KONOWAL
VISION CENTER

where the focus is on you.

Alexandra Konowal, D.O.
Board Certified Eye Surgeon
9500 Corkscrew Palm Circle, Suite 3
Estero, FL 33928
Tel. 239.948.7555
Fax 239.948.8077

Name: _____
(Last) (First) (MI)

Sex: M ☐ F ☐ Date of Birth ____/____/____ Marital Status: S ☐ M ☐ W ☐

Race: _____ Language: _____ Non Hispanic/Latino: _____ Hispanic/Latino _____

Social Security #: ____-____-____

Local Address: _____

_____
City State Zip

Phone _____ Alternate _____

E-Mail _____

Northern Address: _____

_____
City State Zip

Employer: _____ Occupation: _____

Insurance Subscriber & Date of Birth*: _____
*If patient is listed as a dependent

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Preferred Pharmacy Information:

Name: _____ Phone Number: _____

Location/Intersection: _____ City: _____

Prescription insurance if any: _____

How did you hear about us? _____
(Facebook, Radio, Newspaper, Yellow Pages, Website)

KONOWAL
VISION CENTER
where the focus is on you.

Alexandra Konowal, D.O.
Board Certified Eye Surgeon
9500 Corkscrew Palm Circle, Suite 3
Estero, FL 33928
Tel. 239.948.7555
Fax 239.948.8077

MEDICAL HISTORY

Eyes

Previous Surgery	____Yes	____No
Contact Lens	____Yes	____No
Pain	____Yes	____No
Double Vision	____Yes	____No
Glaucoma	____Yes	____No
Cataracts	____Yes	____No
Macular Degeneration	____Yes	____No
Dry eyes	____Yes	____No
Flashes	____Yes	____No
Floaters	____Yes	____No

Ear, Nose, Throat

Hard of Hearing	____Yes	____No
Ringing in Ears	____Yes	____No
Vertigo	____Yes	____No

Cardiovascular

Chest Pain	____Yes	____No
Dizziness	____Yes	____No
Fainting Spells	____Yes	____No
Shortness of Breath	____Yes	____No
Irregular Heart Beat	____Yes	____No
Difficulty Lying Flat	____Yes	____No
Heart Attack	____Yes	____No
Stroke	____Yes	____No

Constitutional

Fatigue/Weakness	____Yes	____No
Fever	____Yes	____No
Weight Gain/Loss	____Yes	____No

Respiratory

Cough	____Yes	____No
Congestion	____Yes	____No
Wheezing	____Yes	____No
Asthma	____Yes	____No
COPD	____Yes	____No

Gastrointestinal

Heartburn	____Yes	____No
Nausea/Vomiting	____Yes	____No
Jaundice/Hepatitis	____Yes	____No
Ulcer	____Yes	____No

Genito-Urinary

Pain/Difficulty	____Yes	____No
Blood In Urine	____Yes	____No
History od Kidney Stones	____Yes	____No
Prostate Problems	____Yes	____No

Psychiatric

Anxiety/Depression	____Yes	____No
Mood Swings	____Yes	____No
Difficulty Sleeping	____Yes	____No

Endocrine

Increased Thirst	____Yes	____No
Increased Hunger	____Yes	____No
Increased Urination	____Yes	____No
Increased Sweating	____Yes	____No
Fingernail Changes	____Yes	____No

Blood/Lymphnode ____Yes ____No

Easy Brusing	____Yes	____No
Gum Bleed Easily	____Yes	____No
Prolonged Bleeding	____Yes	____No
Heavy Aspirin Use	____Yes	____No
Anemia	____Yes	____No

MusculoSkeletal

Stiffness	____Yes	____No
Arthritis	____Yes	____No
Joint Pain/Swelling	____Yes	____No

Skin

Rash/Sores	____Yes	____No
Lesions	____Yes	____No
Hives/Eczema	____Yes	____No
Cancer	____Yes	____No

Neurological

Seizures	____Yes	____No
Weakness/Paralysis	____Yes	____No
Numbness	____Yes	____No
Tremors	____Yes	____No
Alzheimer's	____Yes	____No
Parkinson's	____Yes	____No

Immunologic

Hives	____Yes	____No
Itching	____Yes	____No
Runny Nose	____Yes	____No
Sinus Pressure	____Yes	____No

KONOWAL
VISION CENTER
where the focus is on you.

