Lake Mary Eye Care – Adult Form

Today's Date _____
Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
Date of Birth _____ Age _____
Patient's SSN _____ Sex: M F
Employer _____
Occupation _____
Marital Status: single married widowed divorced
Spouse's Name _____
Spouse's Work _____
What is the main reason for today's visit?

_____

_____

Any problems with your current contact lenses or glasses?

_____
_____
_____

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

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.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory?
❑ Web Page: Which Web Site? _____
❑ Other _____

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?

Please indicate hobbies and interests:

Computers ❑ No❑ Yes Hrs per day_____
Fishing ❑ No❑ Yes Hrs per day_____
Golfing ❑ No❑ Yes Hrs per day_____
Hunting ❑ No❑ Yes Hrs per day_____
Music ❑ No❑ Yes Hrs per day_____
Reading ❑ No❑ Yes Hrs per day_____
Other _____ Hrs per day_____

Do you use any of the following:

cigarettes/tobacco ❑ No❑ Yes Frequency:_____
alcohol ❑ No❑ Yes Frequency:_____
other substances? ❑ No❑ Yes Frequency:

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

❑ No ❑ Yes (Please check boxes)

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

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 provide the highest level of service to enhance the quality of life in our community. Our doctors and staff strive to show compassion in practice with the highest ethical standards to establish a trusting relationship. This we pledge to our patients.

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

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

Are you currently experiencing any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Eye Surgery
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other eye disorders_____
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing

Patient Medical History

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: _____

Are you pregnant? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problem? If yes, please explain:

❑ Allergy _____
❑ Cardiovascular (high blood pressure, cholesterol) _____
❑ Constitutional (anemia, fatigue, fevers, weight loss/gain) _____
❑ Endocrine (Thyroid, Diabetes) _____
❑ Gastrointestinal (Liver, Colon) _____
❑ Genitourinary (Incontinence, Bladder, Kidney) _____
❑ Ears, Nose, Mouth, Throat _____
❑ Hematologic/ Lymphatic (Blood Disorders) _____
❑ Immunologic (HIV, Lupus) _____
❑ Integumentary (Skin) _____
❑ Musculoskeletal (Arthritis) _____
❑ Neurological (Dyslexia, Seizure) _____
❑ Psychiatric (Depression, Anxiety) _____
❑ Respiratory (Asthma, Bronchitis) _____
❑ Cancer _____

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

Lake Mary Eye Care - Robert Love, O.D., F.A.A.O.

Signature_____

Medicare Insurance Only

ADVANCE BENEFICIARY NOTICE (ABN)

To our Medicare patients:
We are committed to providing you the very best eye care available. Unfortunately Medicare does not cover all the services that may be provided during your eye examination. If you simply need to get your glasses changed, Medicare will not cover this procedure. We truly regret any inconvenience or undue burden this may cause. These rules and restrictions are set by Medicare and we must abide by them.

Refraction charge
Refraction is done to determine whether or not glasses are necessary or need to be changed. This is an essential part of your eye exam. **The refraction is critical to helping us determine precisely how well you can see.** Once again, **Medicare will not pay for a refraction**, although it is a fundamental part of a comprehensive eye examination and **a fee of $35 is due at the time of service.**

We expect that Medicare will not pay for the item(s) or service(s) that are described below.
Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. Listed below are items or services that will not be paid for by Medicare.

Items or Services: **Refraction, Contact Lens Evaluation, Frames And Lens**
Because: **Medicare does not consider as medically necessary**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **PRINT**, **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

☐ **Option 2. NO. I have decided not to receive these items or services.**

_____

Date

_____ _____

Print Name: **Sign Name:**

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 _____

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 _____

PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

I GIVE PERMISSION TO LAKE MARY EYE CARE TO RELEASE ANY OF MY PERSONAL HEALTH INFORMATION, INCLUDING ANY MEDICAL INFORMATION IN MY CHART TO:

1. Name _____ Phone # _____

   RELATIONSHIP TO PATIENT _____

2. Name _____ Phone # _____

   RELATIONSHIP TO PATIENT _____

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

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 discloses 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 or 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