Monroe Benaim, MD

Thank you for choosing our office: Date: _____

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

☐ American Indian/Alaskan Native ☐ Asian ☐ Hispanic/Latino ☐ African American/Black

☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White ☐ Other: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss Date of Birth: _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Business Phone Number: _____ E-Mail: _____

Social Security Number: _____ Occupation: _____

Name of Employer: _____ Work Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

How did you hear about us?

☐ Google ☐ Previous Patient (has not been seen in 3 years)
☐ Insurance Provider ☐ Social Media
☐ Kravis/Maltz ☐ Walk-In
☐ Newspaper/Print ☐ WebMD/Healthgrades/Vitals

☐ Doctor: _____ ☐ Friend/Relative: _____

☐ Website: _____ ☐ Other: _____

Insurance Information:

Primary Insurance Plan Name (Or Medicare Number): _____

Policy Holder Name: _____ Policy Holder DOB: _____

ID Number: _____ Group Number: _____

Secondary/Supplement Insurance Plan Name: _____

Policy Holder Name: _____ Policy Holder DOB: _____

ID Number: _____ Group Number: _____

Medical Information:

When was your last eye examination? _____ 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? _____

Monroe Benaim, MD

Patient Name: _____ Date: _____

Please list **ALL** medications or vitamins that you are currently taking:

Please list **ALL** eye drops/eye medications you are currently taking:

Are you allergic to any medications? If yes, what?

Please list **ALL** previous eye/general surgeries:

Please list any general health problems in your immediate family:

Please CHECK Yes or No to all that apply below:

History of Tobacco: ☐ Yes ☐ No **History of Alcohol:** ☐ Yes ☐ No **History of Drugs:** ☐ Yes ☐ No

Cancer	☐ Yes	☐ No	**Skin Rash/Hives**	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	**Arthritis**	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	**Gout**	☐ Yes	☐ No
Human Immunodeficiency Virus (HIV)	☐ Yes	☐ No	**Artificial Joint**	☐ Yes	☐ No
Acquired Immune Deficiency Syndrome (AIDS)	☐ Yes	☐ No	**Fever Blisters**	☐ Yes	☐ No
Post-Traumatic Stress Disorder (PTSD)	☐ Yes	☐ No	**Stomach Ulcers**	☐ Yes	☐ No
Amyotrophic lateral sclerosis (ALS)	☐ Yes	☐ No	**Hepatitis**	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No	**Cirrhosis**	☐ Yes	☐ No
Parkinson's Disease	☐ Yes	☐ No	**High Cholesterol**	☐ Yes	☐ No
Multiple Sclerosis (MS)	☐ Yes	☐ No	**High Blood Pressure**	☐ Yes	☐ No
Other - Medical Conditions of the same kind or class as or comparable to those above	☐ Yes	☐ No	**Organ Transplant**	☐ Yes	☐ No
			Chest Pains	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No	**Pace Maker**	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	**Cardiovascular Disease**	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No	**Heart Surgery**	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	**Hemophilia**	☐ Yes	☐ No
Psychiatric Treatment	☐ Yes	☐ No	**Leukemia**	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	**Emphysema**	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No	**Sinus Problems**	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	**Asthma**	☐ Yes	☐ No
Bladder Problems	☐ Yes	☐ No	**Tuberculosis**	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No	**Fuchs Dystrophy**	☐ Yes	☐ No
Brain Injury	☐ Yes	☐ No	**Migraines**	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No	**Pregnant**	☐ Yes	☐ No

Preferred Pharmacy: _____ Phone Number: _____

Patient Signature: _____ Date: _____

1015 West Indiantown Road, Suite A201, Jupiter, Florida 33458
Phone: (561) 747-7777 Fax: (561) 575-1921
www.BenaimEye.com

BENAIM EYE

Monroe Benaim, MD

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I understand that as part of my healthcare, **BENAIM EYE, LLC**, originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, 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.

1. I authorize **BENAIM EYE, LLC** to use and disclose the protected health information described below to

_____

PRINTED NAME OF AUTHORIZED REPRESENTATIVE AND HIS/HER RELATIONSHIP TO PATIENT

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

3. Extent of Authorization
   - ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

     ****OR****

   - ☐ I authorize the release of my complete health record with the exception of the following information:
     - ☐ Mental Health Records
     - ☐ Communicable Diseases (including HIV and AIDS)
     - ☐ Alcohol/drug abuse treatment
     - ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purpose as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I may revoke this authorization in writing at any time by sending a written request to **BENAIM EYE, LLC**, at **1015 West Indiantown Road, Suite A201, Jupiter, FL 33458**. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient's Signature/Authorized Representative: _____ Date: _____

Monroe Benaim, MD

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

Patient Name: _____ DOB: _____

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 service. 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-insurances, 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. A photocopy of this authorization shall be considered as effective and as valid as the original. If my account is sent to collection or an attorney for non-payment, I agree to pay collection expenses and attorney fees. Most insurance 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/
Authorized Representative: _____ Date: _____

If signed by the Patient's Authorized Representative, please print the name and relationship to patient below.

