PATIENT INFORMATION

Name as it appears on your insurance card

Street Address

City, State and Zip code

Cell Phone Number

Alternate Phone Number

Email

Birthdate Age

Employer

Single/ Married/ Widowed/ Divorce

Northern Address (if applicable)

Street Address

City, State, Zip Code

Northern Phone Number

EMERGENCY CONTACT

Name

Relationship to Patient

Phone Number

INSURANCE INFORMATION: Please bring your insurance cards so that we may make a copy.

Name of Primary Insurance

Policy Number

Name of Secondary Insurance

Policy number of Secondary Insurance

If policy holder of insurance is other than **self** than please provide Policy holders name, address and date of birth.

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Karen Chapman for any services furnished by her for my medical care. I authorize any holder of medical information about me, to release to the Heath Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated on line 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature_____ Date_____

FINANCIAL POLICY

Dr. Chapman participates in most insurance plans. We will file all claims with Medicare and primary insurance carriers in which we are a participating provider. Co-payments will be collected at the time of your appointment.

We do not file claims with insurance companies in which we are not a participating provider. You will be required to pay any fees at the time of your visit. We will provide you with a receipt with the necessary information for you to submit your claim for medically necessary procedures.

Our office does not file secondary insurance claims, however in most cases Medicare will forward your claim to your secondary insurance for processing.

If your primary insurance policy is "managed care", or an HMO policy, and requires an authorization for office visits, it is your responsibility to obtain authorization. We are unable to provide services if we do not have authorization.

Authorizations can be faxed to 941-953-5808. Insurance coverage, authorization or referral from your primary care physician is **not a guarantee of payment.**

If you do not have insurance coverage, payment will be expected at the time of your appointment.

Photocopies will be made of your insurance cards and government issued photo identification. This information will remain in your medical records for any needed reference. We are sensitive to concerns regarding your identify and identity theft. Your medical records are protected under the health insurance portability and accountability act (HIPAA) of 1996.

ALL accounts will be subject to collections 60 days past receipt of your first statement. Accounts sent to collections may be charged an additional 35% for collection fees and possible attorney fees.

⟶I certify that I (or my dependent) have coverage with the insurance carrier listed and that my insurance claims will be filed with the information that I provided. Assignment of benefits for services rendered will be paid to Dr. Karen Chapman.

⟶I understand that I am responsible for all co-payments, co-insurance and deductibles as determined by my insurance carrier. I am also responsible for charges not covered by insurance.

⟶I understand that I am responsible for any and all cosmetic procedure fees.

⟶I hereby authorize the release of any medical information necessary to secure payment of benefits.

⟶I authorize the use of this signature on all insurance submissions.

Responsible Party Signature | Relationship to patient (self, parent, or guardian) | Date

MEDICAL HISTORY

Name_____ **Date of Birth**_____

Referring Dr. _____ **Primary Care Physician** _____

Reason for today's consultation: _____

Social History

Do you smoke? ____**NO** ____**YES** _____per day

Do you drink alcohol? ____**NO** ____**YES** How often? Daily / weekly / socially

Do you exercise? ____**NO** ____**YES** How often? Daily / weekly / occasionally

Your occupation_____ Do you drive? **NO** **YES** Do you live alone? **NO** **YES**

Ocular History

Have you ever had any injuries to your eyes or face? ____**NO** ____**YES** **When?**_____

Type of injury and treatment:_____

Have you ever had any eye or eyelid surgeries or procedures? ____**NO** ____**YES**

Type of surgery and dates:_____

Have you ever had any facial or sinus surgeries or procedures? ____**NO** ____**YES**

Type of surgery and dates:_____

Have you ever been diagnosed with any eye disease or condition? ____**NO** ____**YES**

Please explain_____

_____

Date of last eye exam: _____ Dr's name_____

Do you wear contact lenses? _____ How old is your present pair of glasses?_____

Ocular Medications

Do you use **artificial tears**? ____**NO** ____**YES** What brand?_____ How often?_____

Do you use any **prescription eye drops, eye ointments or eye medication?** ____**NO** ____**Yes**

Please list:_____

Do you use any **other** Over-The-Counter eye drops, ointment, or eye medications? ___NO ____YES

For what condition? _____

Are you currently on a **therapeutic aspirin regimen?** ____**NO** ____**YES**

Please list your current oral medications, including prescription medication, over-the-counter medications, vitamins, supplements and herbal products:

Name	**Strength**	**Times/day**	**Name**	**Strength**	**Times/day**

MEDICAL HISTORY

Do you have, or have you had previously, any problems in the following areas? Please indicate the condition and give approximate time of onset.

	No	Yes	Condition and approximate time of onset.
High blood pressure	____	____	_____
Heart attack/heart disease	____	____	_____
Arrhythmia	____	____	_____
Pacemaker	____	____	_____
Defibrillator	____	____	_____
Valve replacement	____	____	_____
Lung / Breathing problems	____	____	_____
Sleep Apnea/CPAP	____	____	_____
Neurological conditions	____	____	_____
Stroke or Blood disorders	____	____	_____
Diabetes	____	____	_____
Kidney disease	____	____	_____
Thyroid disease	____	____	_____
Stomach or intestines	____	____	_____
Muscular / skeletal	____	____	_____
Joint replacement	____	____	_____
Autoimmune disease	____	____	_____
Infectious disease	____	____	_____
Cold sores	____	____	_____
Ears, nose, mouth, throat	____	____	_____
Psychiatric illness	____	____	_____
Cancer (including skin)	____	____	_____
Migraine headaches	____	____	_____

Date of last physical:_____ Date of last EKG:_____

Surgical history: list any procedures / surgeries and approximate dates:

_____

_____

Allergies to medications and reactions:_____

Reactions to or complications from anesthesia: ____NO ____YES _____

I acknowledge that current and past health information is essential to my medical/surgical care. I confirm that the above information I have provided is true and accurate to the best of my knowledge. I also confirm that I have not withheld any health information.

_____ _____

Patient signature Date Reviewed Date

_____

Reviewed Date

Karen L. Chapman, M.D., F.A.C.S.
1750 South Osprey Avenue
Sarasota, FL 34239
941-953-5800

Our office is in compliance with the Health Insurance Portability and Accountability Act of 1996, commonly referred to as the patients right to privacy. Our policies and procedures in regard to privacy will be strictly enforced.

Please initial each statement below:

_____I understand that this office will leave messages on my answering machine/voice mail or at the number provided to remind me of appointments. I also understand that a message may be left asking me to contact this office.

_____I understand that uses and disclosures of my protected health information may be made for treatment. I understand that I must provide additional signed authorization for any other disclosure, unless required by law.

_____I understand that I may request that this office contact me by alternate means such as a different mailing address.

_____I understand that my treatment will not be conditioned upon refusal to sign this notice.

_____I understand that I must provide this office with a copy of Power of Attorney papers or Healthcare surrogate papers, only if applicable.

I understand that Dr. Chapman and her staff will not discuss my medical condition or treatment with anyone, including my spouse, unless I have authorized them to do so. I give permission for Dr. Chapman and her staff to discuss my protected health information with the below listed persons:

_____ _____

_____ _____

_____ _____

Any change in the above listed individuals must be provided in writing.

_____
Signature of Patient or
Patient representative (with legal papers only)

_____
Witness

_____
Date