Lake Mary Eye Care – Child Form

Patient Information

Today's Date _____
Last _____
First _____ MI _____
Date of Birth _____ Age _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
May we text to confirm and/or remind you of upcoming appointments? ☐ **Yes** ☐ **No**
Email Address _____
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? _____
What is the main reason for today's visit?
_____

Insurance Information

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 _____

Questions for the School Aged Child

Does your child experience any of the following?

	Yes	No
School performance not up to potential	❑	❑
Reading below grade level	❑	❑
Had special education testing or receives special education services	❑	❑
Poor reading comprehension	❑	❑
Poor spelling ability	❑	❑
Difficulty with word recognition	❑	❑
Letter/word reversals when reading or writing	❑	❑
Transpositions of letters or numbers	❑	❑
Failure to complete work in allotted time	❑	❑
Errors in copying from blackboard to paper	❑	❑
Poor printing or handwriting	❑	❑
Mistakes words with similar beginnings or endings	❑	❑
Confuses similar words	❑	❑
Fails to recognize same word in next sentence	❑	❑
Uses finger to keep place when reading	❑	❑
Often loses place; skips or rereads words when reading	❑	❑
Complains of blurred vision during reading or writing, or when looking up from the desk	❑	❑
Complains of headaches with visual tasks	❑	❑
Complains of print "running together" or "jumping" or "moving"	❑	❑
Complains of seeing double	❑	❑
Closes or covers one eye in bright light or during visual tasks	❑	❑
Experiences unusual fatigue after visual tasks	❑	❑
Reports eyes hurt, burn, or tire while reading	❑	❑
Frowns, scowls, or squints with visual tasks	❑	❑
Tilts or turns head excessively with visual tasks	❑	❑
Avoids near work (reading, writing)	❑	❑
Short attention span, easily distracted, or extensive daydreaming	❑	❑

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	❑ _____

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

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 _____

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)_____

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

Has your child had any surgeries? ❑ Yes ❑ No If so, please explain _____

Was your child full-term? ❑ Yes ❑ No
Did your child have complications after birth? ❑ Yes ❑ No If so, please explain
_____

Has your child had any special testing? (hearing, speech, psychological) ❑ Yes ❑ No

Has your child ever had any type of therapy? (speech, auditory, physical, occupational) ❑ Yes ❑ No

Has your child ever been diagnosed or treated for the following health problems? If so, 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 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.

Parent or Legal Guardian's Signature

Refraction

Refraction is done to determine whether adult or pediatric patients need a prescription for glasses/contact lenses or if the prescription needs to be changed. *Eye drops are not needed for this test* **This is an** essential **part of your eye examination and is** especially important for children **of all ages to help us identify problems such as amblyopia (lazy eye) and strabismus (crossed eye), as well as to determine why a child may have failed vision screenings at school or at the pediatrician's office.. Unfortunately most medical insurances will** not **pay for a refraction, although it is a fundamental part of your exam. These rules are set by insurance companies and we must abide. We apologize for any inconvenience this may cause. However, you will need to pay** a $35 fee for this service on the day of the exam.

Circle One

1. I **DO** WANT A REFRACTION
2. I **DO NOT** WANT A REFRACTION

Signature _____ Date: _____

Contact Lens Evaluation Includes:

- Fitting /refitting if necessary
- Tear film evaluation /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 exchange any contact lens boxes that are **unopened** within 90 days of purchase. **The boxes must be purchased from our office.**

In most cases insurance companies will not cover this service. They consider contact lenses **"not medically necessary".** The fee for contact lens evaluation starts at $75. The fee to renew, update or change your contact lens prescription is determined by the type of lens you are being fitted for and the complexity of the case. **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 Blue 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.

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.

☐ **Yes, I was offered a copy of the HIPPA Policies.**

Printed Patient Name _____

Signature _____

Parent or Guardian name (if minor) _____

Parent or Guardian signature (if minor)_____

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 _____ Phone # _____

2. Name _____ Phone # _____

   RELATIONSHIP TO PATIENT _____ Phone #_____

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