Brian D. Haas, M.D., PL

PATIENT INFORMATION

NAME: _____ DATE: ____/____/_____
Last First M

ADDRESS: _____
Street City State Zip Code

Married Single Widowed Divorced Social Security # _____ Sex: M F Birthday: ___/____/_____

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE_____

PLEASE ENTER EMAIL ADDRESS: _____

PHONE NUMBERS:

HOME: (_____)_____ WORK: (_____)_____ CELL: (_____)_____
PREFERRED NUMBER: HOME WORK CELL

EMPLOYERS NAME: _____ OCCUPATION: _____

EMPLOYERS ADDRESS: _____

FRIEND/ RELATIVE WE COULD CALL TO REACH YOU IN CASE OF EMERGENCY/RELATIONSHIP/PHONE

_____ EMERGENCY: (____)_____

INSURANCE INFORMATION

NAME OF INS CO: _____ PATIENT ID#: _____

INS ADDRESS: _____ PHONE #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER SS#: _____

BIRTHDATE: ____/_____/_____ RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

SECONDARY INSURANCE INFORMATION

NAME OF INS CO: _____ PATIENT ID#: _____

INS ADDRESS: _____ PHONE #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER SS#: _____

BIRTHDATE: ____/_____/_____ RELATIONSHIP OF POLICY HOLDER TO PATIENT: _____

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby authorize the physicians and staff of Brian D. Haas, M.D., PL, to perform such treatments to me as may be prescribed by my attending physician during any and all of my visits to Brian D. Haas, M.D., PL. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to obtain authorization for future treatment and with regard to processing claims. I certify the information I furnish is true and correct and that I know it is a crime to fill out this form with facts that I know are false or to leave out facts that are important. I assign payment directly to Brian D. Haas, M.D., PL, which may be due to me from the Medicare program or other health insurance companies. I understand I am financially responsible to Brian D. Haas, M.D., PL, for any non-covered insurance services.

Patient or Responsible Party: **X** _____ Date:____/_____/____

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of the signature is as valid as the original.

Payment is requested at time of service for self-pay patients. A bookkeeper can assist you if arrangements must be made. We will be glad to assist with insurance forms. Your policy and coverage is a contract between you and your insurance company. You are responsible for all payments.

Signature Patient or Responsible Party: **X**_____ Date: ____/_____/_____

PATIENT HISTORY RECORD

Patient's Name: _____ Date: ___/___/_____
Date of Birth: ____/____/____ Age: _____ Sex:_____ Referred By: _____
Medical Doctor: _____ Height_____ Weight_____
Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions? (Diabetes, high blood pressure, arthritis, thyroid, etc.)? No___ Yes___ List _____

2. Have you ever had any eye disease (glaucoma, cataract, wandering or lazy eye, retinal detachment, etc.)? No ___ Yes___ List _____

3. Have you ever had any surgery? No ___ Yes ___ List_____

4. Have you ever been hospitalized? No ___ Yes ___ List _____

5. Have you ever had any cosmetic procedures? No ___ Yes ___ List _____

   - If yes, when was most recent? _____

6. Do you currently take any medications? No ___ Yes ___ List _____

7. Do you currently take any eye medications? No ___ Yes ___ List _____

8. Do you have any drug or food allergies? No ___ Yes ___ List _____

REVIEW OF SYSTEMS: Do you currently have any of the following problems:

Chronic fever, unexpected weight loss/gain, fatigue? No ___ Yes ___ List _____

Ear/nose/throat problem (hearing loss, sinus problem, sore throat) No ___ Yes ___ List _____

Heart problems (chest pain, irregular heart beat)? No ___ Yes ___ List _____

Respiratory problems (shortness of breath, wheezing, coughing)? No ___ Yes ___ List _____

Gastrointestinal problems (heartburn, pain, diarrhea, vomiting)? No ___ Yes ___ List _____

Urinary problems (pain, discomfort, blood in urine)? No ___ Yes ___ List _____

Skin problems (rashes, excessive dryness)? No ___ Yes ___ List _____

Musculoskeletal problems (muscle aches, joint pain)? No ___ Yes ___ List _____

Neurologic problems (numbness, weakness, headaches)? No ___ Yes ___ List _____

Psychiatric problems (depression, anxiety)? No ___ Yes ___ List _____

Bleeding problems (prolonged periods or easy bruising)? No ___ Yes ___ List _____

AIDS/HIV No ___ Yes ___

Hepatitis (Type_____) No ___ Yes ___ If Yes, Are you currently Active?_____

FAMILY AND SOCIAL HISTORY
Do any medical or eye diseases run in your family (Diabetes, High Blood Pressure, Cancer, Glaucoma, etc.)? No___ Yes ___ List _____
Do you smoke? No ___ Yes ___ how much? _____
Do you drink alcohol? No ___ Yes ___ how much? _____

Your Pharmacy Name: _____ Tel Number: _____
I allow Dr. Haas to access my medication information from pharmacy _____ (initials)
X_____ ___/_____/_____ _____ ____/____/____
Patient Signature Date Physician Signature Date

Brian D. Haas, M.D. PL
415 Briercliff Drive
Orlando, FL 32806
407 841-1490

ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practice (NPP) provides information about how we may use and disclose protected health information about you. You have the right to review our NPP before signing this form. As provided in our NPP, the terms may change. If we change out NPP, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations as described in our Notice.
You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I also authorize Dr. Brian Haas and staff to contact me via text, email, or automated phone calls to remind me of upcoming appointments or provide me with other useful health related information.

