Gulani Vision Institute
New Patient Questionnaire

Patient Name (First, MI, Last): _____ DOB: _____/_____/_____ Age: _____

Sex: Male / Female Marital Status: _____ Ethnicity: _____Race: _____

Social Security#: _____-_____-_____ Driver's License#: _____

Employer: _____ Occupation: _____

Home Address Street: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Contact Information Cell Phone (_____) _____-_____ Home Phone (_____) _____-_____

Primary Email: _____ Work Phone (_____) _____-_____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Cell Phone (_____) _____-_____

How did you hear about us? *Circle all that apply*:

Gulani Vision Patient Name: _____ Doctor Name: _____

OR

News
Medical Publication
Website/Online Research
Other: _____

Social Media:

Pharmacy Information

Pharmacy Name: _____ Phone #: (_____) _____-_____

Pharmacy Address: _____

Physician Information

Eye Doctor Name:_____

Phone: (_____) _____-_____ Email:_____

Address: City, State, Zip, Country: _____

Primary Care Physician (PCP):_____

Phone: (_____) _____-_____ Email:_____

I hereby understand that the information I have provided is accurate to the best of my knowledge.

Patient Signature: _____ Date of Consultation: _____/_____/_____

Gulani Vision Institute
New Patient Questionnaire

Address: City, State, Zip, Country: _____

Name (First, MI, Last): _____ DOB: _____/_____/_____ Age: _____

Last Medical Exam: _____/_____/_____ Last Eye Exam: _____/_____/_____ Eye Dr: _____

DO NOT LEAVE ANY SECTION BLANK IF IT DOES NOT APPLY TO YOU, CHECK "NO"

CARDIOVASCULAR

High blood pressure	YES □ NO □
Irregular heartbeat	YES □ NO □
Congestive heart failure Y	YES □ NO □
High cholesterol	YES □ NO □
Heart attack	YES □ NO □
Bleeding problems	YES □ NO □
DVT or PE (blood clot)	YES □ NO □
Heart stents/surgery	YES □ NO □
Other cardiovascular	YES □ NO □

SKELETOMUSCULAR

Arthritis	YES □ NO □
Rheumatoid arthritis	YES □ NO □
Gout	YES □ NO □
Degenerative disk disease	YES □ NO □
Other skeletomuscular	YES □ NO □

NEUROLOGICAL

Migraines	YES □ NO □
Seizures/epilepsy	YES □ NO □
Stroke or TIA (mini stroke)	YES □ NO □
Neuropathy	YES □ NO □
Fibromyalgia	YES □ NO □
Parkinson's disease	YES □ NO □
Multiple Sclerosis	YES □ NO □
Dementia	YES □ NO □
Other neurological	YES □ NO □

RESPIRATORY

Asthma	YES □ NO □
COPD/Emphysema	YES □ NO □
Sleep apnea	YES □ NO □
Other respiratory	YES □ NO □

GASTROINTESTINAL

Acid reflux	YES □ NO □
Crohn's	YES □ NO □
Ulcerative colitis	YES □ NO □
Hepatitis	YES □ NO □
Cirrhosis of liver	YES □ NO □
Other gastrointestinal	YES □ NO □

PSYCHIATRIC

Depression	YES □ NO □
Anxiety Disorder	YES □ NO □
ADHD	YES □ NO □
PTSD	YES □ NO □
Bipolar	YES □ NO □
Other psychiatric	YES □ NO □

ENDOCRINE

Type 1 diabetes	YES □ NO □
Type 2 diabetes	YES □ NO □
Thyroid	YES □ NO □
Other endocrine	YES □ NO □

GENITOURINARY

Kidney disease/failure	YES □ NO □
Kidney stones	YES □ NO □
Have ever taken Flomax?	YES □ NO □
Other genitourinary	YES □ NO □

OTHER

Cancer	YES □ NO □
HIV Y	YES □ NO □
Shingles	YES □ NO □
Cold Sores	YES □ NO □

FEMALES ONLY:

Are you pregnant?	YES □ NO □
Are you nursing?	YES □ NO □

SOCIAL HISTORY

Alcohol: Current □ Past □ Never □ Drinks/week: _____

Tobacco: Current □ Past □ Never □ Type: _____ Amount/Day: _____

Recreational Drugs: Current □ Past □ Never □ Type: _____ Frequency: _____ Years: _____

DRUG ALLERGIES (include drug & reaction) No Known Drug Allergies □

I hereby understand that the information I have provided is accurate to the best of my knowledge.

