Gulani Vision Institute

Patient Questionnaire

Please Print Clearly Date: ____/_____/_____

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

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

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

Home Address: Street: _____

City: _____ State: _____ Zip Code: _____

Country: _____ Email: _____

Phone: *Home* (_____) _____-_____ *Cell* (_____) _____-_____ *Work* (_____) _____-_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone #: (_____) _____-_____

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

Pharmacy Address: _____

How did you hear about us?:

Circle all that apply: Worldwide Patients. Eye Doctor. News. Medical Publication. Website. Facebook. YouTube.

Other: _____ Gulani Vision Patient (Name):_____ Doctor (Name): _____

Insurance Information

Primary Insurance Company: _____

Member ID#: _____ Group #:_____

Secondary Insurance Company: _____

Member ID#: _____ Group #:_____

Physician Information

Eye Doctor: _____ Tel. #: (_____) _____-_____

Address, City, State, Zip: _____

Primary Care Physician (PCP): _____Tel. #: (_____) _____-_____

Address, City, State, Zip: _____

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

Signed: _____ Date: ____/_____/_____

Medical History Questionnaire

NAME: _____ DATE: ___/____/_____ DOB: ___/____/_____

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

PERSONAL MEDICAL HISTORY (Current or Past):

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

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

RESPIRATORY	YES	NO
Asthma	☐	☐
COPD/Emphysema	☐	☐
Sleep apnea	☐	☐
Other respiratory	☐	☐

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

GENITOURINARY	YES	NO
Kidney disease / failure	☐	☐
Kidney stones	☐	☐
Have you ever taken Flomax	☐	☐
Other genitourinary	☐	☐

OTHER	YES	NO
Cancer	☐	☐
HIV	☐	☐
Shingles	☐	☐
Cold Sores	☐	☐

FEMALES	YES	NO
Are you pregnant?	☐	☐
Are you nursing?	☐	☐

SKELETOMUSCULAR	YES	NO
Arthritis	☐	☐
Rheumatoid arthritis	☐	☐
Gout	☐	☐
Degenerative disk disease	☐	☐
Other skeletomuscular	☐	☐

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

ENDOCRINE	YES	NO
Type 1 diabetes	☐	☐
Type 2 diabetes	☐	☐
Thyroid	☐	☐
Other endocrine	☐	☐

PSYCHIATRIC	YES	NO
Depression	☐	☐
Anxiety Disorder	☐	☐
ADHD	☐	☐
PTSD	☐	☐
Bipolar	☐	☐
Other psychiatric	☐	☐

SOCIAL HISTORY

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

Tobacco ☐ Current ☐ Past ☐ Never Amount/ Day:_____

Type: _____ Years:_____

Recreational Drugs ☐ Current ☐ Past ☐ Never

Type:_____ Frequency:_____

DRUG ALLERGIES (include drug & reaction) NONE ☐

_____

_____

_____

MEDICATIONS (INCLUDE DOSE & FREQUENCY Rx and Over the Counter) : **Flomax**: Y/N.

Others:_____

_____

_____

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

Signed: _____ Date: ____/_____/_____

Ocular History

Do you have a history of:

Glaucoma? Y N If yes, diagnosed when?_____

Eye disease? Y N If yes, what? _____

Eye Injury? Y N If yes, when? _____

Retina ? Y N If yes, when? _____

Lazy eye? Y N

List Any Eye Surgeries:

Procedure:	Which Eye:	Name of Surgeon (Country/State):	Date:

Are you experiencing any of the following?:

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

GLASSES WEAR

How many years have you worn corrective eye wear? _____

How old is your current prescription? _____ Who prescribed your glasses? _____

CONTACT LENS WEAR

Do you currently wear contact lenses? Y N Did you wear contact lenses in the past? Y N

If yes, what type of lenses do/did you wear? ☐ Soft ☐ Hard ☐ Scleral ☐ Rigid Gas Permeable ☐ Toric ☐ Other: _____

How many years have you used contact lenses? _____

How many days has it been since you last wore your lenses? _____

FAMILY HISTORY Has any family member had these diseases (circle all that apply and indicate which family members)

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other Heritable Disease:_____

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

Patient's Signature: _____ Date: ____/_____/_____

Physician's Signature: _____ Date: ____/_____/_____

GULANI VISION INSTITUTE

Signature on File, Assignment of Benefits, Financial Agreement

_____ _____

Beneficiary Name *(print)* Insurance Member Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Gulani Vision Institute, for services furnished me by Gulani Vision Institute. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Gulani Vision Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Gulani Vision Institute, if possible or otherwise to me.

3. **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 or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Gulani Vision Institute maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Gulani Vision Institute has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Gulani Vision Institute if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Gulani Vision Institute's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Gulani Vision Institute to obtain necessary health care service plan authorizations.

6. **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.

Any additional balance after your claim is processed by your insurance will be your 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. Any benefits of any type under any policy of insurance, insuring the patient, or any other party liable to the patient, are hereby assigned to Gulani Vision Institute. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Gulani Vision Institute. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

_____ _____

Beneficiary Signature or Authorized Party Date

GULANI VISION INSTITUTE
ARUN C. GULANI, M.D., M.S.

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

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

This notice is effective May 5, 2020.

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

Signature: _____

Date: _____/_____/_____

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

Gulani Vision Institute

Authorization for Release of Medical Information

Patient Name: _____ SSN: _____-_____-_____

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

I Authorize Release of Medical Records to: Gulani Vision Institute

Please fax records to: (888) 397 – 4699

Please check the following and include name, addresses and telephone numbers:

To obtain from: _____

_____

_____

To release to: **GULANI VISION INSTITUTE**
8075 Gate Parkway West Ste. 102
Jacksonville, Florida 32216
Phone: (904) 296 – 7393
Fax: (888) 397 – 4699

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

Y N Medical History	Y N Operative Report	Y N Treatment or Test
Y N Lab Report	Y N Consultations	Y N Pathology Report
Y N Hospital Report	Y N X-Ray Reports	Y N Social History
Y N Medication Record	Y N Substance Abuse Records	Y N Mental Health Records
Y N HIV/AIDS Record	Y N Sexual Assault Records	Y N Child Abuse Records
Y N Minor's Report	Y N Venereal Disease Records	Y N Medical Examiner's Report
Y N Specify _____		

The information is needed for the following purposes:

_____
_____
_____
_____

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:

_____	____/_____/_____	_____
Signature of Patient/Legal Guardian	Date	Relation to patient

Prohibition of Disclosure: The information is being disclosed to you from records whose confidentiality is protected by state laws, specifically FL Statutes 395.325, 455.667, & 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.