WELCOME TO EYE CARE CENTER OF OCALA

Patient Name:_____ Nickname:_____ Today's Date:_____

Address:_____

City/State/Zip:_____

Telephone: Home: (_____)_____Cell: (_____)_____Work: (_____)_____

Date of Birth:_____ Sex: ☐ M ☐ F SSN:_____ Email:_____

How do you prefer to be contacted? ☐ Email ☐ Mail ☐ Phone ☐ Text Marital Status: ☐ Single ☐ Married ☐ Other

The Federal Government requires us to ask the following as part of the American Recovery and Reinvestment Act:

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiin or Pacific Islander

Do you smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No Language: ☐ English ☐ Spanish ☐ French

Employment: ☐ Retired ☐ Unemployed ☐ Employed ☐ Full Time Student ☐ Part Time Student

Occupation:_____ Hobbies:_____

Guardian Contact Name:_____ Relationship:_____ Phone: (____)_____

Emergency Contact Name:_____ Relationship:_____ Phone: (____)_____

Primary Care Physician:_____ Physician Phone Number:(_____)_____

Whom may we thank for referring you? ☐ Your Physician ☐ A Patient ☐ A Friend ☐ Insurance ☐ Internet ☐ Other _____

What is the name of the patient / friend / physician that referred you to us? _____

OPTOMAP RETINAL EXAM

An Optomap Retinal Exam is a widefield image of the retina giving your doctor a more detailed view of your retina. It is fast, easy, and comfortable and can detect the presence of diseases such as macular degeneration, glaucoma, retinal tears or detachments, as well as other health problems such as diabetes, high blood pressure, and high cholesterol. It provides a permanent record for your medical file, enabling your doctor to make a comparison from year to year. Your doctor strongly believes the Optomap is an essential part of your comprehensive eye health examination and highly recommends it for all patients once a year.

The Optomap Retinal Exam is a screening* tool not covered by your insurance, meaning you would be responsible for the charges. The **cost** of the Optomap Retinal Exam is **$39**.

*If you are already being monitored by our doctors for macular degeneration, glaucoma, diabetic retinopathy, or any other retinal or optic nerve pathology you can decline this test as we have other diagnostic equipment made especially to track the progression of these diseases.

Please check one:

□ I understand the above and consent to have the Optomap Retinal Exam.

□ I understand the above and decline the Optomap Retinal Exam. I understand the Optomap is an important part of a comprehensive eye exam and that I am declining the Doctor's recommendation to obtain a comprehensive view of my retina.

I hereby authorize all licensed professionals employed by Eye Care Center of Ocala to perform such professional diagnostic, laboratory, medical and surgical procedures as are necessary in their judgment, and to render such care and services as are customary and necessary.

Signature _____ Date _____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

OFFICE POLICY ON PAYMENT:

I understand that I am responsible for payment on all charges. As a courtesy, my vision or medical insurance will be billed for me providing I present this information prior to the start of my eye examination today. It is my responsibility to pay deductible, co-pay, co-insurance or any other balance not paid by my insurance company. I authorize my insurance benefits to be paid directly to Eye Care Center of Ocala. Any uncollected balances will be turned over to our collections agency.

MEDICAL INSURANCE POLICY:

As part of our services at Eye Care Center of Ocala we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1) The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2) When your insurance provider(s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3) To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4) I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5) I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.

VISION INSURANCE POLICY:

1) I understand that if there is a medical diagnosis associated with your reason for visit, Eye Care Center of Ocala will be filing a claim to your medical insurance and will coordinate benefits with your vision insurance.
2) I understand that medical testing out of pocket fees are based on my medical insurance deductible and co-pay in addition to my vision insurance co-pay.
3) I understand that vision insurance is for routine care of a non-medical nature and does not cover exams for pathology.

OFFICE POLICY FOR PATIENTS THAT ARE UN-INSURED:

1) I understand that I can be given a prompt pay discount for paying for my entire exam on the date of service. In order to qualify for this discount I agree that I am NOT covered under Medicare OR any other third-party insurance that pays or reimburses me for these exam fees. In the event I submit a claim to any third-party payer, I agree to recognize the discount received from our usual and customary fees and realize that I will have to refund that discount to Eye Care Center of Ocala.

REFUND/ RETURN POLICIES:

No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds for unopened boxes of contact lenses can only be made within 7 days of receiving the product, provided that the product is returned to the store without damage at the time the refund is issued. Opened boxes, marked boxes, or boxes with missing UPC labels of contact lenses are non-refundable.

_____ _____

Signature Date

MEDICAL HISTORY QUESTIONNAIRE

NAME:_____DOB:_____ DATE:_____

REFERRED BY:_____ DATE OF LAST EYE EXAM:_____

WHO IS ACCOMPANYING YOU TODAY:_____ RELATIONSHIP:_____

DO YOU USE ANY RECREATIONAL DRUGS:_____ DO YOU DRINK:_____

ARE YOU PREGNANT OR NURSING:_____

LIST ANY MEDICATIONS YOU CURRENTLY TAKE (PRESCRITPION AND NON-PRESCRIPTION):

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO
IF SO WHICH MEDICATIONS:_____

FAMILY HISTORY: M = MOTHER / F = FATHER / S = SIBLING / GP = GRANDPARENT

DISEASE	YES	NO	DISEASE	YES	NO
BLINDNESS			CATARACTS		
GLAUCOMA			ARTHRITIS		
CANCER			DIABETES		
HEART DISEASE OR HYPERTENSION			KIDNEY DISEASE		
LUPUS			STROKE		
THYROID DISEASE			OTHER		

LIST ALL MAJOR INJURIES OR ILLNESSES (GLAUCOMA, DIABETES, HIGH BLOOD PRESSURE, HEART ATTACK, STROKE, AUTO-IMMUNE DISEASES, ETC…) AND WHEN YOU WERE DIAGNOSED:

_____

LIST ANY SURGERIES YOU HAVE HAD (CATARACTS, LASER, APPENDECTOMY, ETC…) AND WHEN THEY HAPPENED:

_____

	YES	NO	EXPLAIN
EYES (GLAUCOMA, CATARACTS, ARMD, ETC…)			
GENERAL / CONSTITUTIONAL(FEVER,WEIGHT GAINLOSS)			
EARS/NOSE/MOUTH/THROAT(SINUS,COUGH,INFECTION)			
CARDIOVASCULAR (HEART,CIRCULATION,HTN,ETC…)			
RESPIRATORY (ASTHMA, EMPYSEMA, ETC…)			
GASTROINTESTINAL (ULCERS,INTESTINAL DISEASE,ETC…)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (ARTHRITIS, ETC…)			
SKIN (SKIN CANCER, ETC…)			
NEUROLOGICAL (STROKE, SEIZURES, ETC…)			
PSYCHIATRIC (ANXIETY, DEPRESSION, INSOMNIA, ETC…)			
ENDOCRINE (DIABETES, THYROID CONDITIONS, ETC…)			
BLOOD / LYMPH (HIGH CHOLESTEROL, ANEMIA, ETC…)			
ALLERGIC / IMMUNOLOGIC (HAY FEVER,LUPUS,SJOGRENS)			

Medical History Signature: _____ Date _____

I acknowledge that I have received a copy of Eye Care Center of Ocala, Notice of Privacy Practices.

Signature _____ Date _____