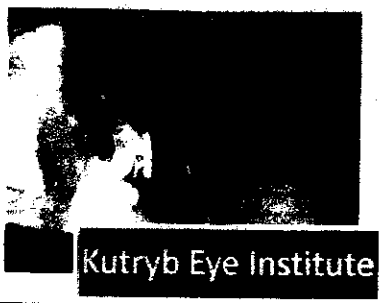

PATIENT REGISTRATION

LAST NAME		FIRST NAME & MIDDLE INITIAL	
ADDRESS LINE 1			
ADDRESS LINE 2			
CITY	STATE	ZIP	HOME PHONE
DATE OF BIRTH	SEX	MARRIED STATUS (M/S)	REFERRED BY
PATIENT S.S. #	ETHNIC ORIGIN: *PLEASE CIRCLE:* AMER. INDIAN ASIAN BLACK		
PATIENT'S EMPLOYER	WHITE W HISPANIC B HISPANIC OTHER NO RESPONSE		
EMPLOYER ADDRESS			
CITY	STATE	ZIP	
EMPLOYER PHONE	EXTENSION		
RESPONSIBLE PARTY LAST NAME	FIRST NAME & INITIAL	RELATIONSHIP	
ADDRESS			
CITY	STATE	ZIP	PHONE
RESPONSIBLE PARTY DATE OF BIRTH	RESPONSIBLE PARTY S.S. #		
SPOUSE'S NAME	SPOUSE'S WORK PHONE		

IN CASE OF EMERGENCY

NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU	RELATIONSHIP TO PATIENT
RELATIVE/FRIEND HOME PHONE	RELATIVE/FRIEND WORK PHONE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kutryb Eye Institute or insurance company to release any information required to process my claims.

_____ _____

PATIENT/ GUARDIAN SIGNATURE DATE

Kutryb Eye Institute

Financial Policy

The Doctors and Staff at the Kutryb Eye Institute would like to welcome you to our practice. We will strive to provide you with excellent medical care and our goal is to make your visits as pleasant as possible.
By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Our office sends monthly statements on all accounts with an outstanding balance to the address we have on the account.
- Your account is to be kept current-accordingly, all self pay, or insurance co-payments, co-insurances and deductibles will be collected at **the time of service**. Payments can be made by cash, check, Visa, Mastercard .
- A returned check will result in a $25.00 service charge and all future payments will be required in the form of cash or credit card.
- We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

If you have health insurance coverage:
We will submit your claims, however **we must emphasize that as medical providers, Our relationship is with you not your insurance company.**
By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- Not all services are covered benefits with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under you insurance policy
- You are responsible for any non covered charges not payable by your insurance policy.
- We do not file third insurance companies only primary and secondary.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

Patient Name _____ Patient Signature _____ Date _____

Patient Name _____ Responsible Party _____ Date _____

KUTRYB EYE INSTITUTE

"A Tradition of Excellence in Eye Care"

Refraction Service and Fee

Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of the comprehensive eye exam and is necessary to write a prescription for eyeglasses.

Most insurance plans , including Medicare do NOT cover this service. Medicare requires a separate charge for that portion of the exam, since it is non-covered service.

Our office fee for the refraction is $ 50.00, which we reduce to $30.00 for patients paying at the time of service.

Thank for trusting Kutryb Eye Institute with your vision care.

Patient Signature _____

Date _____

KUTRYB
EYE INSTITUTE

Michael J. Kutryb, M.D.
Board-Certified Ophthalmologist

2568 Ridgewood Ave. (HWY 1) Suite 4 • Edgewater, Florida 32141
Volusia Co. 386-424-1422 • Brevard Co. 321-383-7888

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment or health operations.**
- **The Practice has a Notice of Privacy and that I have received this Notice.**
- **The Practice reserves the right to change the Notice of Privacy Policies.**
- **I have the right to restrict the uses of their information but the Practice does not have to agree with those restrictions.**
- **I may revoke this Consent in writing at any time and all future disclosures will then cease.**
- **The Practice may condition treatment upon the execution of this Consent.**

This consent was signed by: _____
Signature of Patient or Representative **Date**

Relationship to Patient (if other than patient): _____

In front of: _____
Signature of Staff Witness **Date**

KUTRYB EYE INSTITUTE MEDICATION LIST

Patient Name	Allergies

DATE	MEDICATION NAME	DOSAGE /FREQUENCY			
Start / Stop					

KUTRYB EYE INSTITUTE

Michael J. Kutryb, M.D.

