

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 it's 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 \_\_\_\_\_

Today's Date \_\_\_\_\_

**Patient Information**

Last \_\_\_\_\_  
First \_\_\_\_\_ MI \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Patient's SSN \_\_\_\_\_ Sex: M F  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Occupation \_\_\_\_\_ Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_  
Occupation \_\_\_\_\_ Phone \_\_\_\_\_  
Guardian's Name \_\_\_\_\_  
Occupation \_\_\_\_\_ Phone \_\_\_\_\_  
Who does the child live with? \_\_\_\_\_

Email Address \_\_\_\_\_

What is the major purpose of this visit?  
\_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_

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

**WELCOME TO OUR OFFICE**

**Insurance Information**

Vision Insurance \_\_\_\_\_  
Subscriber Name \_\_\_\_\_  
Subscriber SSN \_\_\_\_\_  
Subscriber Birth Date \_\_\_\_\_  
Primary Medical Insurance \_\_\_\_\_  
Subscriber Name \_\_\_\_\_  
Subscriber ID \_\_\_\_\_  
Subscriber Birth Date \_\_\_\_\_

**Patient Eye History**

Date of Last Eye Exam \_\_\_\_\_  
By Whom? \_\_\_\_\_

Has your child ever tried contact lenses?  Yes  No

Does your child currently wear contact lenses?  
 Yes  No

What kind? \_\_\_\_\_  
Solutions used \_\_\_\_\_

Has your child ever experienced, been diagnosed or treated for any problems with his/her eyes?  Yes  No  
If so, please explain \_\_\_\_\_

Has your child ever had any eye injury or surgery?  
 Yes  No  
If so, please explain \_\_\_\_\_

**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  \_\_\_\_\_
  - Eye turn  \_\_\_\_\_
  - Glaucoma  \_\_\_\_\_
  - Heart Disease  \_\_\_\_\_
  - Lazy Eye  \_\_\_\_\_
  - Macular Degeneration  \_\_\_\_\_
  - Retinal Problems  \_\_\_\_\_

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

Patient Medical History	
Name of Family Physician _____	
Town _____	
Date of Last Physical Check-up _____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins)	
_____	
_____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications? _____	
Has your child had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, please explain _____	
Was your child full-term? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did your child have complications after birth?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, please explain _____	
Has your child had any special testing? (hearing, speech, psychological) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child ever had any type of therapy? (speech, auditory, physical, occupational) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Has your child ever been diagnosed or treated for the following health problems?</b>	
	<b>Yes</b> <b>No</b>
Allergies	<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"/>
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"/>
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"/>

Questions for School Aged Child		
<b>Does your child experience any of the following?</b>		
	<b>Yes</b>	<b>No</b>
School performance not up to potential	<input type="checkbox"/>	<input type="checkbox"/>
Reading below grade level	<input type="checkbox"/>	<input type="checkbox"/>
Had special education testing or receives special education services	<input type="checkbox"/>	<input type="checkbox"/>
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>
Poor spelling ability	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with word recognition	<input type="checkbox"/>	<input type="checkbox"/>
Letter/word reversals when reading or writing	<input type="checkbox"/>	<input type="checkbox"/>
Transpositions of letters or numbers	<input type="checkbox"/>	<input type="checkbox"/>
Failure to complete work in allotted time	<input type="checkbox"/>	<input type="checkbox"/>
Errors in copying from blackboard to paper	<input type="checkbox"/>	<input type="checkbox"/>
Poor printing or handwriting	<input type="checkbox"/>	<input type="checkbox"/>
Mistakes words with similar beginnings or endings	<input type="checkbox"/>	<input type="checkbox"/>
Confuses similar words	<input type="checkbox"/>	<input type="checkbox"/>
Fails to recognize same word in next sentence	<input type="checkbox"/>	<input type="checkbox"/>
Uses finger to keep place when reading	<input type="checkbox"/>	<input type="checkbox"/>
Often loses place; skips or rereads words when reading	<input type="checkbox"/>	<input type="checkbox"/>
Complains of blurred vision during reading or writing, or when looking up from the desk	<input type="checkbox"/>	<input type="checkbox"/>
Complains of headaches with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Complains of print "running together" or "jumping" or "moving"	<input type="checkbox"/>	<input type="checkbox"/>
Complains of seeing double	<input type="checkbox"/>	<input type="checkbox"/>
Closes or covers one eye in bright light or during visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Experiences unusual fatigue after visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Reports eyes hurt, burn, or tire while reading	<input type="checkbox"/>	<input type="checkbox"/>
Frowns, scowls, or squints with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Tilts or turns head excessively with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>
Avoids near work (reading, writing)	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span, easily distracted, or extensive daydreaming	<input type="checkbox"/>	<input type="checkbox"/>
We may need to instill drops to examine your child's eyes. These drops may cause temporary light sensitivity and blurred vision. Please do not discuss the drops with your child prior to the examination. The doctor will instill the drops as pleasantly as possible.		
Guardian Signature _____		

