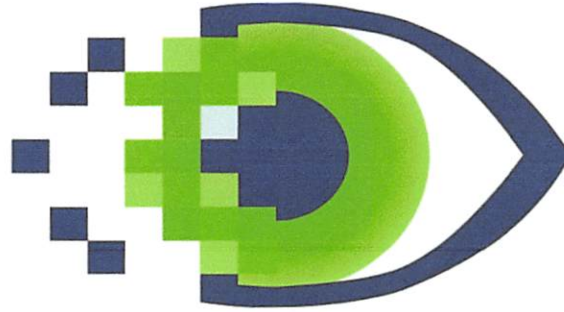


InFocus
FAMILY EYECARE

Acknowledgement of Pupil Dilation:
I understand that the Florida Board of Optometry requires optometrists to perform a dilated exam of the retina during the patient's comprehensive exam. I understand that the optometrist recommends it to more thoroughly evaluate the internal health of my eyes. Please indicate your preference:

_____ I wish to be dilated today if necessary (**Required for New Patients**)

_____ I would like to discuss the dilation with the doctor

_____ I refuse the dilation and agree to release InFocus Family Eyecare of any and all legal responsibility

OCT Retinal Exam:
The Ocular Coherence Tomographer, also known as the OCT retinal exam, is a scanning digital image of the retina, macula, and optic nerve. It allows the Doctor to better diagnose, treat, and follow changes to the retina over time. The OCT Retinal Exam is a "non-covered service" with most vision insurance plans, meaning the patient would be responsible for the charges. The Doctor highly recommends it for all patients once a year. The fee for the OCT is **$45.00**

_____ I wish to have the OCT Retinal Exam

_____ I refuse the OCT Retinal Exam

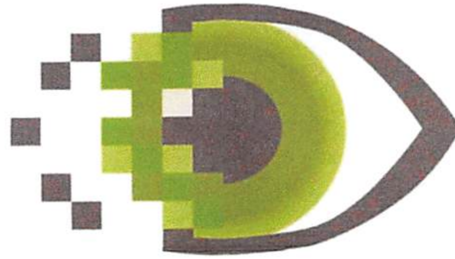
*****PLEASE NOTE: Payment is expected at the time of service*****

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payment of medical payments to InFocus Family Eyecare for any services rendered to me by any doctors of InFocus Family Eyecare.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, co-insurance and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of services provided.

Acknowledgement of HIPAA:
I acknowledge that I received a copy of InFocus Family Eyecare's Notice of Privacy Practices (HIPAA).

Signature of Guarantor_______________________________________ **Date:**___________________________



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Vision Plans versus Medical Insurance- Explanation of Coverage

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and InFocus Family Eyecare accepts most insurance plans in both categories: 1) Vision plans (such as VSP, EyeMed and others) and 2) Medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

•Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care.

•Medical insurance must be used for medical eye care involving the diagnosis, management and treatment of eye health conditions such as: diabetes, dry eye, eye infections, cataracts, glaucoma, ocular allergy, etc...

•If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

•If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

Until a comprehensive eye exam has been completed, it is not possible to determine if a medical diagnosis exists that might require additional diagnostic testing and medical treatment. If a medical diagnosis is identified (or suspected) during the comprehensive eye exam and additional testing and treatment is medically indicated, InFocus Family Eyecare is required by our vision plan and medical insurance contractual relationships to submit the claim(s) to the appropriate carrier.

Medical Plans Only

When using your medical insurance such as Medicare, Aetna, and United Health Care etc... your refraction is not covered. We are considered a specialist and your specialist copay will apply, along with the refraction fee of $30.00, and any other services not covered by your medical insurance.

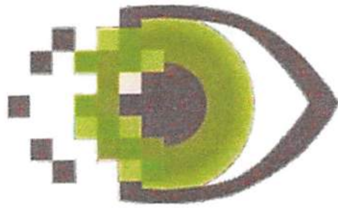
Out of Network Plans

For the convenience of our patients, InFocus Family Eyecare participates with almost every major vision and medical insurance carrier. In the event that we do not participate with your medical or vision insurance, we are happy to provide you with an itemized receipt so that you may file with your insurance carrier and obtain reimbursement for out-of-network benefits. If you have any questions, please let us know.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance or Medicare card on file for future billings to your insurance. We will always notify you and get your approval before we bill any insurance plan.

I acknowledge understanding of the information above and authorize InFocus Family Eyecare to file claim(s) with my insurance(s) as appropriate.

