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On behalf of the doctors at Aker Kasten Eye Center we would like to welcome you as a new patient, and thank you for choosing us for your eye care needs. We have enclosed an information packet regarding our Center and the services we provide for you to review at your leisure. If you have any questions, please do not hesitate to call us.

We request that you please bring the following items with you to your first appointment:

1. The **NEW PATIENT FORM**.
2. Your **INSURANCE CARDS** and a **PHOTO ID CARD**.
3. A **LIST OF MEDICATIONS AND DAILY DOSAGE** you are currently taking.

**If you are considering cataract surgery, we will be unable to perform necessary testing unless you discontinue wearing your contact lenses according to the following time parameters:**

**Gas permeable lenses – 2 weeks**  
**Hard lenses – 2 weeks**  
**Soft contact lenses – 1 week**

Our office accepts Medicare assignment. The 20% co-payment will be collected at the time of your office visit. If you participate in MediGap, your supplementary insurance will automatically be submitted for you by your insurance company.

Again, we welcome you as a new patient and look forward to meeting you!



# PATIENT INFORMATION

PLEASE PRINT AND FILL OUT COMPLETELY

Date \_\_\_\_\_ Mr. Mrs. Ms. Rev. Dr. of: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_ Spouse: \_\_\_\_\_

Local Street Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Development \_\_\_\_\_ Is this a Nursing Home? Yes No

Patient's Email Address: \_\_\_\_\_ In Florida from: \_\_\_\_\_ to \_\_\_\_\_

Phone H ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_

**Contact person for messages (family or friend)**

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

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**Out of Area Address:**

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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PHARMACY \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**How were you referred to this office (please check all that apply)?**

<input type="checkbox"/> Your eye doctor	<input type="checkbox"/> Screening Van	<input type="checkbox"/> Internet/Website
<input type="checkbox"/> Your Primary care doctor	<input type="checkbox"/> Radio Advertisement	<input type="checkbox"/> Caridad Clinic
<input type="checkbox"/> Friend/Reputation	<input type="checkbox"/> Magazine Advertisement	<input type="checkbox"/> Other _____

Primary Care Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Name of Eye Doctor: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Patient's Rights of Disclosures:** In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

**List all persons** in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical records.

\_\_\_\_\_

\_\_\_\_\_

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

Yes No

- Hypertension # of years \_\_\_\_\_
- Liver
- Pulmonary Disease
- Cardiac Disease / Chest Pain
- Cholesterol
- Thyroid Disease

Yes No

- Cancer type: \_\_\_\_\_
- Stroke / TIA
- Kidney
- Diabetes Last blood sugar \_\_\_\_\_ # of years \_\_\_\_
- Arthritis
- Other: \_\_\_\_\_

## Medications / Dosage / How Often:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you **ever** taken Flomax?  Yes  No

## Drug Allergies and Reactions:

_____	_____	_____
_____	_____	_____

## Your Eye History: (Have you been diagnosed with any of the following conditions in the past?)

Yes No

- Cataracts \_\_\_\_\_
- Retinal Disease \_\_\_\_\_
- Glaucoma \_\_\_\_\_

Yes No

- Eye Injury \_\_\_\_\_
- Any Other Eye Disorders: \_\_\_\_\_

**Cataract Surgery date** Right \_\_\_\_\_ Left \_\_\_\_\_

**Yag Laser date** Right \_\_\_\_\_ Left \_\_\_\_\_

**Retinal Surgery date** Right \_\_\_\_\_ Left \_\_\_\_\_

**LASIK Surgery date** Right \_\_\_\_\_ Left \_\_\_\_\_

## Surgical History and Hospitalizations within the last year:

Type of surgery / reason for admission	Surgery/admission date	Type of surgery / reason for admission	Surgery/admission date
_____	_____	_____	_____
_____	_____	_____	_____

## Family History

(Mother, Father, Grandparent, Sibling)

<p>Has any member of your family had these diseases (circle all that apply)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis</p> <p>Other heritable disease: _____</p>
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## Social History

<p>Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, how much? _____</p> <p>If yes, how much? _____</p>	<p>How many years? _____</p>
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## Insurance Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_

If the primary insurance is in the name of someone other than the patient, we need the following:

Name of Insured: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_

If the secondary insurance is in the name of someone other than the patient, we need the following:

Name of Insured: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

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## Patient Authorization

**Insurance Lifetime Authorization:** I request that payment of my insurance benefits be made to the physicians of Aker Kasten Eye Center. I authorize medical information be released to the insurance company to determine these benefits for services.

