Dear Patient:

Please print the following forms and complete them as accurately as possible and bring them with you to your office visit. If you have any questions about the forms you can call my office at 850-208-1900 and then can assist you. Below please find some office policies that I wanted to make you aware of as well:

- New patients usually have a dilated examination. This will blur your vision for the remainder of the day. Please have someone accompany you to the office that can drive you home.

- If you are coming for a second opinion it is helpful to have your old records from your previous eye doctor if possible.

- I appreciate your time is valuable and my office and I will make every effort to stay on schedule. However, I have a referral practice and commonly see eye emergencies that will need to be worked in. This can disrupt the schedule.

- Please bring all of your insurance information (including your cards) with you to the office. If you are in an HMO and require a pre-authorization for your visit you are responsible for obtaining this *prior* to your examination. If the office does not have authorization at the time of your visit we cannot bill your HMO and you will be expected to pay for your examination at the time of your visit. Any co-pays, co-insurance, and deductibles will be collected at the time of your examination.

- If you have an emergency and need to reschedule please call my office as soon as possible during normal business hours (Monday thru Friday - 8 A.M. to 4 P.M.)

- If you wear prescription eyeglasses please bring them with you to your examination.

- I limit my practice to surgery and diseases of the eye and do not do routine eye examinations. If the purpose of your visit is to get an eyeglass examination or contact lenses please call my office and inform them of this. They can recommend you to another eye doctor.

My staff and I consider it a compliment that you have chosen us to evaluate your eye condition and we look forward to meeting you. Please call if you have any questions or concerns.

Sincerely,

Saul Ullman, M.D.

P.S. Please remember to bring your completed forms to your office visit!

Ullman Eye Consultants Patient Registration Form

Have you seen by Dr. Ullman in the past 3 Years? ____ Yes ____ No Todays Date: _____

Last Name: _____ First Name: _____ MI: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Social Security # _____Date of Birth: _____ Sex: ___ Male ___ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Drivers License Number and State: _____

Marital Status: ___ Married ___ Single ___ Widow ___ Divorced

Preferred Language: _____ Email*_____*Will not be shared

Race: ___Am Indian or Alaskan Native ___Asian ___Black/African American

___ Native Hawaiian or Pacific Islander ___ Patient Refusal ___White

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Patient Refusal

Referring Doctor _____ Are you employed? ____ Full Time ___ Part Time ___ No

Employer Name and Address _____

Emergency Contact Person: _____ Relationship _____ Phone: _____

Insurance Plan and Responsible Party Information*

Primary Insurance Company: _____

Policy Holders Name: _____ Policy Holder's Social Security # _____

Policy Holders Date of Birth: _____ Policy Holder's Occupation _____

Relationship of Policy Holder to Patient: _____

Policy Holder's Employer Name: _____

Policy Holder's Employer Address:_____

Policy Holder's Employer Phone: _____

Secondary Insurance Company: _____

Policy Holders Name: _____ Policy Holder's Social Security # _____

Policy Holders Date of Birth: _____ Policy Holder's Occupation _____

Relationship of Policy Holder to Patient: _____

Policy Holder's Employer Name: _____

Policy Holder's Employer Address:_____

Policy Holder's Employer Phone: _____

***All Information must be completely filled out in order to file your insurance. Thank you**

Lifetime Insurance Assignment and Authorization Form

Saul Ullman, M.D., P.A. is pleased to file insurance for our patients. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

I authorize payment directly to Saul Ullman, M.D., P.A. of benefits otherwise payable to me by my insurance company(ies). I do hereby assign, set over and transfer to Saul Ullman, M.D., P.A. my right to proceeds from any insurance company who is or may be liable at any time for all or part of my charges on this account to the extent necessary to pay such charges in full. If my insurance does not pay Saul Ullman, M.D., P.A directly, I agree to pay Saul Ullman, M.D., P.A. amounts equal to all health insurance benefits which I receive for medical care provided at the Ullman Eye Consultants immediately upon receipt of such payments.

I authorize Saul Ullman, M.D., P.A. to release to my insurance carrier(s) or it representative any information needed from my medical records concerning the examination or treatment rendered to me that is necessary to process insurance claims.

Patient Name	Signature*	Date

*If patient is under 18 and unmarried, parent/guardian must sign below.

Parent/Guardian	Signature	Date

Statement of Financial Responsibility

I acknowledge I am responsible for all charges for Saul Ullman, M.D., P.A. services provided to me, whether incurred in the past or future, including any amount not paid and/or not covered by my insurance or other third party payors, excluding contractual insurance adjustments. I understand that Saul Ullman, M.D., P.A. will not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim. I agree to pay the charges for care provided to the patient by Saul Ullman, M.D., P.A. within sixty (60) days of the date of the first date of the first monthly bill. Any account not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. Should collection action become necessary, I agree to pay reasonable attorney's fees, expenses and court costs incurred by Saul Ullman, M.D., P.A.

I have read and understand the terms stated above. These terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of Saul Ullman, M.D., P.A. I acknowledge receipt of a copy of this agreement.

Account Responsible Party	Signature	Date

Patient History Form – Saul Ullman, M.D.

Patient Name: _____ Date: _____

Please complete the following questions as completely as possible. If you do not know the answer to the question, please put a question mark in the appropriate space.

Do you have a history of?

	YES	NO		YES	NO
Glaucoma	____	___	Lazy Eye (Amblyopia)	____	___
Prior Eye Surgery	____	___	Family History of Glaucoma	____	___
High Blood Pressure	____	___	Insulin Use	____	___
Diabetes	____	___	Bleeding Problems	____	___
Heart Disease	____	___	Asthma	____	___
Stroke	____	___	Cancer	____	___
Drug Allergies	____	___	(If yes, Please List) _____		

Please list any other known medical problems:

_____

_____

Please list all medications taken regularly by mouth:

_____

_____

_____

Do you have a family history of any disease? (Please list):

_____

Have you ever taken a medication called Flomax or Tamsulosin? Yes / No

Are you currently or have you ever worn contact lenses? Yes / No

What is height? _____ What is your current weight? _____ lbs

Who is your family physician? _____

Are you: Married / Single / Divorced / Widowed

Do you have children? Yes / No Are you a smoker? Yes / No

Occupation: Retired / Other: (Please specify): _____

How did you hear about this office?

_____ Thank you!

ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received the Ullman Eye Consultant's Notice of Privacy Practices.

This Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

I understand that Ullman Eye Consultants is required to maintain the privacy of my health information. Ullman Eye Consultants will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of treatment, payment and healthcare operations. These may include: access to my health information by Ullman Eye Consultants staff and physicians; billing to me or a third party payer; in addition, business associates of Ullman Eye Consultants may have access to my health information. I am assured that proper business associates agreements are in place, insuring the protection of my health information. Upon the physicians best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that persons involvement in my care. Health information may be used for research data, organ procurement, marketing, FDA, public health or legal authorities; and or law enforcement purposes.

I agree that Ullman Eye Consultants may request and use my prescription medication history form other healthcare providers or third party pharmacy benefit payers for treatment purposes.

The undersigned hereby acknowledges receipt of Notices of Privacy Practices for Ullman Eye Consultants.

_____ _____ _____

Patient Signature Printed Name Date

_____

Witness

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, complete the following:

List efforts taken to get patient's acknowledgement and reasons acknowledgement was not signed:

_____

_____

_____ _____ _____

Signature of Staff Member Printed Name of Staff Member Date