VISION CARE & SURGERY ASSOCIATES

777 E 25th St Suite 412-414 • Hialeah, FL 33013
PH: 305-835-7588 FAX: 305-835-6372

Patient Last Name: _____First Name: _____Ml: _____

SS# (required for insurance billing purposes): _____DOB: _____Sex: _____

Address: _____

City: _____ State: _____Zip Code: _____

Cell Phone #: _____Home Phone #: _____Work Phone #: _____

Email: _____ Emergency Contact Person: _____

Phone Number: _____Relationship to patient: _____

Primary Physician: _____Phone Number: _____

Whom may we thank for referring you? _____

Date of last eye exam: _____Do you wear glasses? **Yes** ☐or **No** ☐ Contact lens? **Yes** ☐or **No** ☐

What is the reason for your visit today? _____

_____

Past eye/ocular history: _____

Past surgical history: _____

Allergies to Medications: _____

Pharmacy: _____Phone # or Zip Code: _____

Please list all current medications taken: _____

_____

_____ _____

PLEASE SIGN patient/parent or guardian DATE

VISION CARE & SURGERY ASSOCIATES

Diplomates of the American Board of Ophthalmology
Diseases and Surgery of the Eye

Orlando A. Galindez, MD
Michelle Levin, OD
Jacquelyn M. Lopez, OD
Wendy Sosa Guzman, OD

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES & AUTHORIZATION OF MEDICAL RECORDS RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO VISION CARE AND SURGERY ASSOCIATES, INC., ORLANDO A. GALINDEZ, M.D. P.A., MICHELLE LEVIN, O.D., JACQUELYN LOPEZ, O.D. OR WENDY SOSA GUZMAN O.D. BENEFITS DUE TO ME FROM MY INSURANCE COMPANY OTHERWISE PAYABLE TO ME. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER(S). A COPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICARE CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION. I HAVE READ AND UNDERSTAND THE ABOVE.

I ALSO AUTHORIZE VISION CARE & SURGERY ASSOCIATES, INC., TO REQUEST AND OR OBTAIN MEDICAL NOTES AND OR MEDICAL HISTORY FOR THE PURPOSE OF TREATMENT OR CARE. I ALSO AUTHORIZE THAT MY MEDICAL NOTES BE SENT TO MY PROVIDERS SUCH AS PRIMARY CARE PHYSICIANS AND OR ANY ENTITY THAT I HAVE GIVEN CONSENT TO.

By my signature below, I acknowledge that I have received Vision Care and Surgery Associates, Inc. Notice of Privacy Practices and have read and understand the notice above.

Name

Signature

Date

VISION CARE & SURGERY ASSOCIATES

TCPA CONSENT

I agree to receive recurring telephone calls and/or SMS or MMS text messages for appointment reminders and or marketing purposes at the phone number provided, including but not limited to calls or texts sent using an automatic telephone dialing system or an artificial or prerecorded voice. I am authorized to consent to receive text messages sent to the phone number provided. I understand that I may revoke my consent at any time. I understand that consent is not a condition of purchase. Message and data rates may apply. View our Terms of Service for details.

Include Telephone numbers that are permitted to receive the phone calls and or text messages below. This may include cell phone, home phone, secondary contact and or emergency contact.

Phone Number 1: _____

Phone Number 2: _____

Phone Number 3: _____

Phone Number 4: _____

With my signature below I am consenting to receiving such calls and or text messages.

Patient Name: _____ Date: _____

Legal Guardian Name (If Applicable): _____

Patient or Gaurdian Signature: _____

VISION CARE & SURGERY ASSOCIATES

Agreement for Financial Responsibility

I, _____, hereby agree to be financially responsible for any costs associated with the services provided by Vision Care & Surgery Associates.

I understand that:

1. Insurance Coverage: While my insurance may cover some or all of the services, there is no guarantee of full coverage. If my insurance provider denies coverage for any reason, I agree to pay the full amount for the services rendered.

2. Copays and Deductibles: I am responsible for any copayments, deductibles, or coinsurance amounts required by my insurance policy. I agree to pay these amounts in accordance with the providers' payment policies.

3. Non-Covered Services: If any service or procedure is deemed non-covered or out-of-network by my insurance provider, I acknowledge that I am responsible for full payment.

4. Timely Payment: I agree to make payments promptly and understand that failure to do so may result in additional fees, interest, or collection actions as permitted by law.

By signing below, I acknowledge that I have read and understand this agreement, and I accept full financial responsibility as stated.

Patient Name/Legal Guardian: _____

Signature: _____

Date: _____