TREASURE COAST EYE ASSOCIATES, P.A.

WELCOME TO OUR OFFICE

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_____

(PLEASE FILL OUT OTHER SIDE ALSO)

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

EYE HISTORY

How long ago was Last Eye Examination?_____
By Whom? _____

Do you wear glasses? YES NO
All the time Occasionally Driving Only
Reading Only Distance Only

Contact Lens Wearers Only:
What kind/brand of contacts do you wear?

_____
Cleaning solutions used: _____
How often do you replace your contacts? _____
How often do you sleep in your contacts?_____

Are you satisfied with the vision and comfort of your current contact lenses? YES NO

Are you experiencing any of these symptoms since your last exam? (Please circle)

Blurry Vision
Red Eyes
Burning
Double Vision
Discharge
Flashes of Light
Seeing spots
Dry Eye
Tearing
Itching
Light Sensitivity
Night Vision Problems
Temporary Loss of Vision
Other_____

Have you ever been diagnosed or treated for any of the following? (Please circle)

Glaucoma
Cataracts
Macular Degeneration
Eye Injury
Retinal Disease/Detachment
Blindness
Eye Turn/Strabismus
Lazy Eye/Amblyopia
Diabetic Eye Problems
Dry Eye
LASIK surgery
Cataract surgery
Diabetic eye laser treatment
Glaucoma laser treatment
Other_____

MEDICAL HISTORY

Primary Care Physician_____
Last Physical Exam_____

Have you ever been diagnosed or treated for any of the following health problems? (Please circle)

Anxiety
Allergies
Arthritis
Asthma/Emphysema/COPD
Blood disorder
Cancer
What kind?_____
Depression
High Cholesterol
Diabetes: Type 1 or Type 2
How long diagnosed?_____
Ears/Nose/Throat/Sinus
Heart condition
What type?_____
High Blood Pressure
HIV/AIDS
Kidney Disease
Lupus/other autoimmune disease
Migraine headaches
Muscle/Bone problems
Pacemaker
Rheumatoid arthritis
Shingles
Skin condition
Stroke
Other brain disease
Psychological
Thyroid
Pregnant
How many weeks?_____
Other_____

OTHER QUESTIONS

How many hours per day are you on a computer or digital device?
_____Hrs

How many hours per week to you spend outdoors?
_____Hrs

Smoking Status: (Please circle)
Never Former Smoker Occasional Every Day

Alcohol Use: (Please circle)
Never Socially Heavy

CURRENT MEDICATIONS (including eyedrops and over the counter)

_____
_____
_____
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MEDICATION ALLERGIES

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FAMILY MEDICAL/EYE HISTORY

Does anyone in your family have any of the following conditions? Please circle and list the affected family members.

Glaucoma_____
Cataracts_____
Macular Degeneration_____
Retinal Disease_____
Blindness_____
Lazy Eye/Eye Turn_____
Diabetes_____
Cancer_____
Heart Disease_____
Other_____

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 for eye disease and updating eyeglass and contact lens prescriptions. Routine exams have a final diagnosis of nearsightedness (myopia), farsightedness (hyperopia) or astigmatism. "Vision Plans" such as VSP, Eyemed, Spectera, Davis and others are prepaid or discount benefits usually provided by your employer or health insurance plan for the purpose of covering or discounting routine examinations, glasses and contact lenses. The plans are separate from medical or health insurance.

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. Medical exams have a final diagnosis of conjunctivitis, dry eye, cataracts, glaucoma, diabetes, etc. These types of exams must be billed to your health or medical insurance plan, such as Medicare, Blue Cross Blue Shield, United Healthcare, etc. just like your visits to you primary care doctors and specialists.

A **refraction** is a part of an eye exam that determines your eyeglass prescription. It typically involves looking through a device with changing lenses and involves questions like, "which is clearer – one or two?". Vision plans and some HMO medical plans generally cover this procedure, whereas medical insurance does not. This service has a fee of $35 if it is not covered.

Please supply all insurance information (vision and medical) prior to your examination. The determination of which insurance will be billed is based on the complaints addressed during the exam, testing done, as well as any treatment given. Insurance coverage does not mean payment. Many health plans have copayments and deductibles that must be met before insurance will pay any amount toward your bill. You are ultimately responsible for all charges whether insurance pays or not. Please direct all questions about billing and financial responsibilites to the front desk.

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

_____ **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:

Type of evaluation	Cost	# progress visits included
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_____

Retinal Health Screening Tests

Treasure Coast Eye Associates takes pride in offering advanced eye care technology and our market research tells us that patients want technology that helps safeguard their eye health. The doctors recommend a screening test at your annual eye examination. This test is not covered by insurance plans because it is preventative in nature, but we keep the price as low as possible to ensure everyone has access to it. This test is fast, painless, and safe. There are two versions of the test as described below.

Please make your selection:

_____ **Digital Retinal Imaging** **$25**

Who is this test for?: Recommended for ***new or established*** *patients at annual exams*

Computerized imaging that allows instant viewing of the retina and optic nerve in great detail. Both the doctor and the patient review the images on screen. This technology promotes early diagnosis of abnormal conditions, which could prevent permanent vision loss. These images are stored permanently and compared against any changes in the future.

OR

_____ **Ultrawide Field Digital Retinal Imaging** **$39**

Who is this test for?: ***Established*** *patients under 65 with no eye disease, diabetes, or high myopia (nearsightedness* >-4.00D)

This state-of-the-art technology is similar to the above test, but allows us to acquire a 200 degree view of the inside of your eye **without** having to dilate your pupils, but still allows us to see high resolution details as small as 0.007mm. It does not replace dilated eye exams, but is the next best thing when you don't have the time or can't be inconvenienced by the blur and light sensitivity that comes with having dilated pupils. The doctors still recommend a dilated examination every **2-3 years**.

_____ **I decline both screening tests**

SIGN HERE:_____ **DATE:**_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (PERMISSION TO SHARE)

If you give permission for Treasure Coast Eye Associates to share information about you with another person or persons, please make sure that you fill out all sections below.

I, _____, give my permission for Treasure Coast Eye Associates to disclose the protected health information described below to the following individuals (i.e. family members, friend, and/or doctor):

_____ _____
_____ _____
_____ _____

This authorization for release of information covers the period of healthcare from:

O All past, present, and future periods.

OR

O _____ to _____
date date

Extent of Authorization

O I authorize the release of my complete health record

OR

O I authorize the release of my complete health record with the exception of the following information: (please be specific)

_____
_____
_____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entitiy has already acted on my authorization or as a condition of obtaining insurance coverage.

Signature of Patient or guardian_____ Date_____