**Fee Consent:** I assume full responsibility for all charges at Aker Kasten Eye Center.

Patient's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE HAVE YOUR INSURANCE CARD READY FOR US TO MAKE A COPY.

Fax #: 561-338-7785



1445 NW Boca Raton Boulevard, Boca Raton, FL 33432  
Phone:(561) 338-7722 Fax: (561) 338-7785

I, \_\_\_\_\_, as a patient of Alan B. Aker MD, may be scheduled for  
(Patient Name)  
a procedure at the Aker Kasten Eye Center. Under current Florida law and in compliance with Medicare regulations, the Center may not provide services to a patient unless the patient signs a written notice acknowledging the disclosure of certain matters.

**1. Advance Medical Directives**

I understand that my Advance Directives will not be honored at the Aker Kasten Eye Center. If you suffer a life threatening situation you will be transferred to a higher level of care. Upon request additional information regarding Advance Directives will be provided to me.

\* YES  NO Do you have a living will?

\* YES  NO Would you like to have a living will?

\* If you have a Living Will or Advance Directive, or plan to have one in the future, it is your responsibility to provide this office with a copy.

\*For information concerning these documents please contact [www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov) or call (888) 419-3456

**2. Patient Bill of Rights and Responsibilities**

I have received the Aker Kasten Eye Center Summary of the Florida Patient Bill of Rights and Responsibilities.

**3. Disclosure of Ownership Interest**

I understand that Alan B. Aker, MD and Ann G. Kasten, MD are co-owners of Aker Kasten Eye Center. The physician performing your procedure has a financial and ownership interest in the Aker Kasten Eye Center. You have the right to choose where to receive services, whether it be an alternative site or one in which your physician may have a financial interest.

By my signature below, I (or my legal representative), acknowledge that this information above was received (verbally and in writing) in advance of the date of admission to the Aker Kasten Eye Center. I have read and fully understand the information presented.

X \_\_\_\_\_  
Signature of patient (or Representative)

\_\_\_\_\_  
Date



## **Summary of the Florida Patient's Bill of Rights and Responsibilities**

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility.

### **Summary of Patient Rights**

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

## **Summary of Patient Responsibilities**

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, existence of advance directives and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

## **Filing Complaints**

If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at:

1-888-419-3456 (Press # 1) or write to the address listed below:

AGENCY FOR HEALTH CARE ADMINISTRATION CONSUMER  
ASSISTANCE UNIT DOH/MQA/CSU  
4052 BALD CYPRESS WAY, BIN C-75  
TALLAHASSEE, FL 32399-3275

If you have a complaint against a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1-888-419-3456 (Press # 2) or write to the address below:

AGENCY FOR HEALTH CARE ADMINISTRATION  
INVESTIGATIVE SERVICES UNIT DOH/MQA-ISU  
4052 BALD CYPRESS WAY, BIN C-70  
TALLAHASSEE, FL 32399-3270

Site for address and phone number of Medicare Beneficiary Ombudsman:

[www.medicare.gov/Ombudsman/resources.asp](http://www.medicare.gov/Ombudsman/resources.asp)

This Center regards the doctor-patient relationship to be sacred requiring trust, mutual respect and confidentiality. To that end, if you have any comment, grievance or complaint regarding the care you received by this facility or a physician or employee of this facility, please voice your concern by letter or telephone call to:

THE AKER KASTEN EYE CENTER  
C/O FACILITY ADMINISTRATOR  
1445 NW BOCA RATON BOULEVARD  
BOCA RATON, FL 33432  
(561) 338-7722

This center will not discriminate or use any concern or reprisal against you for taking action to solve a problem or voice a concern.