Dr. Steven J. Zorn, OD, F.A.A.O., Welcomes You to Our Office

Personal Information

Patient's Name: _____ Martial Status: circle one **M S D W**

Parent/Guardian (if child): _____ Gender: circle one **Male Female**

Address: _____ Date of Birth ____/____/_____

City: _____ State: _____ Zip: _____ SSN - last four digits _____

Home Phone: _____ Cell: _____ Occupation: _____

Email: _____ Hobbies _____

Race Ethenicity ☐ Asian ☐ Hispanic ☐ Latino ☐ White ☐ African American ☐ American Indian
☐ Native Hawaiian or other Pacific Islander / Primary Language: ☐ English ☐ Spanish ☐ Other _____

Personal Health Information

Reason for today's visit: _____

Do you wear glasses? **Yes No** / Contact Lenses? **Yes No** / Are you interested in contact lenses: **Yes No**

Circle any of the concerns below that you have with your eyes.

Blurry vision	Eyestrain/headache	Eye itching/irritation
Spots/floaters	Flashes of light	History of eye injury
Dry eyes	Double vision	History of eye surgery

Do you have high blood pressure? **Yes No** / Are you diabetic? **Yes No** / **Are you pregnant? Yes No**
Do any of the following conditions apply to you? Circle those which apply.

Heart/circulation	Thyroid	Allergies	Nose/throat
Lung/breathing	Blood	Gastrointestinal	Muscle/bones
Mental Illness	Hearing	Genitourinary	Skin

List any medications you take: _____
List any medications you are allergic to: _____
Do you use any of the following? Please circle: Cigarettes/Tobacco Alcohol Social Drugs

Family Health History

Have any of your blood relatives had any of the following conditions: Please circle

Glaucoma	Cataract	Macula degeneration
Lazy eye	Retinal detachment	Heart disease/stroke
Diabetes	High blood pressure	Other

Insurance Information

Do you have insurance which helps you pay for your visit? **Yes No** If so, which plan? _____
Policy holder's name: _____ / Policy holder's social security # - last 4 digits _____
Is there a secondary insurance policy? **Yes No** / If yes policy holder's name _____
Policy holder's date of birth: ____/____/_____

STEVEN J. ZORN, O.D., F.A.A.O.

8889 W. Colonial Drive (Good Homes Plaza)
Ocoee, FL 34761
Phone: 407-298-4631 Fax: 407-298-3311

PATIENT ACKNOWLEDGEMENT
NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices describes in detail how your health information may be used and disclosed, and how you can access your information may be used and disclosed, and how you can access your information. The document is available for you to read in our office or on our website. A written copy is available for you upon request.

By signing below you acknowledge that we have made our Notice of Privacy Practices available.

Signature _____ Date _____

Printed name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative) _____

CONSENT OF DISCLOSURE
FOR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

During the course of providing services to you, we create, receive and store health information that identifies you. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to safeguard your confidentiality. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

When you sign this document, you acknowledge and authorize that we may disclose your health information for treatment, payment for our services, and to perform health care operations, that includes:

- The use and disclosure of your health information for treatment purposes, not only includes care and services provided here, but also disclosures of your health information, as may be necessary for you to receive follow-up care from us or another health care professional.
- The use and disclosure of your health information for the purposes of payment, including, but is not limited to, providing this information to your insurance company, third party, billing agent or other vendor for eligibility, determination of benefits, processing claims and receiving payment.
- We may have indirect treatment relationships with other organizations (such as laboratories and vendors) and may have to disclose personal health information for purposes of treatment, payment, or health care operations.
- Support personnel employed by this professional practice of any affliated agencies, vendors or companies, including Steven J. Zorn will have access to your health information.
- The payment of medical insurance benefits to Steven J. Zorn, O.D. or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

By signing below you acknowledge that you have read and understand the above information and voluntarily consent to the statements herein.

Signature _____ Date _____

Printed name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative) _____

INSURANCE IDENTIFICATION

Insurance identification and a picture ID are required for all patients.

- Your insurance identification card will be photocopied for identification purposes, before the examination.
- We cannot honor third party insurance benefits without your proper identification.
- Prior authorization of insurance benefits from your insurance company is required before service is provided.
- Your insurance claim will not be processed without verification of eligibility, by our office, before your exam.
- If we cannot verify eligibility of benefits at the time of your exam, you will be responsible for the professional fees and obligated to pay at the time of service.

OUR FINANCIAL POLICY

As a courtesy to our patients, we participate in many health care insurance programs. Insurance is considered a method of reimbursing the patient for professional fees paid to the doctor and is not a substitute for your responsibility of payment for services provided.

- As the patient, it is your responsibility and obligation to understand your health insurance benefits and obligations. This includes your financial obligations for services provided, by the participating physician, and to obtain prior authorization when necessary.
- Health care regulations require the collection of all co-payments, deductables, balances and non-covered professional fees at the time of service. It is your responsibility to pay any deductable amount, co-insurance, or any other fees not paid by your insurance company.
- If your insurance company does not pay for professional services within a reasonable time period, we have the right to bill you for the balance on your account.
- All examination fees and co-payments are collected at the times you received services. Insurance co-payments are collected at every visit.
- Some insurance companies only pay a portion of the professional fees (fixed allowances or percentages). Depending on your plan, you may be required to pay any outstanding balances on your account.
- Certain procedures, such a contact lens fittings, are elective and are not covered by insurance benefits. You will be responsible for all professional fees for any non-covered service.
- Professional examination fees are collected separate from the purchase of any eyewear.
- Discounts are not accepted in conjunction with any other discount, insurance benefit or third party program.
- You must provide discount verification at the time of service. Refunds, credits and account adjustments will not be provided at a later date.
- A $25 administrative fee is charged on all returned checks.
- There is a $30 fee due at the time of replacement for warranted frame or lens to cover shipping and handling.

By signing below, I acknowledge that I have read and understand the financial policy of Steven J. Zorn, O.D. I accept financial responsibility for the professional services and understand that I will be responsible for any unpaid balance on my account, in the event my third party insurance does not fulfill their contractual obligations.

Signature _____ Date _____

Printed name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative) _____

Thank you for your confidence in our professional services and practice.
We look forward to serving you.