COHEN LASER AND VISION CENTER

Name: _____

What is your reason for coming into our office today? (Ex: pain, redness, blurred vision)

_____

When did you first notice this problem? _____

Have you ever been examined or treated for this problem? If so, when? _____

Date of last eye exam? _____

Please circle all that apply to you:

Eye injury or trauma	Diabetes	Chest pains	Chronic cough
Eye surgery	High blood pressure	Shortness of breath	Migraines
Glaucoma	Heart Disease	Heart surgery	Arthritis
Cataracts	Irregular heartbeat	Dizziness	Kidney problems
Eye infections	Seizures	Skin disease	Liver disease
Retina detachment	Multiple sclerosis	Easy bleeding	Thyroid disease
Color blindness	Stroke	Asthma	Tuberculosis
Macular degeneration	Pacemaker	Emphysema/bronchitis	Cancer, type_____

Smoke ☐ Yes ☐No *If so*, for how long? _____

Drink alcohol on a regular basis ☐ Yes ☐No _____

Any previous eye surgery? *If so*, what kind? _____

Other surgery? _____

Do any diseases run in your family? *If so*, please list: _____

List all medications please include strength/dosages _____

_____

_____

Please list eye medications: _____

_____

Please list all drug allergies: _____

Name/Address and phone number of last eye doctor: _____

_____

NAME: LAST_____ FIRST_____ MI_____

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE (H) _____ (W) _____ (C)_____

EMAIL ADDRESS _____

RACE_____ETHNICITY_____LANGUAGE_____

DATE OF BIRTH_____ AGE_____ SEX M___F___ MARITAL STATUS_____

EMPLOYER _____ ADDRESS_____

OCCUPATION_____ EMERGENCY CONTACT _____

RELATIONSHIP OF EMERGENCY CONTACT _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ SUBSCRIBER _____ DOB _____

INSURANCE ID NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE _____ SUBSCRIBER _____ DOB _____

INSURANCE ID NUMBER _____ GROUP NUMBER _____

_____

PRIMARY CARE PHYSICIAN _____ TELEPHONE NUMBER _____

ADDRESS _____

PHARMACY _____ PHONE _____

REFERRED BY: _____ INTERNET _____ OPTOMETRIST _____ PHYSICIAN _____ OTHER _____

*OTHER SOURCE _____

Signature of Patient or Authorized Individual: I authorize release of medical or other information necessary to process all government, commercial, and worker's compensation insurance claims. I authorize the payment of medical benefits to the attending physician or supplier for services rendered. I understand that I am financially responsible for all charges not paid by my insurance and/or Worker's compensation carrier.

Signature: _____ Date: _____

CLVC
COHEN LASER AND VISION CENTER

TO INSURE THE PRIVACY OF OUR PATIENTS PLEASE COMPLETE THE FOLLOWING:

_____
Print Name

1. CLVC may leave any messages on my answering machine in the event that I am not home.
2. CLVC (Dr. Cohen) may discuss my medical history with the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____
Patient Signature

_____
Date

3020 N. Military Trail • Suite 150 • Boca Raton, Florida 33431

INTRODUCTION TO PATIENT-PHYSICIAN AGREEMENT

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country—claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU

We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

We demonstrate this commitment to you with our signature on this form.

WHAT WE ARE ASKING YOU TO DO

We are asking you or any representative to commit to this process also, by using only board-certified physicians expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action.

We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

Patient Copy - For Your Records

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____. ***(insert name of patient or guardian)***

"Physician" shall be understood to mean __G. Richard Cohen MD and Cohen Laser and Vison Center.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the __AMERCIAN ACADEMY OF OPHTHALMOLOGY

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the _AMERICAN ACADEMY OF OPHTHALMOLOGY_ and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
Physician	Patient/Guardian
_____	_____
Effective from Date of Treatment:	Date of Signature

Notice of Privacy Practices

Effective: 01/01/2018

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court OrderNecessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it

will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.
With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.
Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit.
While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

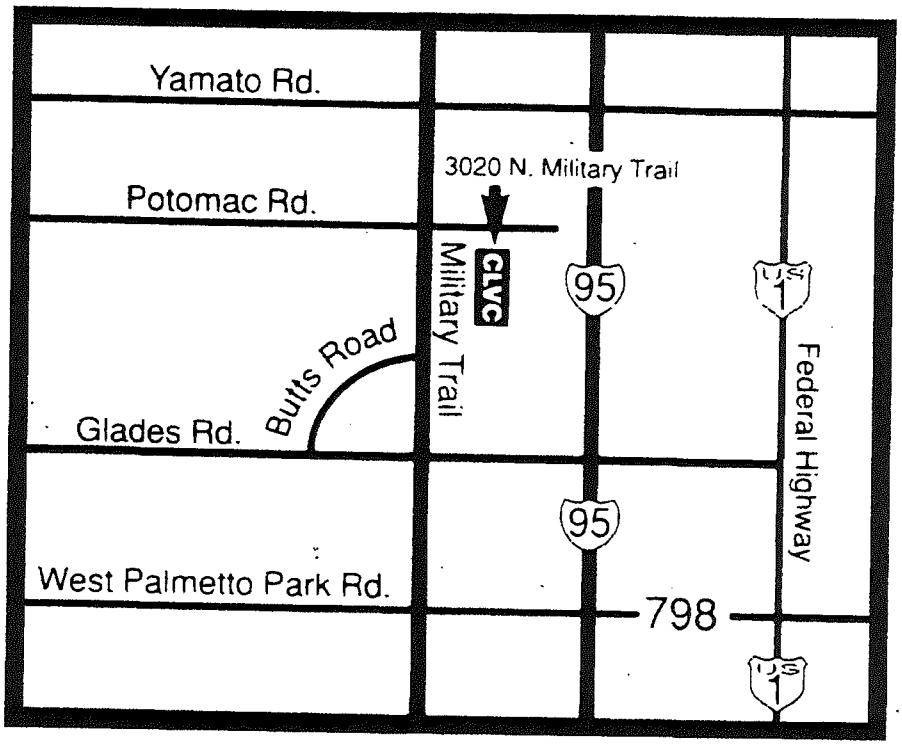
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Cohen Laser and Vision Center.* If you have questions and would like additional information, you may contact us at 561-981-8400.

SIGNATURE:_____ PRINT NAME:_____
DATE:_____

Directions From the South:
1-95 North to West Palmetto Park Road. Travel west to Military Trail, make right. Travel north, CLVC is on the right, (east side).

Directions From Glades Road:
Turn onto Butts Road. Follow all the way around to Military Trail. Make a left. Go north on Military Trail. CLVC will be on the right hand side of the street.

Directions From the North:
1-95 South to Yamato Road west to Military Trail, make left, Travel south, one mile and just past Potomac Road, CLVC will be on the left, (east side).



CLVC
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G. Richard Cohen, M.D.
3020 N. Military Trail
Suite 150
Boca Raton, Florida 33431

Toll Free 1-877-WOW-I-SEE