

PLEASE UPDATE

PATIENT INFORMATION

Date _____

Name _____

Street _____

City/State _____ Zip _____

Home Phone _____ Cell Phone _____

Sex: M F Work Phone _____

Age _____ Date of Birth _____

Email _____

Would you like to receive communications by:

text e-mail phone

Marital Status: Single Married Widowed Divorced

Soc Sec #: _____

Employer: _____

Occupation: _____

What is the main reason for today's visit? Check one

____ Annual Routine Exam (no complaints) ____ Contact Lenses
 ____ Referral from another doctor ____ Diabetes exam
 ____ Specific problem with eyes or vision (describe below)

INSURANCE INFORMATION

Vision Plan _____

Subscriber Name _____

Subscriber Soc Sec# _____

Subscriber ID# _____

Subscriber Birth date _____

Medical insurance WILL cover eye examinations in many cases. Please enter your information below so we can determine your coverage.

Medical Insurance _____

Subscribers Name _____

Subscriber Soc Sec# _____

Subscriber ID# _____

Subscriber Birth date _____

Secondary Insurance _____

Which pharmacy would you like prescription medications sent to: (Name and Location):

PRIVACY PRACTICE ACKNOWLEDGEMENT

A copy of Treasure Coast Eye Associates' Notice of Privacy Practices is available for review in the waiting room. Please look over this document if you desire, and sign below that you have had an opportunity to review it. Copies are available if you would like a copy to take with you.

Signature _____

Date _____

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 (check one and provide details)

- Another Doctor _____
- Insurance List _____
- Website _____
- Newspaper/Radio/TV _____
- Other _____

ASSIGNMENT AND RELEASE (Sign below to allow us to file your insurance)

Medicare and most medical insurances do NOT pay for routine vision examinations or refractions (to determine prescription for glasses). If refraction is necessary or requested during the exam, these insurances will disallow it, stating it is a non-covered service. Therefore, the patient will be responsible for the refraction charge. The refraction charge is **\$35**. If by chance your insurance does pay, we will refund that money to you.

The practice of waiving deductible and coinsurance amounts is illegal. I understand I am responsible for these payments.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the companies provided and assign directly to Treasure Coast Eye Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that my insurance contract is between me and my insurance, not Treasure Coast Eye Associates, and I am responsible for all charges whether or not paid by my insurance. If my insurance has not reimbursed this office in full within 90 days, I will be billed the outstanding balance. A 1.5% interest charge will be assessed monthly thereafter for past due balances. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of Insured/Parent/Guardian _____

Date _____

CONTACT LENS SERVICES

Contact lenses are Class II medical devices regulated by the FDA which require ongoing evaluation to ensure safe and comfortable wear. This service is separate and in addition to your comprehensive eye health and vision examination and includes:

- Contact lens insertion, care, and removal training
- Trial lenses to establish a good fit
- Evaluation of the fit of current or new lenses on the eye
- Evaluation of corneal, conjunctival, and eyelid health as related to contact lens wear
- Progress checks related to contact lens comfort and vision for 60 days following evaluation and/or fitting of lenses
- A contact lens prescription. The contact lens Rx will be dispensed to the patient once the fit is finalized by the doctor.

Contact lens service fees are charged annually and the global fee includes a limited number of progress checks.

Evaluation Fees are as follows:

<u>Type of evaluation</u>	<u>Cost</u>	<u># progress visits included</u>
Soft Spherical Single Vision	\$75.00	1
Soft Toric Single Vision and/or Monovision	\$90.00	2
Soft Multifocal	\$110.00	2
Rigid Gas Permeable Single Vision	\$110.00	2
Rigid Gas Permeable Toric/Bitoric or Monovision	\$125.00	2
Rigid Gas Permeable Multifocal	\$150.00	3
Specialty Contact Lens Fits	\$250.00+	unlimited for 60 days

I have read the above and understand the following:

**These fees are for the contact lens evaluation ONLY and DO NOT include any supply of contact lenses. Some or all of these fees may be covered by a vision plan or medical insurance which we will file for you, but these fees are ultimately the patients responsibility.

**The follow-up period for progress checks and finalizing a contact lens prescription is 60 days. Any follow-ups needed in addition to the included visits during those 60 days will be charged a \$25.00 per visit fee.

**Every possible effort will be made to see that you are a good candidate for contact lens wear, however, situations arise that may preclude you from wearing lenses. There are NO REFUNDS on services.

Patient/Parent/Guardian _____ Date _____

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(PERMISSION TO SHARE):**

I give my permission for Treasure Coast Eye Associates to disclose my protected health information to the following individuals (i.e. family members, friends, etc.) until further notice:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ I decline to have mt records released to anyone

Signature of Patient or Guardian: _____ **Date:** _____

ROUTINE VS MEDICAL EYE EXAM:

- A **routine** eye examination is defined by insurance companies as an office visit for the purpose of checking vision, screening foe eye disease and updating eyeglasses and contact lens prescriptions.
- A **medical** eye examination is defined by insurance companies as an office visit for the purpose of assessing, diagnosing, and/or treating an eye problem.
- A **refraction** is a part of an eye exam that determine your prescription. This service has a fee of \$35 if it is not covered under the insurance provided.

If any medical eye complaints are addressed, pharmaceutical prescriptions are written, referrals for surgery or letters to other physicians are send, you visit will be billed to your medical insurance as is required by our insurance contracts.

Please sign below that you have read and understand the statement above.

Signature of Patient or Guardian: _____ **Date:** _____

RETINAL HEALTH SCREENING TESTS:

Treasure Coast Eye Associates takes pride in offering advanced eye care technology. The doctors recommend this test below at your annual eye examination. This test is NOT covered by insurance plans.

_____ **Digital Retinal Imaging \$30**

Recommended for **NEW** or **ESTABLISHED** patients each year

Computerized imaging of the eye that allows instant viewing of the retina and optic nerve. These images are stored permanently and compared against any changes in the future.

_____ I decline this test

Signature of Patient or Guardian: _____ **Date:** _____