



PATIENT DEMOGRAPHIC SHEET

Patient Information

Last Name First Name MI Date of Birth Age
Marital Status: Married Widowed Single Other

Social Security Number Marital Status

Occupation/Retired Employer
Language: English Spanish Contact: Mail Phone Email

Preferred Language Contact Preference Email Address
Ethnicity: Not Hispanic or Latino Latino Decline Other

Ethnicity Drivers License Number

Patient's Home Address City State Zip Code

Home Phone Number Work Phone Number Cell Phone Number

Spouse's Full Name Date of Birth Age Phone Number Spouse's SS#

Emergency Contact (If Unable to Reach Patient)

Name Relationship Phone Number

If Patient is a Minor, Please Complete

Person Responsible or Guardian Date of Birth Social Security # Phone # (if different)

Person Responsible or Guardian's Home Address City State Zip Code

Physician Information

Primary Care Physician Phone Number

Address City State Zip Code

## Pharmacy Information

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Preferred Pharmacy

Phone Number

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Address

City

State

Zip Code

## Primary Insurance Information

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Insurance Carrier

Policy Number

Group Number

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Policy Holder

Social Security #

Date of Birth

## Secondary Insurance Information

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Insurance Carrier

Policy Number

Group Number

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Policy Holder

Social Security #

Date of Birth

## Vision Plan Information

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Insurance Carrier

Policy Number

Group Number

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Policy Holder

Social Security #

Date of Birth

## Workman's Comp Information

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Workman's Comp Carrier

Contact Person

Phone Number

Please provide the receptionist with a copy of your driver's license and insurance cards in order for a copy to be added to your file.

## Who Should We Thank for Referring You to Our Practice?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Family / Friend     | <input type="checkbox"/> Florida Hospital Waterman        | <input type="checkbox"/> Newspaper / Publication   |
| <input type="checkbox"/> Yellow Pages        | <input type="checkbox"/> Leesburg Regional Medical Center | <input type="checkbox"/> Referring Physician Name: |
| <input type="checkbox"/> Insurance Directory | <input type="checkbox"/> Villages Regional Medical Center | <input type="checkbox"/> Other:                    |
| <input type="checkbox"/> Seminar / Screening | <input type="checkbox"/> Billboard                        |  |
| <input type="checkbox"/> Internet            | <input type="checkbox"/> Workman's Comp                   |  |

If you were referred by another physician, are being treated for diabetes, or are taking Plaquenil please provide us with the name of your physician so that our doctors can send a letter regarding your care.

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The above information is correct. Any changes to my information will be provided as soon as I am notified of the change

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Patient Signature

Date



**PATIENT MEDICAL HISTORY**

**Patient Name** \_\_\_\_\_

**In order to ensure that your medical history is complete and accurate, please answer the following questions.**

What problems are you having with your eyes?

Yes  No

Date of last eye exam

How old are your current glasses?

Are you a contact lens wearer?

Have you ever been treated for any eye surgery, laser treatment, disease or injury?  Yes  No

If yes, please give date and description:

Please list any medications you are currently taking:

Are you allergic to any medications?  No  Yes:

Are you allergic to LATEX?  No  Yes

**You can now request prescription refills by visiting [www.lakeeye.com](http://www.lakeeye.com)**

Please list all past major injuries or illnesses (diabetes, high blood pressure, heart attack, etc):

Please list any surgeries you have had (including dates):

## Review of Systems

Do you currently have any problems in the following areas?

Review of Systems	Yes	No
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss/gain, unusually tired, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR (blood pressure, racing pulse, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
EARS, NOSE, MOUTH, THROAT (chronic sinusitis, hearing loss, ringing in ears, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
EYES (poor vision, eye pain, tearing, redness, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc)	<input type="checkbox"/>	<input type="checkbox"/>
GENITAL, KIDNEY, BLADDER (painful or frequent urination, impotence, jaundice, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY / SKIN (pimples, warts, rash, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC (anxiety, depression, insomnia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE (diabetes, hypothyroid, etc)	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, trouble re: blood transfusions, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
FEMALES-Are you pregnant or nursing?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above, please provide additional information.

## Family and Social History

Please check if any member of your family has been diagnosed with the following diseases and specify their relation (**M**-mother, **F**-father, **S**-sibling, **G**-grandparent).

_____ Blindness	_____ Cataract	_____ Glaucoma
_____ Heart Disease	_____ Hypertension	_____ Diabetes
_____ Stroke	_____ Cancer	_____ Arthritis
_____ Thyroid Disease	_____ Other: _____	

Do you drink alcohol?  No  Yes

How much? \_\_\_\_\_

Do you smoke?  No  Yes

How much? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date



*Welcome!*

We want to extend our personal greetings and a very warm welcome to our practice. For over 30 years, Lake Eye Associates has been committed to doing everything possible to provide you with quality and customized eye care. We hope to make not only your first visit, but all visits to our office, as pleasant and comfortable as possible.