Board-Certified Ophthalmologist

2568 Ridgewood Ave. (HWY 1) Suite 4 • Edgewater, Florida 32141
Volusia Co. 386-424-1422 • Brevard Co. 321-383-7888

Name: _____ Sex: _____ Date of Birth: _____ Date: _____

Are you presently under the care of a physician? ☐ No ☐ Yes

List any medications you are currently taking: _____

_____

Are you allergic to any medications? ☐ No ☐ Yes If so, please list: _____ _____

_____

PLEASE CHECK ALL OF THE EYE SYMPTOMS YOU EXPERIENCE (X):

__Redness	__Light Sensitivity	__Dry Eye Feeling
__Eye Pain/Soreness	__Mucous Discharge	__Sties/Chalazion
__Chronic infection of eye or lids	__Sandy or Gritty Feeling	__"Tired" Eyes
__Itching/Burning	__Fluctuating Visual Acuity	__Other

Do you use lubricating eye drops?	Y N	What name brand? _____
Do you wear contact lenses?	Y N	How long have you had them? _____
Are they comfortable?	Y N	Have you tried to wear them before and quit? Y N
Do you wear glasses?	Y N	How long have you had them? _____
Have you ever had an eye injury?	Y N	Describe: _____
Have you ever had eye surgery?	Y N	Describe: _____

OVERALL MEDICAL HISTORY

Please indicate if you or a blood relative have or have had any of the following conditions:

Diabetes	☐ No	☐ Self	☐ Family	Relationship: _____
Heart Disease	☐ No	☐ Self	☐ Family	Relationship: _____
High Blood Pressure	☐ No	☐ Self	☐ Family	Relationship: _____
Cancer	☐ No	☐ Self	☐ Family	Relationship: _____
Asthma/Respiratory	☐ No	☐ Self	☐ Family	Relationship: _____
Arthritis	☐ No	☐ Self	☐ Family	Relationship: _____
Epilepsy	☐ No	☐ Self	☐ Family	Relationship: _____
Stroke	☐ No	☐ Self	☐ Family	Relationship: _____
Headaches/Migraines	☐ No	☐ Self	☐ Family	Relationship: _____
Glaucoma	☐ No	☐ Self	☐ Family	Relationship: _____
Allergies	☐ No	☐ Self	☐ Family	Relationship: _____
Gastrointestinal/Liver	☐ No	☐ Self	☐ Family	Relationship: _____
Blood related problem	☐ No	☐ Self	☐ Family	Relationship: _____
Kidney stones	☐ No	☐ Self	☐ Family	Relationship: _____
Kidney failure	☐ No	☐ Self	☐ Family	Relationship: _____

SOCIAL HISTORY

Do you smoke?	☐ Yes	☐ No	_____ Packs per day
Do you drink alcohol?	☐ Yes	☐ No	_____ Drinks per day
Do you use street drugs (cocaine, marijuana, etc.)	☐ Yes	☐ No	

Patient Signature: _____ Date: _____

New Patient Referral Information

Date_____

Patient Name

_____

Name of Referring Physician or Patient

_____

If neither, how did the Patient hear about us?

_____Friend

_____Internet

_____Community Event (Home Show, Health Fair, ect.)

_____Advertising

_____Other

_____

ASSIGNMENT OF MEDICARE BENEFITS

PATIENT NAME:_____

MEDICARE NUMBER:_____

I request that payment of authorized Medicare benefits be made on my behalf to **KUTRYB EYE INSTITUTE** for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance, or the 20% Medicare does not pay, and for any non-covered services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

SIGNATURE:_____

DATE:_____

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Kutryb Eye Institute, or any physician of that group, for services provided to me by a physician of that group. I authorize any holder of medical information about me to release it to my Medigap insurer, _____, or any information needed to determine these benefits for related services.

The assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

SIGNATURE:_____

DATE:_____

Kutryb Eye Institute

_____/_____/_____ _____ _____
Today's Date Name

Cosmetic Procedure Questionnaire

Please check box or boxes that fit:

- o YES. **I am interested** in physician treatments that promote Healthy and Youthful **skin.**
  - o Skin Procedures
    - o Botox for wrinkle and sun damage treatment
    - o Facial fillers such as Juvederm
    - o Lip and Eye area treatments
- o **NO. I am not interested** in cosmetic treatment of my skin at this time.
- o **Please contact** me with special offers, newsletter, and events:
  - o E-Mail:_____
  - o **Phone:** _____

FOR OFFICE USE ONLY

DISCUSSION:

_____

_____

_____

_____

_____Appt Booked

_____Call Made

_____
Date