GULFSTREAM EYE
Restorative & Aesthetic Eyelid Surgery

Phone: 772-448-4865
Fax: 772-448-4864

Name:_____ Date: _____/_____/_____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home #: ( )_____ Cell #: ( )_____ Work #: ( )_____

Email: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Language: _____

Place of Employment: _____

Please complete the following ONLY if someone other than the patient is responsible for payment.

Responsible Party: _____ Relationship: _____

Address: _____ DOB: _____/_____/_____

Home #: ( )_____ Cell #: ( )_____ Work #: ( )_____

Social Security #: _____ Is this the Patient's Legal Representative ☐ Yes ☐ No

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Out of Town Address: _____ Phone #: ( )_____

City: _____ State: _____ Zip Code: _____

(Use this address from _____/_____/_____ to _____/_____/_____)

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS
INSURANCE INFORMATION, FINANCIAL AGREEMENT

Patient's Name: _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Gulfstream Eye, for services furnished to me. 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 payable for 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 as a Secondary Insurance (in Item 9 of the HCFA 1500 claim form or electronically transmitted), my signature authorizes releasing the information to the insurer shown. Gulfstream Eye, accepts the charge determination of Medicare and I am responsible for coinsurance, deductibles and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to Gulfstream Eye, for services furnished to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

FINANCIAL AGREEMENT: I agree that in return for the services provided by Gulfstream Eye, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the practice. If my account is sent to collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. Most insurance companies require you to pay co-payments and deductibles. These are due, if known, at the time of service as well as any non-covered services. It is understood that I am primarily responsible for the payment of any services not covered by my insurance.

_____ _____

Signature of Patient or Authorized Representative Date

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PEOPLE WITH WHOM WE CAN DISCUSS YOUR HEALTHCARE

Name: _____

Relationship: _____

Contact Phone Number: _____

Name: _____

Relationship: _____

Contact Phone Number: _____

Name: _____

Relationship: _____

Contact Phone Number: _____

Name: _____

Relationship: _____

Contact Phone Number: _____

Name: _____

Relationship: _____

Contact Phone Number: _____

_____ _____

Patient Signature **Date**

_____

Patient Name (Please Print)

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

I understand that as part of my healthcare, Gulfstream Eye originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment. In addition to health records, they maintain insurance information and other correspondence received on a day-to-day basis.

The doctors, staff and business associates of Gulfstream Eye are authorized to use and disclose this information in the normal course of their workday. Similarly, pharmacies, other physicians and their staff, health insurers, billing agencies, and family or friends involved in my healthcare may also receive my health information.

I understand that I may revoke this authorization in writing at any time by sending a written request to the practice at 260 NW Peacock Blvd, Suite 101, Port St Lucie, Florida 34986, Attn: Office Administrator, except to the extent that action has been taken in reliance on this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by federal privacy rule.

This authorization shall expire seven years after my last day of service.

_____ _____

Signature of Patient or Authorized Representative Date

If signed by Patient's Representative, please print name and describe the representative's authority to act on your behalf.

Representative's Name: _____

Representative's Authority: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE PATIENT OR PATIENT'S REPRESENTATIVE

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Patient Name:_____ Patient DOB:_____ Todays Date:_____
Height:_____ Weight:_____

Reason for todays visit? _____
Referring Doctor: _____ Primary Care Doctor:_____

Do you have someone responsible for making health care decision if you are unable? Yes:☐ No:☐
If Yes, Name/phone/address:_____

Medical History:

Condition	Yes	No	Surgery
Afib			
Anxiety			
Arthritis			
Asthma/COPD			
Cancer			
Depression			
Diabetes			
Ear/Nose/Throat issues			
High Blood Pressure			
High Cholesterol			
Heart condition(s)			
Pacemaker/Defibrillator			
Thyroid disease			
Prior Eyelid Surgery			
Prior Eyeball Surgery			
Facial Surgery			
Facial Trauma			

Medication(s) Please include OTC meds.

Name: Strength: Frequency:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other Medical conditions(s) not listed above:_____

Medication Allergies: ☐None ☐Penicillin ☐Sulfa ☐Other:_____

Social History:
Do you smoke? ☐ Yes ☐ No Previous smoker? ☐Yes ☐ No

Do you drink alcohol? ☐Yes ☐No If yes, how often & how much?_____

Who is your preferred ***short*** term pharmacy? Name:_____ Location:_____

FINANCIAL INFORMATION

INITIAL EVALUATION DEPOSIT FOR SELF-PAY PATIENTS

NON-REFUNDABLE LESS THAN 24 HOURS BEFORE APPOINTMENT

To secure an appointment with Dr. Vickers a deposit of $150 must be made in advance. The Initial Evaluation deposit is non-refundable if the patient cancels less than 24 hours before the scheduled appointment.

APPOINTMENT CONFIRMATION FOR ALL PATIENTS

MISSED APPOINTMENTS ARE SUBJECT TO FEES

Gulfstream Eye is committed to providing all our patients with exceptional care. When a patient cancels an appointment without giving enough notice, they prevent another patient from being seen. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Appointment Cancellation/ No Show Policy:

- Effective August 1, 2024 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24-hours' notice will be considered a No Show and charged a $50.00 fee.
- Repetitive cancellations or no-shows by a patient are grounds for dismissal from the practice.
- Any new patient who fails to show without prior notification given, you will forfeit your deposit for the missed appointment.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patients next office visit and/or upon receipt of statement, whichever comes first.

By signing below, I have read and understand Gulfstream Eye's No Show/Missed appointment Guidelines and agree to its terms.

_____

PRINT PATIENT NAME TODAYS DATE

_____

PATIENT SIGNATURE (OR PARENT/GUARDIAN IF MINOR) RELATIONSHIP TO PATIENT

Once this is signed, please send back to our office for scheduling the initial evaluation. Office phone number 772-448-4865.