KUTRYB EYE INSTITUTE

Patient Forms

Name: _____ Sex: _____ D.O.B _____

Name of Primary Care Provider? _____

Medications allergic to? _____

PLEASE CHECK ALL OF THE SYMPTOMS YOU EXPERIENCE:

___ Redness ___ light sensitivity ___ Dry Eye Feeling

___ Eye Pain/ Soreness ___ Mucous Discharge ___ Sites/ Chalazion

___ Chronic infection of eye or lids ___ Sandy or Gritty Feeling ____ Tired Eyes

___ Itching/ Burning ___ Fluctuation Visual Activity ____ Other _____

Do you use lubrication eye drops? ____ What name brand? _____

Do you wear contact lenses? _____ How long have you had them? _____

Are they comfortable? _____ Have you tried to wear them before and quit?

Do you wear glasses? _____ How long have you had them? _____

Have you ever had an eye injury? _____ Describe: _____

Have you ever had eye surgery? _____ Describe: _____

OVERALL MEDICAL HISTORY

Please indicate if you or a blood relative have or have had any of the following conditions:

Diabetes	__ No ___ Self	___Family	Relationship: _____
Heart Disease	__ No __Self	___ Family	Relationship: _____
High Blood Pressure	__No ___ Self	__Family	Relationship: _____
Cancer	__No ___ Self	__ Family	Relationship: _____
Asthma/ Respiratory	__No ___ Self	__ Family	Relationship: _____
Arthritis	___No ___ Self	__ Family	Relationship: _____
Epilepsy	__ No __ Self	___ Family	Relationship: _____
Stroke	___ No ___ Self	___ Family	Relationship: _____
Headaches/ Migraines	__ No ___ Self	___ Family	Relationship: _____
Glaucoma	___ No ____ Self	___ Family	Relationship: _____
Allergies	___ No ____ Self	___ Family	Relationship: _____
Gastrointestinal/ Liver	___ No ___ Self	___ Family	Relationship: _____
Blood related Problem	____ No ___ Self	___ Family	Relationship: _____
Kidney Stone	____ No ____ Self	___ Family	Relationship: _____
Kidney Failure	__ No ___ Self	___ Family	Relationship: _____

Social History

Do you smoke? ___ No____ Yes packs per day: ____ Former Smoker: ___ Months___ Yrs. Stopped

Do you drink alcohol? ____ No ____ Yes, Drinks per day

Do you use street drugs (cocaine, marijuana, etc.?) ____ Y ____ N

Patient Signature: _____ Date: _____

Michael J. Kutryb, M.D.
Board-Certified Ophthalmologist

321.267.2020

730 S Washington Ave.
Titusville, FL 32780

HIPAA PRIVACY AUTHORIZATION

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act 45 CFR Parts 160 & 164

Patient Name: _____ MRN: _____
D.O.B: _____/ _____/_____ E- Mail Address: _____

KUTRYB EYE INSTITUTE
C/O: MEDICAL RECORDS DEPARTMENT
730 S. WASINGTON AVE.
TITUSVILLE FL, 32780

◯ **Medical Records** ◯ **Appointment Info** ◯ **Results** ◯ **Images/ Films/ Reports**

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition treatment and prognosis of the following individuals (s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I request the following restriction (s) to releasing my PHI:
I understand that I am entitled to a copy of Kutryb EYE Institute. I can access a copy of the Notice of Privacy Practice the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which this authorization expires.

Signature of Patient **Date**

KUTRYB EYE INSTITUTE

Patient Forms

Pt. Name: _____ Pt. DOB: _____

Dear _____ Date: _____

Welcome to Kutryb Eye Institute

Appointment Date: _____ Time: _____ With: _____

730 S. Washington Ave
Titusville FL, 32780

Enclosed you will find your New Patient Paperwork. It is important that you complete this paperwork in it's entirely and bring it with you for your appointment.

If you were referred by your primary care physician or another physician they should have faxed your medical records to our office.

If your insurance plan requires authorization or referral from your primary care physician to be seen by a specialist, it is necessary that you **contact your PCP for the authorization**. Our office must receive authorization before you are seed for your appointment.