_____

BENAIM EYE

Monroe Benaim, MD

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received. Please note: a copy fee may be charged for Medical Records.

Patient Name: _____ DOB: _____

Please **OBTAIN** information **FROM** the following:

Name of Physician: _____

Name of Clinic/Hospital: _____

Street Address: _____

City, State, Zip Code: _____

Fax Number: _____

Please **SEND** my medical information **TO** the following:

Name of Physician/Self: _____

Name of Clinic/Hospital: _____

Street Address: _____

City, State, Zip Code: _____

Fax Number: _____

By **checking** the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone or fax:

☐ Medical Records Needed for Continuity of Care ☐ Diagnostic Imaging Reports ☐ Pathology Reports ☐ Laboratory Reports ☐ Other: _____

Patient's Signature/
Authorized Representative: _____ Date: _____

If signed by the Patient's Authorized Representative, please print the name and relationship to patient below.

_____

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Monroe Benaim, MD

Patient Name: **Date of Birth:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare does not pay for the items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Items or Services:	Reason Medicare May Not Pay:	Estimated Cost:

WHAT YOU NEED TO DO NOW:
Read this notice, so you can make an informed decision about your care.

Ask us any questions you may have after you finish reading.

Choose an option below about whether to receive the items or services listed above.
*Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

[ ] **OPTION 1**. I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

[ ] **OPTION 2**. I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and I cannot appeal if Medicare is not billed.

[ ] **OPTION 3**. I do not want the items or services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: **Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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Monroe Benaim, MD

PATIENT VISION AND LIFESTYLE QUESTIONNAIRE

Thank you for selecting our practice for your vision exam and treatment, we want to help you maintain excellent vision as an important step in understanding how you use your eyes on a daily basis. We ask you to answer the brief questions below. Please **check** all that apply in how you use your eyes, we will be reviewing this during your visit.

Patient Name: _____

Date: _____ DOB: _____

If employed, what is your occupation? _____

Do you mind wearing glasses? ☐ Yes ☐ No

Do you have difficulty with any of the following activities?

☐ Reading, sewing, or other near activities?
☐ Working on the computer
☐ Seeing/reading road signs at a proper distance
☐ Reading shopping labels
☐ Recognizing faces or seeing the clock across the room
Other: _____

Have you experienced any of the following?

☐ Halos, glare, or difficulty seeing at night
☐ Difficulty with color perception
☐ Difficulty with depth perception
☐ Overall decrease in vision

What activities do you enjoy or do frequently?

☐ Reading ☐ Computer ☐ Watching TV ☐ Other: _____
☐ Playing Cards ☐ Cooking ☐ Watching/playing sports

List your 3 favorite hobbies/work activities	**Length of time spent each day on this activity**
1.	1.
2.	2.
3.	3.

Where do you hold your reading material? ☐ Arm's Length ☐ Half Arm's Length ☐ 8 – 10 Inches

What kind of light do you use when reading? ☐ Dim ☐ Bright Overhead Light ☐ Lamp off to the side

Patient Initials_____

BENAIM EYE

Monroe Benaim, MD

REFRACTION

Patient Name: _____ Date: _____

WHAT IS THE REFRACTION TEST?

The Refraction Test, also termed vision test, is an examination that measures an individual's ability to see an object at a specific distance. The test involves looking through a device called a "phoropter" to read letters or recognize symbols on a wall chart through lenses of different strengths which are contained in the device. (During this process, the Doctor/Technician will ask you "Which is better? One or Two?") This test is performed diagnostically as part of a normal, medical vision examination. It is also used to determine the prescription for eyeglasses or contact lenses. Our office charge will be a $50.00 fee for refractions, expected at the time of your exam.

☐ I will pay the $50.00 refraction fee if a refraction is needed, and a glasses prescription is given.

☐ I opt out of refraction and understand that no glasses prescription will be given, and no $50.00 fee charged.

According to the Medicare Handbook, Chapter 16, Section 90 –

Routine Service and Appliances: Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

Patient Signature: _____ Date: _____

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