Patient Signature: _____ Date of Consultation: _____/_____/_____

Gulani Vision Institute
Patient Ocular History Questionnaire (Current & Past)

_____

MEDICATIONS (INCLUDE DOSE & FREQUENCY of each Rx and Over the Counter): Flomax: YES □ NO □

_____

_____

Are you currently experiencing any of the following:

Reduced Vision	YES □ NO □	Red Eyes	YES □ NO □
Loss of Vision	YES □ NO □	Eye Pain	YES □ NO □
Headache	YES □ NO □	Halos around Objects	YES □ NO □
Double Vision	YES □ NO □	Light Sensitivity	YES □ NO □
Tearing	YES □ NO □	Difficulty Reading	YES □ NO □
Itching	YES □ NO □	Other: _____	

List Any Previous Eye Surgeries or Procedures			
Procedure Name	Date	Which Eye	Name of Eye Surgeon (Country or State)

Do you have a history of:

Glaucoma? YES □ NO □ If yes, diagnosed when? _____

Retina? YES □ NO □ If yes, when? _____

Eye disease? YES □ NO □ If yes, what? _____

Eye Injury? YES □ NO □ If yes, when? _____

Lazy eye? YES □ NO □ If yes, which eye? _____

GLASSES WEAR How many years have you worn corrective eye wear? _____

Who prescribed your glasses? _____

How old is your current prescription? _____

CONTACT LENS WEAR Do you currently wear contact lenses? YES □ NO □

Did you wear contact lenses in the past? YES □ NO □

If yes, what type of lenses do/did you wear? Circle below:

Soft Soft-Toric Rigid Gas Permeable Scleral Hard Other: _____

How many years have you used contact lenses? _____

How many <u>days</u> prior to today's appointment did you stay out of your contacts? _____

FAMILY MEDICAL HISTORY Has any family member had these diseases (if yes, indicate which family members)

I hereby understand that the information I have provided is accurate to the best of my knowledge.

Patient Signature: _____ Date of Consultation: _____/_____/_____

Physician Signature: _____ Date of Consultation: _____/_____/_____

Gulani Vision Institute
Patient Ocular History Questionnaire (Current & Past)

Blindness	YES □ NO □ _____	Heart Disease	YES □ NO □ _____
Cataract	YES □ NO □ _____	Stroke	YES □ NO □ _____
Glaucoma	YES □ NO □ _____	Cancer	YES □ NO □ _____
Diabetes	YES □ NO □ _____	Thyroid Disease	YES □ NO □ _____
Hypertension	YES □ NO □ _____	Arthritis	YES □ NO □ _____

Other heritable diseases: _____

I hereby understand that the information I have provided is accurate to the best of my knowledge.

Patient Signature: _____ Date of Consultation: _____/_____/_____

Physician Signature: _____ Date of Consultation: _____/_____/_____

Gulani Vision Institute
Patient Financial Responsibility Agreement

Patient Name (First, MI, Last): _____ DOB: _____/_____/_____ Age: _____

ADVANCED VISION CONSULT (AVC)

You have sought the Advanced Vision Consult which is a specialty evaluation, an in-depth examination and advanced diagnostics, along with a personal consult with Dr. Gulani. This consultation is not billed to medical insurance (if you are a Medicare patient, you understand that our Institute has opted out and that Medicare will not pay for your services). You verbalize full understanding of the same. Having fully understood this and that this is a non-refundable charge, you are herewith acknowledging below.

All charges for services rendered are due and payable at the time of service.

Your signature below forms a binding agreement between Gulani Vision Institute (GVI - the provider of medical services) and you, (the Patient) who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Patient will pay account at the time service is rendered or will make financial arrangements satisfactory to Gulani Vision Institute for payment. The Patient or Responsible Party is the individual who is financially responsible for payment of medical bills.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Gulani Vision Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Gulani Vision Institute for payment. Payment collected at the time of service is just an estimate of patient responsibility. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

RETURNED CASHIER'S CHECK POLICY: If a payment is made on an account by Cashier's check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $20.00 Service Charge. Once notice is received of the returned Cashier's check, GVI will send out a letter to notify the Responsible Party of the returned Cashier's check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and any collection fees accrued will be added to the outstanding balance – in addition to the $20.00 Cashier's Check Service Charge.

NON-PAYMENT ON ACCOUNT: Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that GVI has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due, all court costs, Attorney fees, and collection fees will be added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

I hereby understand that the information I have provided is accurate to the best of my knowledge.

Patient Signature: _____ Date of Consultation: _____/_____/_____

Responsible Party Name: _____

Responsible Party Signature: _____ Date of Consultation: _____/_____/_____

Gulani Vision Institute
Disclosure Of Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In 1996, the federal government set forth new guidelines to protect patients' right to privacy. It is important to us, that you understand your rights according to the Health Insurance Portability and Accountability Act (HIPAA). The responsibility of Gulani Vision Institute is to guard your privacy. It is our duty to maintain the privacy of your Protected Health Information (PHI).

PHI (protected health information) may be used to carry out treatment, payment, or healthcare operations in our practice. You have the right to review this notice prior to signing it and not to sign it. If unsigned, you understand this office may choose not to render treatment. Our practice has the right to change privacy practices and the terms of the notice may change and be revised.