Signature of Guarantor: ______________________________ **Date:** ___________________________



Today's Date:

Patient Information

Last______________________________
First__________________MI___________
Street_____________________________
City_________________State__________
Zip code_____________

*Email Address_____________________
Cell/home phone_____________________
Work phone_________________________

Preferred contact: Email / Cell / Home / Work

Date of Birth _____/_____/______Age________
Sex M F
Patient's SSN_________________________

Employer (or School)___________________
Occupation (or Grade)__________________
Spouse/Parent/Partner__________________
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 hear about our office?
__Doctor
__Insurance List
__Saw sign/Building
__Magazine/ Newspaper
__Hometown News
__Web Site? ________________________
__Other____________________________

*used only for correspondence from our office

Insurance Information

Vision Insurance__________________________
Subscriber Name__________________________
Subscriber Ins. ID#________________________
Subscriber Birth Date______________________

Primary Medical Insurance__________________
Subscriber Name_________________________
Subscriber Ins. ID#_______________________
Subscriber Birth Date____________________
Subscriber Address:_______________________
Subscriber City/State/Zip:__________________
Subscriber phone:_______________________

Do you participate in a flex spending account?
__Yes __No
How will you settle your account today?
__Cash __Check __Credit Card

Lifestyle Questions

Do you……..(check √ if your answer is yes)
__work at a computer?
__think you might benefit from thinner, lighter lenses?
__have interest in a "test drive" of the latest contact lenses?
__spend time outdoors? How much? ___Hrs/week
__have prescription sunwear?
__prefer not to wear your glasses at times?
__want info on Laser Vision Correction surgery?
__have more than 1 pair of current Rx eyewear?
__have family members in need of eyecare?

Date of Last Eye Exam___________________
By Whom?_____________________________
Have you ever tried contact lenses? __Y__N
Do you currently wear contact lenses? __Y__N
What kind?____________________________
Solutions used__________________________
Are you satisfied with the vision & comfort of your contact lenses? __Y __N
Do you sleep in your contact lenses? __Y __N
Are you satisfied with your current bifocal/progressive lenses? __Y __N
Have you used transition lenses? __Y __N

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

Patient Medical History

Name of Family Physician___________________
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 yes, list them here______________________________
____
____

Please list any surgeries and dates if applicable______________________________
____
____

Do you use cigarettes/tobacco? __Yes__No
If yes, how often? ______________________
Do you use alcohol? __Yes __No

Have you ever been diagnosed or treated for the following health problems?

__Allergies
__Blood/Lymph
__Cancer
__Diabetes
__Ears/Nose/Throat
__Fatigue
__Fevers
__High Blood Pressure
__Kidney
__Neurological
__Respiratory
__Arthritis
__Bronchitis
__Cholesterol
__Digestive
__Endocrine
__ Genitourinary
__ Integumentary (Skin)
__Muscle/Bone
__Psychological
__Thyroid
__Unusual weight loss/gain

Patient Eye History

Have you ever experienced, been diagnosed or treated for any of the following?

__Blurry Vision
__Trouble seeing a night
__Sun Sensitivity
__Cataracts
__Glaucoma
__ Headaches
__Uncomfortable glasses
__Burning
__Macular Degeneration
__Itchiness
__Retinal Detachment
__Grittiness
__Other eye disorders______________________
____
__Eye Infections
__Lazy Eye
__Eye Injury
__Floaters/Spots
__Flash of light
__Dryness

Family Medical/Eye History (Check all that apply)

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

(Mother's or Father's Side)

Blindness ____________________
Cataracts ____________________
Corneal problems ____________________
Diabetes ____________________
Glaucoma ____________________
Heart Disease ____________________
Lazy eye ____________________
Macular Degeneration____________________
Retinal Problems ____________________

Signature of patient or guardian______________________________ Date______________________

INFOCUS
FAMILY EYECARE

RECORDS REQUEST FORM

Date ________________

Patient Name ____

Address ____

Date of Birth ____

TO: ____

____

"I request your office release all patient records including medical findings, lab reports and treatments to Dr. ______________. I hereby release you, my practitioner, from any laws governing the disclosure of confidential or privileged information. You are also authorized to communicate orally or in writing any information regarding the requested information."

☐ Spectacle Prescription ☐ Contact Lens Prescription
☐ All Previous Eye Exam Records/Diagnostic Testing ☐ Medication List

Please send all information to our office as requested below:

☐ Via Fax:
(941) 718-4926

☐ Via Mail:
8120 Lakewood Main St. Suite 101
Lakewood Ranch, FL 34202
Tel: (941) 362-2020

Patient Signature ____

Notice to Patient:
You have the right to receive a copy of this authorization.