Hess Pediatric Ophthalmology Specialists
Pediatric Ophthalmology and Strabismus
Diplomats of the American Board of Ophthalmology
601 5th Street South, Suite 601
St. Petersburg, Florida 33701

-Patient Information-

Patient's Name: _____ Male_____ Female_____
Last First Middle

Age:_____ DOB:_____ Social Security #:_____

Patient's Address:_____
Street City State Zip

Home Phone: (_____)_____Cell Phone: (_____)_____

E-Mail: _____ Emergency Contact: (____)_____ Relationship/ Name:_____

Reason for today's visit: _____

Referred By: _____

Primary Care Doctor: _____

(Circle) Father / Guardian / Other :
Name: _____
DOB: _____SS#: _____
Address: _____
_____
(if different from above)
Home Phone: (___) _____
Employer: _____
Work Phone: (___) _____

(Circle) Mother / Guardian / Other :
Name: _____
DOB: _____SS#: _____
Address: _____
_____
(if different from above)
Home Phone: (___) _____
Employer: _____
Work Phone: (___) _____

Divorced Parents: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills. We cannot bill the other parent.

Financial Responsibility: ____Self-Pay _____Medicaid _____Medicare _____Commercial _____Other
Insurance Policy Holder: _____DOB: _____SS#: _____
Insurance Company: _____
Contract #: _____Group #: _____
Insurance Billing Address: _____
_____

I hereby authorize Hess Pediatric Ophthalmology Specialists to release any information acquired in the course of my (or my child's) examination or treatment.
I agree that medical photographs may be taken in the course of evaluation and treatment.
I also authorize any hospital or clinic to provide full details of my medical history and treatment to Hess Pediatric Ophthalmology Specialists.
I hereby authorize payment directly to Hess Pediatric Ophthalmology Specialists, of the amount due me in my pending claim for medical expenses payable under the terms of my insurance.
I agree that any balance not covered by insurances will be paid by me.
I agree to pay for any costs incurred in the collection or litigation of any unpaid balance.

__/__/____ X _____
Date: Signature of parent or legal guardian: (A copy of this signature is as valid as the original)

Note: It is our policy that all office services are payable at the time of the visit. Thank you.

Hess Pediatric Ophthalmology Specialists *-Review of Systems-*
(New Patient Visit)

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Please take a few minutes to answer the following questions. Write explanations in the spaces provided.

Patient Name:_____ Age:_____ DOB:_____

Yes	No	Birth History:
☐	☐	was the patient born premature?
☐	☐	full term pregnancy?
☐	☐	complications during pregnancy?
☐	☐	extended hospital stay?
☐	☐	Other? _____

Yes	No	General Health:
☐	☐	excessive weight loss or gain?
☐	☐	change in appetite?
☐	☐	fever / chills / excessive sweating?
☐	☐	weakness or fatigue?
☐	☐	Other? _____

Yes	No	Head / Ear / Nose / Throat:
☐	☐	headaches?
☐	☐	hearing problems?
☐	☐	ear infections or pain?
☐	☐	bleeding gums or nose?
☐	☐	teeth problems / dentures?
☐	☐	Other? _____

Yes	No	Respiratory / Breathing:
☐	☐	cough / frequent colds?
☐	☐	wheezing or asthma?
☐	☐	Other? _____

Yes	No	Neurological / Developmental:
☐	☐	behavioral problems?
☐	☐	seizures?
☐	☐	developmental delay?
☐	☐	speech or reading difficulties?
☐	☐	Other? _____

Yes	No	Gastrointestinal:
☐	☐	frequent nausea / vomiting?
☐	☐	diarrhea / constipation?
☐	☐	abdominal pain?
☐	☐	bloody bowel movements?
☐	☐	Other? _____

Yes	No	Genital / Urinary:
☐	☐	pain with urination?
☐	☐	frequent urination?
☐	☐	blood in urine?
☐	☐	urinary infection?
☐	☐	Other? _____

Yes	No	Musculoskeletal:
☐	☐	muscle or joint pains?
☐	☐	abnormal walking / gait?
☐	☐	curved spine or neck?
☐	☐	swollen glands?
☐	☐	broken bones?
☐	☐	Other? _____

Yes	No	Skin:
☐	☐	rash or hives?
☐	☐	easy bruising?
☐	☐	Other? _____

Yes	No	Cardiovascular:
☐	☐	shortness of breath?
☐	☐	irregular or fast heartbeats?
☐	☐	fainting?
☐	☐	episodes of turning blue?
☐	☐	Other? _____

List any allergies or reactions to medications: _____
List all medications patient is now taking (including eye medications):_____

Parents:

Yes	No	
☐	☐	**Does your child receive routine pediatric care.**
☐	☐	**Are immunizations (shots) up to date?**
☐	☐	**During the last 30 days, has your child been exposed to any contagious disease (such as measles, chicken pox, etc.)? If yes, please list:** _____

Name of person filling out form: _____
Relationship to patient:_____ Date: _____

Reviewed:
_____

HESS PEDIATRIC OPHTHALMOLOGY SPECIALIST

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Hess Pediatric Ophthalmology Specialist, we are required to keep your health information secure and confidential by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, your file may be reviewed by a specialist doctor who we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, PATTY STEVENSON, at (727) 767-4393 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment I have received a copy of the Hess Pediatric Ophthalmology Specialist Notice of Privacy Practices. Date _____

Signed _____ Name Printed _____

HESS PEDIATRIC OPHTHALMOLOGY SPECIALISTS

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS
DIPLOMATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY

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10080 Balaye Run Dr, Tampa, FL 33619

I, _____, agree that the staff at Hess Pediatric Ophthalmology Specialists has informed me that I may be responsible for the charges of today's visit. I have agreed to pay the cost in its entirety.

Patient's name: _____

Date of Birth: _____

Reason for financial responsibility:

- If patient does not obtain authorization for today's visit.
- Not contracted with patient's insurance.
- Visit goes towards deductible
- Insurance denies for non-coverage.
- Non-covered durable medical goods; i.e.: aphakic lenses
- Other: _____

Signature: _____

Name Printed:_____

Date:_____