Your health information may be used to help treat your disease or problem and it may be disseminated to other health care providers in your best interest to help provide you with excellent health care. PHI may also be used in communicating with other doctors who are taking care of you, insurance companies for payment and for our internal operations.

Though your eye health is your own prime responsibility, and it is important that you follow up on your appointments and reach us in case of any confusion or emergency, Gulani Vision Institute may if needed (this does not replace your own responsibility) send post-card reminders for appointment dates, may contact you by phone, may leave voice messages and send out emails. With your consent we will also send patient statements to your home or other designated location as long as they are marked Personal and Confidential. By your signature below, you authorize us to use and disclose information about you to help in your treatment. All other uses and disclosures will be made only with your approval.

Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our privacy officer.

Our patients have the right to request restrictions on uses and disclosure of PHI (protected health information) for the purpose of treatment, payment, and healthcare operation purposes. Should our patients choose to revoke this consent, it must be given in writing to the practice, i.e., should the patient choose to limit how his or her personal health care information is disseminated for the purpose of treatment, payment, and healthcare operation. However, the Institute is not required to agree to your requested restriction.

You may also revoke this authorization in writing to Dr. Gulani.

Though our track record of satisfied patients worldwide is legend, if for any reason you feel your privacy has been violated, you have the right to make a complaint to our institute. We respect your right to file a complaint and there will be no retaliation in doing so. Please report any such violations to:

Administrator: Gulani Vision Institute
8075 Gate Parkway W. Ste. 102
Jacksonville, FL 32216
(904)-296-7393
gulanivision@gulani.com

I acknowledge that I have read and understand this authorization and its content:

Patient Signature: _____ Date of Consultation: _____/_____/_____

If you would like further information about our privacy policies and practices, please contact:

Gulani Vision Institute
8075 Gate Parkway W. Ste. 102
Jacksonville, FL 32216
(904)-296-7393
gulanivision@gulani.com

This notice is effective August 3rd, 2022.

I, _____ , have read and understand this Notice of Privacy Standards for Gulani Vision Institute. I agree to its terms.

Please specifically list any other family members or close friends with whom we may share your PHI. Understand that we will not share any information with any person, under any circumstances whose name does not appear on this sheet.

_____	_____
Name	Relation
_____	_____
Name	Relation

RELEASE OF INFORMATION:

Gulani Vision Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Gulani Vision Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. Gulani Vision Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data, social media, and marketing or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

I acknowledge that I have read and understand this authorization and its content:

Patient Signature: _____ Date of Consultation: _____/_____/_____

Gulani Vision INSTITUTE ...Vision for the World

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ SSN: _____-_____-_____

Date of Birth: ____/_____/_____ Phone: (_____) _____-_____ Email: _____

The information is needed for the following purposes:

Patient is seeking Dr. Arun Gulani's expertise for ocular health or vision corrective surgery, including 2nd opinion on complex cases or complication correction.

I Authorize Release of Medical Records to: Gulani Vision Institute

Please fax records to: (888) 397 - 4699

To obtain from: Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

To release to: **GULANI VISION INSTITUTE**

8075 Gate Parkway W. Ste. 102 Jacksonville, FL 32216

Telephone: (904) 296 – 7393 FAX: (888) 397 – 4699 Email: gulanivision@gulani.com

Information to be released: 12 months of records will be copied unless otherwise indicated.
(Please circle Yes or No for each category listed)

Medical History	YES □ NO □	Hospital Reports	YES □ NO □	HIV/AIDS Records	YES □ NO □
Operative Reports	YES □ NO □	Radiology Reports	YES □ NO □	Sexual Assault Records	YES □ NO □
Treatment or Tests	YES □ NO □	Social History	YES □ NO □	Child Abuse Records	YES □ NO □
Lab Reports	YES □ NO □	Medication Records	YES □ NO □	Minor's Reports	YES □ NO □
Consultations	YES □ NO □	Substance Abuse Records	YES □ NO □	Venereal Disease Records	YES □ NO □
Pathology Reports	YES □ NO □	Mental Health Records	YES □ NO □	Medical Examiner Reports	YES □ NO □

Specify Other Record: _____

I understand that these records are of a privileged and confidential status. I waive the status for the purpose contained within this authorization. I agree to hold GVI (Gulani Vision Institute) harmless from any and all cost, liability, and damages of any nature whatsoever, including attorney fees, resulting directly or indirectly from GVI release of these records pursuant to this consent. This authorization will automatically expire one (1) year following date of signature without my express revocation.

I acknowledge that I have read and understand this authorization and its content:

Patient Signature: _____ Date _____/_____/_____

Prohibition of Disclosure: The information is being disclosed to you from records whose confidentiality is protected by state laws, specifically FL Statutes 395.325, 55.667, & 394.459. State laws prohibit you from any further disclosure of this date without the specific written consent of the person to whom it pertains, or as otherwise permitted by Florida state statutes and regulations. A General Authorization is not sufficient for this purpose.