

Name Phone Relationship

To be filled by guardian if patient is a Minor (under 18 of age) or has a legal Power of Attorney

Full Name: _____

Last *First* *M.I.*

Date of Birth: _____ Email Address: _____

MM/DD/YYYY

Address 1: _____

Street Apt/Unit

Address 2: _____

City *State* *Zip Code*

Cell Phone: _____ Home Phone: _____

How Did you hear about Orlando North Eye Clinic (check all that apply)?

☐Referring Doctor ☐Family/Friend ☐Internet Search ☐Social Media

☐Event/Exhibit ☐Insurance Plan ☐Other

Insurance Information

At Orlando North Eye Clinic, we strive to make your appointment as smooth as possible. We will do our best to assist and may require further assistance from you. For further questions, please contact our office at (321) 234-7424 or email your questions to info@OrlandoNorthEyeClinic.com.

Primary Medical Insurance:

ID & Group #:_____Relationship:_____

Subscriber Name:_____ DOB:_____

Secondary Medical Insurance:

ID & Group #:_____Relationship:_____

Subscriber Name:_____ DOB:_____

Vision Insurance:

ID & Group #:_____Relationship:_____

Subscriber Name:_____ DOB:_____

Office visits may be categorized as "medical" and/or "routine vision" depending on your needs or findings of your exam. Routine vision exams are typically associated with glasses or contact lenses, while medical exams are associated with medical diagnoses such as pain, red eye, glaucoma, diabetes, etc.

Orlando North Eye Clinic contracts with major insurance plans; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. I understand that I am financially responsible and agree to pay any charges for care rendered to me not covered by my insurance plan (including equipment and/or supplies). I agree that for services rendered to me by Orlando North Eye Clinic, I will pay my account at the time of service or upon insurance claim processing.

If payment plan consideration is necessary, I understand that it is my responsibility to call and make financial agreements satisfactory to Orlando North Eye Clinic for payment.

Any benefits under any policy of insurance or other party liable to the patient, is hereby assigned to Orlando North Eye Clinic. If copayments and/or deductibles are assigned by my insurance company or health plan, I agree to pay them to Orlando North Eye Clinic.

If you do not have insurance, payment is required at the time of service, and you will be seen as a Private Pay patient.

Please be aware that when we call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plan's benefits when your healthcare insurance company receives and processes the claim.

Appointment Reminders

I Agree to Phone Messages left on my/guardian's answering machine regarding Appointments ☐ Yes ☐ No

I Agree to Receive Text Messages on my Cellphone regarding Appointments and Clinic Notices ☐ Yes ☐ No

Dilating Drops and refraction

Dilating Information: Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, so it's best if you make transportation arrangements.

Allergic reaction or Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical and/or surgical attention. Please call us immediately at (321) 234-7424 if you have symptoms including severe pain, eye redness, light sensitivity, and halos, nausea/vomiting following your dilated exam.

I hereby authorize the doctor and/or such assistants as may be designated by him/her to administer dilating eye drops.

Refraction Policy: Refraction is the test used to determine a glasses or contact lens prescription. Your ophthalmologist may also use a refraction to ensure blurry vision is correctable in order to further assess medical problems. Refractions are not always covered by insurance and you may be responsible for the $59.99 fee at the time of service. Medicare does not cover refractions.

Patient Agreement And Privacy Notice

Consent for Treatment: I authorize Orlando North Eye Clinic to assess and treat me, complete tests and administer medications considered necessary or advisable. I understand that my doctor is available to explain the purpose of any procedure and that I have the right to refuse, even if against medical advice.

Release of Medical Information: If I would like a copy of my health information released to me or any individual(s), I will request and submit an Authorization for Release of Medical Information. A release may be revoked by me in writing at any time. I understand that a copy of my records may be subject to fee for labor/supplies/postage.

Notice of Privacy Practices: I acknowledge that I have been made aware of Orlando North Eye Clinic's privacy practice. I understand a copy of the Notice of Privacy Practices is available at my request and is available to me at the following website: www.OrlandoNorthEyeClinic.com .

Patient Code of Conduct: While we understand that medical examinations and treatment can create stress and frustration, our doctor and staff are here to help and support you. We will treat you with professionalism and care and expect the same from you. Verbal and Physical abuse will not be tolerated when interacting with our staff. Orlando North Eye Clinic reserves the right to take appropriate steps if patient behavior is deemed disruptive to the care provided.

Missed Appointment Notice: At Orlando North Eye Clinic, we focus on providing quality care for our patients in a timely manner. When a patient cancels an appointment **without prior notice**, it may prevent another patient from being seen. **Kindly provide 24 hours notice**, to cancel or change a scheduled appointment by calling the office at (321) 234-7424. We reserve the right to charge a $50 Missed Appointment Charge if prior notice has not been given.

Billing Agreement

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Orlando North Eye Clinic. I am responsible for any applicable deductible or copayment prior to the provision of services. Orlando North Eye Clinic will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Orlando North Eye Clinic may file a claim for payment with my insurance company as a courtesy to me. If the primary insurance company fails to pay Orlando North Eye Clinic in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Orlando North Eye Clinic. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

Media and teaching Agreement

At Orlando North Eye Clinic, we value education and endeavors to teach through lectures, publications, teaching conferences, and other media forms. By signing here, you provide permission for Orlando North Eye Clinic to use de-identified testing or unidentifiable photographs in any medium for educational purposes.

I consent to the admittance of qualified observes, including, without limitation, medical students in the clinical setting for purpose of medical education. I understand that such observers will not in any manner participate in my diagnosis or treatment. I understand that I can refuse to have observers at any point during my examination or services.

Records Release

If you provide your Primary Care Physicians name and sign the Authorization to Release and Receive Medical Information, we will attempt to gather the following information from their office. Please provide any updated information or relevant changes. Please note that if we are unable to collect your medical history and medications from your primary care physician, we will review this information during your appointment.

Primary Care Name:_____ Phone Number:_____

Release of Protected Health Information: I hereby authorize Orlando North Eye Clinic to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from third party health care providers, laboratories, radiology facilities or other institutions and providers. I also understand that I have the right to revoke this authorization at any time by sending a written notification to Orlando North Eye Clinic.

ACKNOWLEDGEMENT STATEMENT

By signing below (physical or electronic signature), I acknowledge that I have received, read and understand the contents of this document in its entirety and agree to it.

_____ Date: _____

Patient/Guardian Signature