Alexandra Konowal, D.O.
Board Certified Eye Surgeon
9500 Corkscrew Palm Circle, Suite 3
Estero, FL 33928
Tel. 239.948.7555
Fax 239.948.8077

Please list all MEDICATIONS that you are currently taking, including eye drops, vitamins, herbals:

NAME	MILLIGRAMS	FREQUENCY

Are you ALLERGIC to any medications? Y_____ N_____

If yes, please list:_____

Eye History-Please circle Y or N to indicate the items with which you have been diagnosed:

Cataracts	Y	N
Diabetic Retnopathy	Y	N
Glaucoma	Y	N
Macular Degeneration	Y	N
Retinal Disorders	Y	N
Retinal Detachment	Y	N

Past Medical History (illnesses, injuries, prior surgeries, hospitalizations)

_____
_____
_____
_____
_____

EYE SURGERY/EYE TRAUMA-Please list:

Right Eye

_____
_____
_____

Left Eye

_____
_____
_____

KONOWAL VISION CENTER
where the focus is on you.

Alexandra Konowal, D.O.
Board Certified Eye Surgeon
9500 Corkscrew Palm Circle, Suite 3
Estero, FL 33928
Tel. 239.948.7555
Fax 239.948.8077

Social History

Smoking	Y	N	If Yes:

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoked
- ☐ Unknown if ever smoked

Alcohol	Y	N	If Yes:

- ☐ On occasion
- ☐ Socially
- ☐ 1 glass of wine/day
- ☐ 2 glsases of wine/day
- ☐ >or= 3 glasses of wine/day
- ☐ 1-3 beers/day
- ☐ >3 beers/day

Family History			Relationship	Age	Living or Deceased
Diabetes	Y	N			L or D
Cancer	Y	N			L or D
Heart Disease	Y	N			L or D
Stroke	Y	N			L or D
TB	Y	N			L or D
Kidney Disease	Y	N			L or D
Blindness	Y	N			L or D
Cataracts	Y	N			L or D
Glaucoma	Y	N			L or D
Macular Degeneration	Y	N			L or D
Retina Disease	Y	N			L or D
High Blood Pressure	Y	N			L or D
Arthiritis	Y	N			L or D
Lazy Eye	Y	N			L or D
Other/Explanation:	Y	N			L or D

Primary Care Physician

Name:_____

Address:_____

_____

_____

Patient's Signature

_____

Is this a Workmans Comp Claim?

Y N

Date of Injury_____

Is this an Auto Accident Claim?

Y N

Date of accident_____

PATIENT CONSENT FORM

KONOWAL VISION CENTER

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosure, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient's Name: _____

This Consent was signed by: _____

Relationship to Patient (if other than patient): _____

Date: _____

Employee Initial: _____

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Konowal Vision Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object that that person is entitled to receive information regarding your treatment), (iv) in emergency situation, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing)

Spouse: _____ _____Yes _____No

Parent: _____ _____Yes _____No

Other: _____ _____ Yes _____No

_____ _____ Yes _____No

B. **PRINTED NAME** _____

Patient/Parent /Guardian Signature: _____

Date: _____

C. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

_____

FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

Konowal Vision Center
9500 Corkscrew Palm Circle Suite 3
Estero, Fl. 33928

OFFICE FINANCIAL POLICY

The last several years have been a time of profound change regarding health care reform. It has become necessary to implement the following policies.

PLEASE READ THOROUGHLY AND SIGN THIS SHEET

1. We will collect your deductible, co-pay, uncovered services or the percent you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in, before you are seen by the doctor. **It is the patient's responsibility to know the terms of their insurance plan.**

2. You must bring your insurance card and photo I.D. with you and any authorization information you may have. Without these, we will be unable to see you.

3. We will file your insurance if we are providers for your plan. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should.

4. If your insurance denies payment on your account you will be asked to pay by check, cash or charge. If you do not pay in a timely fashion, you will be responsible for any and all charges not paid by your insurance company in accordance with the laws. Should your account become delinquent and over 90 days old, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

5. HMO or PPO PATIENTS REQUIRING A REFERRAL: You are responsible for making sure your visits with our office are authorized by your primary care physician (PCP). This authorization must be obtained before your scheduled visit. It is the patient's responsibility to make sure we have received authorization. If you do not have the proper authorization, your appointment will be rescheduled and you may be subjected to a $50.00 charge for a missed office visit.

6. SELF-PAY PATIENTS: This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash and money orders. We will provide you with a receipt.

7. Should you need to **cancel or change your office visit appointment**, you will be subject to a **$50.00 charge** if you do not do so with **24 hours business day advanced notice**. By signing below, I agree that I am financially responsible for any charges incurred for missed appointments in which I did not give the required advanced notice.

_____ _____

Patient or Guardian Date

KONOWAL
VISION CENTER
where the focus is on you.

Alexandra Konowal, D.O.
Board Certified Eye Surgeon
9500 Corkscrew Palm Circle, Suite 3
Estero, FL 33928
Tel. 239.948.7555
Fax 239.948.8077

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's 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. A summary of your rights and responsibilities follows:

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.

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, 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 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.

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.

I have read and understand the above policy.

Patient/Guarantor Signature _____ **Date** _____

KONOWAL
VISION CENTER
where the focus is on you.

Name _____ **Date:** _____

Put a check next to the items that bother you (with your glasses or contacts if applicable):

_____ Cataracts
_____ Overal decline in vision
_____ Glare, sensitivity to light
_____ Poor night vision
_____ Seeing rings around lights
_____ Unbalanced vision
_____ Loss of depth perception
_____ Double vision in one or both eyes
_____ Floaters
_____ Seeing starbursts around lights

Do you have trouble seeing when you...

_____ Drive during daylight hours and/or evening hours
_____ Try to read traffic signs and/or try to judge distances
_____ Try to read labels, price tags, small numbers
_____ Doing close needlework or sewing
_____ Doing hobbies such as golf or tennis
_____ Doing hobbies such as puzzles, reading, bingo, or playing cards
_____ Shop for groceries
_____ Walk, stoop, change positions
_____ Use stairs
_____ Other

Do you experience any of the following problems with your eyes:

_____ Dry/gritty/burning feeling
_____ Crusting or mucus on eyes or lids
_____ Over-reacting to smoke, dust, or light
_____ Excessive tearing or watering
_____ Pain or irritation

Which activities are important to you?

_____ Reading
_____ Sewing
_____ Driving
_____ Golfing
_____ Computer work
_____ Playing cards
_____ Watching TV
_____ Other _____

KONOWAL VISION CENTER'S FREQUENTLY ASKED QUESTIONS

What is a refraction?

A refraction is a vision test that determines your best visual acuity. This diagnostic information is used to determine if you need corrective lenses or if any disease may be present that affects your ability to see clearly. **This test is a routine part of your annual comprehensive eye exam and is not covered by most Private Insurance Companies or Medicare. Konowal Vision Center charges $55.00 for this exam.**

Why do I need to be dilated?

A comprehensive eye exam includes a thorough study of your eyelids, lashes and the external surface of your eye. Dr. Konowal will examine the inside of the eye by dilating your pupils with drops. Once you are dilated the Doctor can study your retina, optic nerves and blood vessels in the back of your eye.

Why do I need a contact lens exam when I just had an eye exam?

The contact lens evaluation and fit is not a medical exam of the eye. This is a series of tests to determine the accurate measurements of a medical device (contact lenses) that requires a prescription. During your routine eye exam the Doctor will check your eyes overall health and may write you a prescription for glasses. Contacts are placed on the surface of the eye. They can affect the shape of your eye and if not fitted properly they may cause abrasions to the eyes surface. Getting contact lenses to fit properly will determine your success in wearing contacts.

Eye exams without insurance are $255.00 for Konowal Vision Center.

This does not include a Contact Lens fit, which is a separate fee. Contact lens fees vary.

LASIK CONSULTS DO NOT RECEIVE CONTACT LENS OR EYE GLASS PRESCRIPTIONS AT THE TIME OF THE CONSULTATION

KONOWAL
VISION CENTER
where the focus is on you.

Alexandra Konowal, D.O.
Board Certified Eye Surgeon
9500 Corkscrew Palm Circle, Suite 3
Estero, FL 33928
Tel. 239.948.7555
Fax 239.948.8077

Medical Records Web Portal

www.myeyecarerecords.com

- First time users click register
- Enter all your information.
- You must use Social Security number.
- Have to give social security number to office.
- Only one email address per patient.
- Not allowed to share email address with another family member.
- Enter initial password of 1234.
- Make a password you will remember.
- Submit registration.
- Message that you successfully registered.
- Returned to logon page.
- Enter user name and password
- Will be taken to page to view visits.

KONOWAL
VISION CENTER
where the focus is on you.

Alexandra Konowal, D.O.
Board Certified Eye Surgeon
9500 Corkscrew Palm Circle, Suite 3
Estero, FL 33928
Tel. 239.948.7555
Fax 239.948.8077

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Konowal Vision Center. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment/Cancellation/No Show policy below:

- Effective December 1, 2021 any new or established patient who fails to show, or cancel/reschedule an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $50.00 fee.

- The fee is charged to the patient, not the insurance company and is due at the time a statement is received by the patient. If the fee is unpaid at the time of the next office visit, the $50.00 fee will be collected upon checking in.

As a courtesy we make reminder calls for appointments. Even if you don't receive a reminder call or message the above Policy will remain in effect. We understand there may be times when unforeseen emergencies occur. If you experience extenuating circumstances please contact our office and our office manager, who may be able to waive the No Show Fee.