KOZLOVSKY, DELAY & WINTER EYE CONSULTANTS
An Alliance of Professional Associations

Patient Information

Patient

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SSN: _____ DOB: _____Marital Status: ( ) Single ( ) Married ( ) Other

Gender: ( ) Male ( ) Female Home#:_____Cell#:_____

Employment: _____Work#:_____E-Mail: _____

Emergency Contact:

Name: _____ Phone #:_____ Relationship: _____

If patient is a child or adolescent, please provide the following information:

Parent/Legal Guardian: _____ Relationship: _____

Cell#:_____ Work#:_____ DOB: _____

Other Information: (You may decline to provide this information)

Race: _____ Ethnicity: _____ Language: _____

Referring Physician Information:

Physician Name: _____ Ph#: _____ Fax: _____

Insurance Information Place of Employment: _____

Insured Party: ( ) Self ( ) Spouse ( ) Mother ( ) Father ( ) Other _____

Primary Insurance: _____ Policy#_____

*Policy Holder: _____ DOB if different from insured_____

Secondary Insurance: _____ Policy#_____

*Policy Holder: _____ DOB if different from insured_____

Vision Plan Insurance: _____ Policy#_____

*Policy Holder: _____ DOB if different from insured _____

****ALL AMOUNTS DUE THAT ARE NOT COVERED BY INSURANCE WILL BE COLLECTED AT TIME OF VISIT****

Patient Initials: _____ **Date:**_____

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Patient Medical History

IF INFORMATION DOES NOT APPLY TO YOU, PLEASE FILL IN BLANK AS N/A.

Patient Name: _____ **DOB:**_____

Name of Previous Eye Doctor: _____ **Phone#:**_____

Primary Care Physician: _____ **Phone#:** _____

RX Insurance: _____**Policy Number:**_____**RX Grp:**_____ **RX Bin:**_____

Do you have any of the following?

_____Dry Eyes _____Eye Surgeries _____Wear Glasses
_____Blurred Vision _____Eye Injuries _____Wear Contacts

Do you have problems with any of these systems?

_____Gastrointestinal _____Nervous System _____Mental
_____Ear/Nose/Throat _____Genitourinary _____Cardiovascular
_____Allergic/Immunologic _____Respiratory _____High Cholesterol
_____Blood /Lymph _____Musculoskeletal _____Headaches
_____Skin _____Diabetes/Endocrine How Long?_____
_____Blood Pressure How Long? _____

Family History (Immediate Only)

_____Diabetes _____High Blood Pressure _____Cataracts
_____Glaucoma _____Macular Degeneration _____Retinal Detachment

Please list any major surgery you have had:

_____

Any drug allergies? Please List: _____

Preferred Pharmacy & Location: _____

Do you smoke? ___ **How much?**_____ **Do you drink?**___ **How much?**_____

Interested in contact lenses? Yes or No
Please list medications:

_____

Initials:_____ **Date:**_____

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Financial & Authorization of Treatment

Thank you for choosing KDW Eye Consultants as your health care provider. The following information is provided for your benefit so that we may serve you better. We ask that all patients read and sign policy form.

Payments: I understand that I am responsible for payment of any services rendered to me or my dependents provided by this office. Appointments may be rescheduled for non-payment of co-pays and/or previous balances.

Returned Checks: Returned checks will be subject to collection charges.($30 fee)

Insurance: Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. I acknowledge that the insurance cards provided are current and accurate. If there are changes, I will advise your office at the time I schedule my appointment.

Non-Covered Services: I understand that some services may not be covered by my insurance plan and I am financially responsible for all non-covered services.

Cancellation of Appointment: If you need to cancel or reschedule your appointment, please give us at least 24 hours' notice. Failure to notify us in due time will result in a no-show or late cancellation fee of $40 dollars. EFFECTIVE 01/01/2025 SAME DAY CANCELLATION/NO SHOW FEE WILL GO UP TO $50 DOLLARS.

Refractions: Refraction is the process of determining if there is a need for corrective eyeglasses or contact lens. It is an essential part of the eye exam and necessary to receive a prescription for glasses or contact lens. A prescription is not the only purpose for a refraction, it is medically important for your eye doctor to know if any changes in your vision are occurring, fee is $50 for this service if not covered by medical insurance.

Dilation: Dilation drops are used to enlarge the pupils of the eye to allow the doctor to get a better view of inside the eye. This frequently blurs the vision for a length of time and can make bright lights bothersome. It is not possible to determine how long your vision will be affected. It is best to make arrangements not to drive yourself. Adverse reaction such as acute angle glaucoma may be triggered from the drops. It is extremely rare and treatable with immediate medical attention.

Referrals: If your insurance requires authorization from your Primary Care Physician, we will request this ahead of time. This is done as a courtesy for you (patient), however, we cannot guarantee authorization will be granted by the date of service. We will check status as your appointment gets near to make sure we have received, not receiving authorization by date of service may result in rescheduling or patient paying in full.

Effective January of 2020, due to limited space in our exam rooms and to ensure health of others a patient who is a minor is allowed one parent in the exam room. If two patients who are minors that have appointments, there will need to be two adults present(one parent each). Adult patients who have a medical condition that requires assistance may be allowed one person.

Signing below is an agreement to the above policies and agree to terms regarding payment responsibilities. I authorize for KDW Eye Consultants and staff to use and disclose my protected health information for purposes of examination and/ or treatment, payment, billing and business operations.

Initials:_____ **Date**:_____

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Record Release to Family Members

Parent of patient(IF A MINOR) or Patient's Name I,_____, do hereby authorize KDW Eye Consultants and their staff to release any and all information regarding my records from this office to the following family members:

Name:	Relationship:	Date of Birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Only the family members listed above shall have access to my medical information. No others shall be allowed unless I, the patient of Dr. John F. Kozlovsky, Dr. Richard L. Delay, Dr. Bruce Winter or Dr. Jeannine E. Camacho add their names to the list above.

_____ _____
Parent of/Patient's Signature Date

KDW EYE CONSULTANTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a notice of KDW Eye Consultants notice of Privacy Practices. **(PLEASE ASK RECEPTIONIST IF YOU WOULD LIKE A COPY OF OUR NOTICE OF PRIVACY PRACTICES FORM.)**

This notice describes how KDW Eye Consultants may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

Initials: _____