New patient exams usually take a minimum of 90 minutes. Generally, in the course of your first visit, you will be dilated as an important part of your complete eye examination. Most people are able to drive following dilation, but you may want to bring a driver if you have experienced problems driving after dilation in the past, or if your eyes have never been dilated. Parents of minor children should plan to stay with their child.

At the time of your visit, please bring your completed forms, insurance cards, and a list of your current medications and dosages prescribed. If you wear contact lenses or glasses, please remember to bring them with you as well. Enclosed with your new patient registration forms is a copy of Lake Eye Associates' Financial Policy. Please be sure to read through it carefully as we hope it will give you a better understanding of our billing and payment process.

If you have any questions or need help with the enclosed forms, please feel free to contact any of our locations and one of our caring and professional staff members would be glad to help. Thank you again for choosing Lake Eye Associates and we look forward to assisting in all your eye care needs.

**Sincerely,**  
**The Doctors and Staff**  
**Lake Eye Associates**

**Tavares:** 3310 Waterman Way • Tavares, FL 32778 • (352) 343-2020 • fax (352) 343-1346

**Leesburg:** 601 E. Dixie Avenue, Suite 201 • Leesburg, FL 34748 • (352) 365-2020 • fax (352) 728-3322

**The Villages:** 1400 Us Hwy 441 N, Suite 521 • Lady Lake, FL 32159 • (352) 750-2020 • fax (352) 753-0064



## NOTICE OF PRIVACY POLICY

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information.*

**USES AND DISCLOSURES TREATMENT.** Your health information may be used by our physicians and staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

**PAYMENT.** Your health information may be used to seek payment from your health plan, other sources of coverage such as automobile insurer, or credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

**HEALTH CARE OPERATIONS.** Your health information may be used as necessary to support the day-to-day activities and management of Lake Eye Associates. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to ensure that our practice is meeting state and federal guidelines and laws designated to protect your health care information.

**LAW ENFORCEMENT.** Your health information may be disclosed to law enforcement agencies, without your permission to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

**PUBLIC HEALTH REPORTING.** Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of Florida Department of Health.

**OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION.** Disclosure of your health information or its use for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke authorization will not affect or undo any use or disclosure of any information that occurred before you notified us of your decision.

### ***Additional Uses of Information.***

**APPOINTMENT REMINDERS.** Your health information will be used by our staff to call/send you appointment reminders.

**INFORMATION ABOUT TREATMENTS.** Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health related goods and services that we believe may be of interest to you.

**INDIVIDUAL RIGHTS.** You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to receive accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

**LAKE EYE ASSOCIATES DUTIES.** We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy policies.. We are also required to abide by the privacy policies and practices that are outlined in this notice.

**RIGHT TO REVISE PRIVACY PRACTICES.** As permitted by law, we reserve the right to amend our privacy policies and practices. These changes in our policies and practices may be required by changes in state and federal laws and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

**REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION.** As permitted by federal regulation, we are required that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Practice Manager.

**COMPLAINTS AND CONTACT PERSON.** If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

***Practice Administrator  
3310 Waterman Way  
Tavares, FL 32778***

**EFFECTIVE DATE.** This notice is effective on or after April 14th, 2003.



## REFRACTION AGREEMENT

### REFRACTIONS / ROUTINE VISION TEST

#### 1. What is a refraction?

Refraction is the process of determining the eye's refractive error or the need for corrective glasses and/or contact lenses.

#### 2. Why is it sometimes necessary?

Refraction is necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, refraction would be necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot simply be improved with a glasses prescription. As you can see, refraction is an essential part of an eye exam, however, Medicare and most insurance providers DO NOT cover it.

#### 3. Will I be notified in advance if I need a refraction?

Yes, ONLY a technician or a physician is qualified to tell you that this procedure is necessary. They will let you know if this procedure is necessary BEFORE it is done. You will be given the option to accept or decline the service.

**IMPORTANT:** *If you decline, we will not be able to determine the cause for your decrease in vision. We will not prescribe glasses or contact lenses without a refraction.*

#### 4. How much is a refraction?

Our office policy is to charge \$35.00 for this procedure in addition to the office visit co-pay and/or deductible. This is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. IF your insurance pays the fee, we will gladly refund you the \$35.00 amount once we receive notice from your insurance.

**NOTE:** This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and a new prescription will not be given. The fee covers the technician and/or physician's time and effort in administering the refraction.

### ACKNOWLEDGEMENT

I have read the above information and understand the refraction is a non covered service. I accept full financial responsibility for the cost of the service. The co-pay and deductible are separate from and not included in the refraction fee.

\_\_\_\_\_ I accept the financial responsibility for this service.

\_\_\_\_\_ I **DO NOT** accept the financial responsibility and **DO NOT** wish to receive this service. By choosing this option I am aware that I **WILL NOT** receive a glasses or contact lens prescription today.

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Patient Signature

Date



## FINANCIAL POLICY

**Dear Patient,  
Welcome to our practice!**

This information is being provided so that you may better understand our billing process and payment policy.

If you have any questions about your bill or the policy explained in this information, you may call our billing department between 8:00 a.m.-5:00 p.m., Monday through Friday at (352)343-4798

When you arrive for your first appointment, you will be asked to complete a patient registration form. It is very important that you provide us with accurate information and notify our office of any changes should they occur. We will also need to make copies of any insurance cards you have.

### REFRACTIONS

A refraction is a routine vision test during which you will be asked to read an eye chart, possibly through a different set of lenses. This test determines how well you are seeing, if you need new glasses or a new prescription. Refractions are not considered part of a medical exam and are not covered by Medicare and most insurance. **Payment of \$35.00 for the refraction is due at the time of service.**

### MEDICARE

We will file your claims directly to Medicare and your secondary insurance. **If you do not have insurance, your 20% coinsurance and any remaining Medicare deductible is due at the time of service.**

### MEDICAID

We currently accept Florida Medicaid, Medipass, Pediatric (with PCP authorization) and United Healthcare M Plus **upon verification of eligibility.**

### INSURANCE

We are participating providers for BCBS of Florida, United Healthcare, Cigna HMO, Aetna HMO just to name a few. If we do not participate in your particular plan, we will make every effort to inform you prior to your appointment, **however, it is your responsibility as the patient to verify prior to scheduling an appointment.**

### APPOINTMENTS

Beginning January 01, 2011 we will be assessing a \$25.00 fee if you fail to show for an appointment. We will require that you give our office a 24 hour notice for cancelled or rescheduled appointments.

### CO PAYS & DEDUCTIBLES

To avoid being charged a possible statement fee, co pays, coinsurance and deductibles **must be paid at the time of service.**

### AUTHORIZATIONS & REFERRALS

If your insurance requires prior authorization of referral from your primary care physician, we will make every effort to obtain this prior to your appointment. **If we are unable to obtain this information, you will be responsible for the visit.**

### VISION PLANS

Currently VSP and EyeMed Access Plan are the only routine vision plans we accept. If you are a member of either plan you must notify the front desk prior to being seen. Let them know that you are here for a routine vision exam and you wish us to bill your vision plan.

### SELF PAY

**If you are a self pay patient, payment in full is due when services are rendered.**

### WORKER'S COMP & LIABILITY

If you are injured on the job or in an automobile accident, we will file your claim if you have provided us with the necessary information to do so. **If we do not receive payment within 45 days, you will be held responsible for the visit.**

### PATIENT STATEMENTS

Patient statements are mailed on or around the 10th of each month. Payment is due upon receipt. If you have a question regarding your bill, you must contact our billing department immediately.

### PAST DUE ACCOUNTS

If your balance is not paid within 30 days and you have not contacted our office to arrange payment, your account is considered past due. Our office will make every effort to assist you with settling your account. If, however, all efforts fail and you choose to ignore your obligation, we will have no choice but to pursue further action against you.

### RETURNED CHECKS

If your check is returned from the bank due to "Insufficient Funds," you will be notified **immediately.** In addition to the amount of the check, you will be charged a \$25.00 returned check processing fee. Payment in the form of cash, money order, or credit card must be received within 10 business days. Failure to pay your debt may result in litigation.

### ACCEPTED METHOD OF PAYMENT

Our office accepts cash, personal checks, MasterCard, Visa and Discover.

**We appreciate your cooperation,  
The Physicians and Staff  
Lake Eye Associates**



**LIFETIME AUTHORIZATION FOR RELEASE OF INFORMATION AND  
ASSIGNMENT OF INSURANCE BENEFITS**

**Release of Information**

I authorize Lake Eye Associates to release any information required to process my claim. I hereby certify that the information provided is correct and true to the best of my knowledge.

**Assignment of Insurance Benefits**

I hereby authorize payment directly to Lake Eye Associates of benefits and/or major medical benefits otherwise payable to me under the terms of my policy.

**Acknowledgement of Receipt of Notice of Privacy Policy and Financial Policy.**

I acknowledge that I have received a copy of Lake Eye Associates' *Notice of Privacy Practices* and *Financial Policy*.

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Printed Name of Patient or Patient Representative Date

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Signature of Patient or Patient Representative Date

It may be necessary for a spouse or other family member to become involved in a patient's care. Please indicate the names of those individuals with whom we may discuss your medical and non-medical (insurance, billing etc) information.

Name	Relationship	Medical	Non-Medical
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

**Please note this authorization will remain in effect unless a written request to rescind authorization is submitted.**