



Monroe Benaim, MD
Board Certified Eye Surgeon

Thank you for choosing our office:

In order to serve you properly we will need the following information. (Please Print) All information will be strictly confidential.

Patient Information:

Date: ___/___/___

Dr. Mr. Mrs. Miss. Single Married Widowed Divorced

Name: ___ DOB: ___/___/___ Age: ___

Address: _____

City: ___ State: ___ Zip: ___

Home Number: ___ Cell Phone: ___

Business Phone: ___ Email: ___

S.S. Number: ___ Occupation: ___

Name of Employer: ___ Phone Number: ___

Spouse/ Parent Name: _____

Emergency Contact: ___ Phone Number: ___

Referred By: _____

Primary Physician: ___ Phone Number: ___

Insurance Information:

Primary Insurance Plan (or Medicare #): _____

ID Number: ___ Group Number: _____

Secondary/Supplement Insurance: _____

ID Number: ___ Group Number: _____

Medical Information:

When was your last Eye Exam? ___ With Dr.? _____

Do you wear glasses? Yes ___ No ___ Do you wear Contacts? Yes ___ No ___

What is the reason for today's visit? _____

How long have you had this problem? _____

Please list all previous surgeries: _____

Please list all medications or vitamins that you take: _____

Do you use any eye drops? If yes, what? _____

Are you allergic to any Medications? If yes, what? _____

Please **circle** Yes or No for any conditions you have:

Heart Failure	Yes	No	Stomach Ulcers	Yes	No
Heart Disease	Yes	No	Hepatitis	Yes	No
Chest Pains	Yes	No	Cirrhosis	Yes	No
High Blood Pressure	Yes	No	Crohn's Disease	Yes	No
Heart Defect	Yes	No	IBS	Yes	No
Heart Surgery	Yes	No	Organ Transplant	Yes	No
Pace Maker	Yes	No	Reflux Disease	Yes	No
Blood Transfusion	Yes	No	Hay Fever	Yes	No
Anemia	Yes	No	Sinus Problems	Yes	No
Sickle Cell Anemia	Yes	No	Asthma	Yes	No
Hemophilia	Yes	No	Bronchitis	Yes	No
Leukemia	Yes	No	Emphysema	Yes	No
HIV	Yes	No	Tuberculosis	Yes	No
Stroke	Yes	No	Urinate more than 6x daily	Yes	No
Hearing Loss	Yes	No	Kidney Stones	Yes	No
Earaches	Yes	No	Bladder Problems	Yes	No
Migraines	Yes	No	Dialysis	Yes	No
Dizzy Spells	Yes	No	Sexually Transmitted Disease	Yes	No
Epilepsy	Yes	No	Drink Alcohol	Yes	No
Psychiatric Treatment	Yes	No	Smoke	Yes	No
Brain Injury	Yes	No	Pregnant	Yes	No
Cancer	Yes	No			
Diabetes	Yes	No			
Thyroid	Yes	No			
Skin Rash or Hives	Yes	No			
Arthritis	Yes	No			
Gout	Yes	No			
Artificial Joint	Yes	No			
Fever Blisters	Yes	No			

Please list any general health problems of your immediate family: _____

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



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

Patient's Name: _____ Date: ____/____/____
Patient's Date of Birth: ____/____/____

MEDICARE: I request that payment of authorized Medicare benefits be made to
BENAIM EYE, LLC on my behalf for services furnished to me. I authorize the
holder of any medical or financial information about me to release to Medicare
and Medicaid Services 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 and financial information necessary
to pay the claim(s). If other health insurance is indicated as a Secondary
Insurance (item 9 of the HCFA 1500 claim form or electronically transmitted), my
signature authorizes releasing the information to the insurer shown. BENAIM
EYE, LLC accepts the charge determination of Medicare and I am responsible for
co-insurance, deductibles and non-covered services.

INSURANCE: I request that payment of authorized benefits be made on my
behalf to BENAIM EYE, LLC for services furnished to me. I authorize the holder
of any medical or financial information about me to release to my insurance
company 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 and financial information necessary to pay the
claim(s).

FINANCIAL AGREEMENT: I agree that in return for services provided by
BENAIM EYE, LLC, I will pay my account at the time service is rendered or will
make financial arrangement satisfactory to the practice. If my account is sent to
collection or an attorney for non-payment, I agree to pay collection expenses and
attorney's fees. Most insurances require payment of co-payments and
deductibles. These are due, if known, at the time of service as well as any non-
covered services.

I understand that I am primarily responsible for the payment of any
services not covered by Medicare, Medicaid or my Insurance.

_____/_____/____
Patient's Signature or Authorized Party Date

If Authorized Party, Print Name and describe the authority to act: _____



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Authorization to Use or Disclose Health Information

Name: _____
Date of Birth ____/____/____

I understand that as a part of my healthcare, BENAIM EYE, LLC, originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans 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 doctor and staff of Benaim Eye, LLC 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 BENAIM EYE, LLC, at 1001 W. Indiantown Road, Suite 107, Jupiter, FL 33458, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign 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 re-disclosure by the recipient, and if re-disclosed the information would no longer be protected by the federal privacy rule.

I acknowledge that by my signing below, I have had full opportunity to read and consider the contents of this consent form. I am giving my permission for use and disclosure of my PHI to carry out treatment, payment activities and healthcare operations.

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

Signature of Patient or Authorized Representative ____/____/____
Date

If signed by the Patient's Authorized Representative, please print the name and describe the representative's authority to act for you.

Representative's Name _____

Representative's Authority _____



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REFRACTION TESTING

Non-Covered Service Policy

A REFRACTION is a test used to determine the cause of decreased visual acuity. It is done to determine the need for a change in your prescription eyewear, to determine the need for surgery (e.g. Cataract), and to rule out eye disease as the cause of diminished vision.

Most insurance companies, including Medicare considers this to be a Non-Covered Service for which the patient is responsible for payment.

The fee for this test is **\$50.00**, payable on the day of service. If your insurance company pays for this specific test, you may submit the bill for reimbursement.

If we receive payment from your insurance company for the refraction, we will reimburse you the amount covered by your insurance.

I _____ understand that a Refraction is not a covered service by most insurance companies; I also agree to be responsible for the fee on the day of service.

Patient's Signature

Date