YOU MUST BRING updated medication list, photo ID and Insurance cards, for both medical and vision coverage. Due to the current **Covid 19** crisis we are asking that you wear a mask for your appointment.

If you have any questions, please feel free to contact our office: 321-267-2020
We Look forward to seeing you and participating in your care.

Thank you again for choosing Kutryb Eye Institute.

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KUTRYB EYE INSTITUTE

Patient Forms

Last Name:		First Name:	Middle Initial:
Patient Address:			
City:	State:	Zip:	Phone:
Date of Birth:	Sex: M ◯ F ◯	Married Status: M ◯ S ◯	Referred by:
Patient Social Security Number:		Ethnic Origin: Native American ☐ Asian ☐ Black ☐	
Patient Employer:		Caucasian ☐ Latin ☐ Other ☐ No Response ☐	
Medical Insurance: ◯ Vision Insurance: ◯ Self Pay ◯			
Primary :		ID:	Group:
Secondary :		ID:	
Responsible Party Last Name:		First Name & Middle Initial:	Relationship:
Address:			
City:	State:	Zip:	Phone:
Responsible Party Date of Birth:		Responsible Party Social Security Number:	
Spouse Name:		Spouse Work Phone:	

IN CASE OF EMERGENCY

Nearest Living Relative or Friend Not Living with You:	Relationship to Patient:
Relative or Friend Home Phone:	Relative or Friend Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kutryb Eye Institute or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

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FINANCIAL POLICY

The Doctors and Staff at the Kutryb Eye Institute would like to welcome you to our practice. We will strive to provide you with excellent medical care and our goal is to make your visits as pleasant as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Our office sends monthly statements on all accounts with an outstanding balance to the address we have on the account.
- Your account is to be kept current accordingly, all self-pay, or insurance co-payments, co-insurances and deductibles will be collected at **the time of service**.
- Payments can be made by cash, check, Visa, or MasterCard.
- A returned check will result in a $25.00 service charge and all future payments will be required in the form of cash or credit card.
- We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.

If you have health insurance coverage:

We will submit your claims; however, we must emphasize that as medical providers, **our relationship is with you** not your insurance company.

By signing below, you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any not covered charges not payable by your insurance policy.
- We do not file third insurance companies, only primary and secondary.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

Patient Name:	Patient Signature:	Date:
Responsible Party Name:	Responsible Party Signature:	Date:

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REFRACTION SERVICE AND FEE

Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of the comprehensive eye exam and is necessary to write a prescription for eyeglasses.

Most insurance plans, including Medicare do NOT cover this service. Medicare requires a separate charge for that portion of the exam, since it is a non-covered service.

Our office fee for the refraction is $50.00, which we reduce to $30.00 for patients paying at the time of service.

Thank you for trusting Kutryb Eye Institute with your vision care.

Patient Signature:	Date:

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to you prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health operations.
- The Practice has a Notice of Privacy and that I have received this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.
- I may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Name:	**Patient Signature:**	**Date:**
Responsible Party Name:	**Responsible Party Signature:**	**Relationship to Patient:**
Signature of Staff Witness:		**Date:**

MEDICATION LIST

Patient Name:	Allergies:

DATE	MEDICATION NAME	DOSAGE / FREQENCY
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		
Start:		
Stop:		

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ASSIGNMENT OF MEDICARE BENEFITS

Medicare Number:

I request that payment of authorized Medicare benefits be made on my behalf of **KUTRYB EYE INSTITUTE** for any service furnished to me via a Physician of a group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance, or the 20% Medicare does not pay, and for any non-covered services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Patient Name:	Patient Signature:	Date:

MEDIGAP OR OTHER SECONDARY INSURANCE

Medigap Name:	Medigap Number:

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Kutryb Eye Institute, or any physician of that group, for services provided to me by a physician of that group. I authorize any holder of medical information about me to release it to my Medigap insurer, or any information needed to determine these benefits for related services.

The assignments shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Patient Name:	Patient Signature:	Date: