

Lake Mary Eye Care
1331 S. International Parkway
Suite # 1271
Lake Mary, FL 32746
Phone (407) 323-1130
Fax (407) 323-0979

HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers

Conduct normal healthcare operations, such as quality assessments and physicians certifications

I have been informed by you of your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices and have received a copy of the Patient's Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Printed Patient Name _____

Signature _____

Witness _____

Date _____

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HIPAA PATIENT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept properly confidential. This ACT gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and/or disclose your health information

We may use and/or disclose your medical records only for each of the following purposes:

- **Treatment-** We will use and disclose your Protected Health Information (PHI) to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose information to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- **Payment-** Your PHI will be used, as needed, to obtain payment for your health care services. This may include activities your health plan may take before it approves or pays for health care services such as determination of eligibility or coverage for insurance benefits. For example, obtaining approval for a hospital stay may require that your PHI be disclosed to the health plan to obtain approval.
- **Healthcare Operations-** We may use, or disclose, as needed your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review of activities, and conducting or arranging other business activities. For example, we may use a sign-in sheet at the registration desk, where you will be asked to sign your name. We may also call you by name in the waiting room. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment or to anyone who answers your phone.

You have the following rights with respect to your PHI, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction we must abide by it until you request, in writing, to remove it.
- The right to reasonable requests, to receive confidential communications of PHI from us by alternative means or at alternative locations
- The right to inspect and receive a copy of your PHI
- The right to have an amendment filed with your PHI
- The right to receive an accounting of disclosures of PHI
- The right to obtain a paper copy of this notice upon request
- The right to review the Notice of Privacy Practices and to receive a written copy

ALL RIGHTS ARE TO BE SUBMITTED TO OUR OFFICE IN WRITING

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

Complaints may be directed to Lake Mary Eye Care (in writing) at the above address or to the U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue SW, Washington D.C. 20201 1-877-696-6775 or 202-619-0257

Refraction

Refraction is a measurement performed to determine the lens correction needed to provide the best visual acuity for all viewing distances. It's done to determine if you need an eyeglasses prescription or if you need a change in your prescription.

Refraction exam includes.

Measurement of the patient's most recent eyeglass correction

Measurement of the curve of the front of the eyes

Doctor involved measurement of monocular and binocular refraction at specific working distances

Most insurance companies will not cover this procedure; a \$35 fee is due at time of service.

Circle One

I **DO** WANT A REFRACTION

I **DO NOT** WANT A REFRACTION

Signature _____ Date: _____

Contact Lens Evaluation

Contact Lens Evaluation includes:

- Fitting/refitting if necessary
- Tear film/check how dry your eyes are
- Corneal health analysis
- Visual acuity/how well you are seeing
- Insertion & removal of contact lens
- We also include a trial contact lens and solution starter kit

At Lake Mary eye care we offer a 90-day guaranteed Contact Lens success program. If you cannot adapt or need to change your contact lens, all you need to do is call the office and schedule a re-evaluation at no charge. We will also buy back any unused contact lens boxes that are unopened within 6 months of purchase.

In most cases insurance companies will not cover this service they consider contact lens **“not medically necessary”** The fee for contact lens evaluation starts at \$65 depending upon complexity. The fee to renew, update or change your contact lens prescription is determined by the Doctor. Fee is due at time of service.

Signature _____ Date _____

Lake Mary Eye Care

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

1. **RELEASE OF INFORMATION**---I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or government agency, such as Blur Cross or Medicare or any other physician you are referred by) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/ or diagnosis.
2. **PHYSICIAN INSURANCE ASSIGNMENT**---I hereby authorize payment directly to any physician examining or treating me for vision, pre or post-surgical and/or medical benefits otherwise payable to me for their services but not to exceed the reasonable and customary charge for these services
3. **MEDICARE/MEDICAID**---I certify that the information given by me is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries any information needed for a Medicare/Medicaid claim. I hereby certify all insurance payment shall be assigned to the physician treating me.
4. **I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.** This assignment will remain in effect until revoked by me in writing.
5. I am granting permission to release my eyewear prescription upon request.

FINANCIAL AGREEMENT

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.
2. Not all services are covered benefits under all contracts. All non-covered services are the financial responsibility of the patient.
3. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE COMPANY WITHIN A REASONABLE AMOUNT OF TIME, NOT TO EXCEED 60 DAYS**
4. If this account is assigned to an attorney for collection and/or suit or to a collection agency, the prevailing party shall be entitled to reasonable attorney's fees and all costs of collection.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Date _____

Signature _____

WELCOME TO OUR OFFICE

Today's Date _____

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Date of Birth _____ Age _____
Patient's SSN _____ Sex M F
Employer _____
Occupation _____

Marital Status: single married widowed divorced
Spouse's Name _____

Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
 Another Dr.: If so, by whom? _____
 Insurance List
 Saw Sign/Building
 Newspaper/Radio/TV
 Yellow Pages: Which directory? _____
 Web Page: Which Web Site? _____
 Other _____

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber ID _____
Subscriber Birth Date _____

Do you participate in a flex spending account?
 Yes No

Do you.....(check box if your answer is yes)

- ..work at a computer? How much? ____Hrs/day
- ..think you might benefit from thinner, lighter lenses?
- ..spend time outdoors? How much? ____Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..experience bothersome glare or reflection, particularly when night driving?
- ..have an east/west commute in your daily drive?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current prescription eyewear?
- ..have children?
- ..have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following?

<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Burning
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Corneal Abrasions
<input type="checkbox"/> Crossed eye/Eye turn	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Flash of light
<input type="checkbox"/> Floaters/Spots	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Grittiness	<input type="checkbox"/> Headaches
<input type="checkbox"/> Iritis/Uveitis	<input type="checkbox"/> Itchiness
<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Occasional dryness	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Sunlight Sensitivity	<input type="checkbox"/> Tearing
<input type="checkbox"/> Trouble seeing at night	
<input type="checkbox"/> Other eye disorders _____	



The information in this confidential case history form is critical to the evaluation of your vision and health.

Name of Family Physician _____
 Town _____
 Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
 (List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to medications? Yes No
 If so, what medications? _____

Have you had any surgeries? Yes No
 If so, please explain _____
 Do you use cigarettes/tobacco, alcohol, or other substances? Yes No
 Are you pregnant? Yes No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Date of Last Eye Exam _____
 By Whom? _____

Have you ever tried contact lenses? Yes No
 Do you currently wear contact lenses? Yes No
 What kind? _____
 Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? Yes No
 Have you ever had vision therapy? Yes No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
 No Yes (Please check boxes)

Relationship
 (Mother's or Father's side)

Blindness _____
 Cancer _____
 Cataracts _____
 Corneal Problems _____
 Diabetes _____
 Glaucoma _____
 Heart Disease _____
 Lazy Eye _____
 Macular Degeneration _____
 Retinal Problems _____

We may need to instill drops to examine your eyes. These drops may cause temporary light sensitivity and blurred vision.

Patient Signature _____

Our mission, at Lake Mary Eye Care, is to provide excellence in eye care while maintaining quality, value and dedication to our patients' visual needs. In addition, we will keep our doctors and staff knowledgeable through continuing education to