Patient Name (Print):_____

Signature:_____

Date:_____

Witness:_____

I authorize Dr. Brian D. Haas to release personal information to the following:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

NON-COVERED FEES

Certain charges are considered “non-covered” by insurance companies. The most common are the following

NO SHOWS - We ask you to show consideration by notifying our office at least 1 business day in advance if you are unable to keep an appointment.

This letter serves as notice that if you fail to give us a 24-hour (business day) notice of cancellation in the future, there will be a **$35.00 cancellation fee** billed to your account that is not covered by your insurance. You will bare complete financial responsibility for this fee.

We are concerned that you may not be receiving necessary medical care because of these missed appointments... We value you as a patient.

REFRACTION: The portion of your exam during which time you look through various lenses, read the letters on the wall, and your eyeglass prescription is determined. The charge for this is **$65.00.**

CONTACT LENS: Any exam to fit or prescribe contact lenses, as well as the cost of the lenses. Charge varies.

The above test/procedures will only be done if deemed necessary by your physician. If you have questions regarding these charges, please feel free to discuss them with the business office staff or with your physician.

REFUND POLICY AND PROCEDURE

All refunds involving third party carriers, vendors, and individuals will be reviewed for accuracy and approval at the end of each month. Approved refunds will be issued during the regular payment of invoices in the following month

PATIENT CREDIT

Any credit on your account can be used towards future visits or services, therefore, any remaining credits on your account can be refunded back to you after 120 days. After one year, the books will be closed and payment forfeited.

By signing below, I acknowledge that I have read the above and understand my insurance requirements. **I agree to pay all non-covered services and understand** that Dr. Brian D. Haas will not file these charges with my insurance.

Patient Signature: X_____ Date: _____

BRIAN D HAAS, MD, PL

PATIENT-DOCTOR ARBITRATION AGREEMENT

It is important that you read this document carefully.

This Agreement is made between Brian D. Haas, MD, (Brian D. Haas, MD, PL) and their employees, agents (hereinafter collectively referred to as "Doctor") and _____ (hereinafter collectively referred to as "Patient"). It is the intention of the parties to this Agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons 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 the Doctor listed above for surgical ophthalmology, or for other ophthalmology or medical services of facilities ("Services"). The Patient also understands that there are other physicians and facilities who are qualified to render quality Services and the Doctor is willing to refer the Patient to another physician or facility for those Services if the Patient requests. Both Patient and the Doctor agree that arbitration is a preferable method to resolving any disputes they may have in connection with the Services, and wish to avoid the expense and inconvenience of litigation, whether by judge alone or by jury.

It is mutually agreed that any controversy, dispute or claim arising out of or relating to the Services of any kind, including the medical care rendered or payment of medical or surgical fees, or any matter whatsoever, including the interpretation hereof, shall be settled by arbitration in accordance with the Florida Arbitration Code. The controversy or claim shall be submitted to a single arbitrator (who must be a physician, licensed in Florida) mutually agreed upon by the parties within thirty (30) days of notice of an intent to arbitrate any matter hereunder. If the parties cannot agree upon the arbitrator within such thirty (30) day period, a Florida licensed physician shall be selected to serve as the arbitrator in accordance with the Florida Arbitration Code through a court, which has a situs in Orange County, Florida. The arbitration of such dispute will be held in Orange County, Florida within thirty (30) days after completion of discovery. The award of the arbitrator will be final and binding on all parties to the arbitration and judgment may be entered upon it in accordance with law in any court of competent jurisdiction. In the event of arbitration the parties hereto specifically agree that discovery shall be allowed in the form of written interrogatories, depositions of witness, production, inspection and copying of documents to the same extent as provided under the Florida Rules of Civil Procedure. Provided, however, the time for responding to requests for written interrogatories, production and inspection and copying of documents shall be reduced to ten (10) days, The parties hereto agree to use only American Board of Medical Specialties ("ABMS") board-certified ophthalmologists as expert medical witnesses, who must agree to adhere to the guidelines and/or code of conduct adopted or recommended by the ABMS for expert witnesses. Any disagreements between the parties to the dispute as to the scope and extent of and compliance with the discovery will be referred to the arbitrator and his or her determination shall be final. The parties further agree that such discovery procedures shall not be extended beyond two (2) months from the selection of the arbitrator: provided, however, that for good cause, the arbitrator shall be permitted in his or her discretion to extend said time for discovery. All expenses of the arbitrator and arbitration (exclusive of each party's attorney's fees, if any) shall be borne equally between the Patient and the Doctor. The parties hereto agree that should any noneconomic damages be awarded, in no event shall the amount of the noneconomic damages awarded exceed the limits set forth in Florida Statutes sec. 766.118(2) (generally $500,000.00, with greater amounts allowed under limited exceptions). The definition of noneconomic damages and calculation thereof shall be consistent with the use of said term and the calculation of noneconomic damages under Florida Statutes (2003) secs. 766.202(8) and 766.118(2). Provided, further, the parties hereto agree that no punitive damages may be awarded. Should any part of the provision of this Agreement be held unenforceable or in conflict with law, the validity of the remaining parts or provisions shall not be affected by such holding.

This Agreement shall remain in effect for all treatment, services and surgery provided to the patient presently and at any future date. I (we) have set our hand(s) this

_____ day of _____ (month), _____ (year).

DOCTOR:
By: _____
Authorized Agent

PATIENT:
By: X_____
Patient (Guardian or Guardian if patient is minor)
By: _____Patient's Spouse (if available)

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES AND HEALTH RELATED BENEFITS AND SERVICES

We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you via email newsletters, which may be administered by third party vendor. In accordance with the Telephone Consumer Protection Act, we are notifying you that you will receive an automated telephone call or text message, on the land line or cell phone provided by you, to remind you of upcoming appointments and recall appointments.

_____

Patient Name (print)

_____

Patient Signature

_____

Date