Southwest Orlando EyeCare
Your Vision Is Our Focus

Last Name: _____ M.I. ____ Name: _____Date: _____
Occupation: _____ Address: _____
Social Security #:_____ City: _____ State: _____ Zip Code: _____
Email: _____ Phone: Home: _____ Cell: _____
Race: _____ Work: _____
Date of Birth: _____ ☐ **M** ☐ **F** Date of last eye exam: _____
Reason for visit: _____
How were you referred to our office: _____

List of any medications you currently take (prescription and over-the-counter)_____
_____
Are you allergic to any medications? **YES** **NO**
If YES, list the medications:_____
List all major illness (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):_____
List any surgeries you have had (cataract, appendectomy):_____
_____

Do you ***currently*** have any problems in the following fields? If YES, please circle or add additional information.

	YES	**NO**		**YES**	**NO**
EYES: poor vision, eye pain, tearing, redness, etc.			**FEMALES**: Are you pregnant? Nursing?		
PSYCHIATRIC: anxiety, depression, insomnia			**CARDIOVASCULAR**: high BP, racing pulse, etc.		
ENDOCRINE: diabetes, hypothyroid, etc.			**SKIN**: pimples, warts, growths, rash, etc.		
MUSCLES, BONES, JOINTS: joint pain, stiffness, swelling, cramps, arthritis, etc.			**BLOOD/LYMPH**: bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.		
GASTROINTESTINAL: upset stomach, diarrhea, constipation, hernia, ulcers, etc.			**ALLERGIC / IMMUNOLOGY**: sneezing, swelling, redness, itching, hives, lupus, etc.		
NEUROLOGICAL: numbness, headache, seizures, paralysis, etc.			**EARS, NOSE, THROAT**: hard of hearing, stuffy nose, earache, cough, dry mouth, etc.		

FAMILY HISTORY (Mother, Father, Grandparents, Siblings):

Has any member of your family had these diseases? (Circle all that apply) **YES** **NO**
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease: _____

SOCIAL HISTORY:

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**
Are you interested in Lasik? **YES** **NO**
Do you drink alcohol? **YES** **NO** If **YES**, how much? _____
Do you smoke? **YES** **NO** If **YES**, how much? _____ How many years? _____

INSURANCE INFORMATION:

Ins. Provider:_____ Group#:_____
Insured Name: _____ Ins. ID #: _____
Insured Date of Birth:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent

SOUTHWEST ORLANDO EYE CARE

Financial & Insurance Policy:

Thank you for choosing Southwest Orlando Eye Care as your Vision Care Provider. As a part of our services, we try to contain the ever-rising cost of vision care. In an effort to do so, we advise you to read and sign the following financial policy prior to treatment. Patient or responsible party must complete our information and insurance form before seeing the doctor.

- **FULL PAYMENT, CO-PAYMENT, PERCENTAGES AND/OR DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED.** We accept cash, checks, Visa, MasterCard, American Express and Discover. If you are purchasing eyeglasses or contacts, you will be expected to pay in full before any orders can be processed. _____ ***(Initial)***
- **NO SHOW POLICY:** A patient is considered a "No Show" if an appointment is missed or cancelled with less than 24 hours' notice. When this occurs, Southwest Orlando Eye Care loses the opportunity to care for other patients that wish to be seen. Failure to give 24 hours' notice will result in a $50 fee. _____ ***(Initial)***
- **Office Policy:** Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. If your insurance has not paid within 60 days, you (the patient) will be notified. Orders are for a custom product. Please make your selection carefully.
- **Minor Patients (under the after of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in **ADVANCE** and we must have parents or guardians written permission prior to treatment of a minor.
- **Returned Checks:** A $50.00 service charge will be applied to your account for returned checks. All returned checks will not be redeposited. All balances must be paid in cash or by credit card. One attempt will be made to collect this debt from the patient, if not collected within 5 days of the returned check; the account will be turned over to our collection agency. We request a copy of your driver's license for your records if you wish to make payments by check.
- **Spectacle Prescription:** If the patient wishes to take their eyeglass prescription elsewhere, Southwest Orlando Eye Care will not be responsible for any warranty on eyeglasses manufactured elsewhere. If you need to verify your prescription on lenses purchased elsewhere, our opticians can verify the prescription for $40. Your purchase comes with a 90-day warranty. If you are not satisfied with your purchase, we will work to make it right. Please note that because ophthalmic lenses are a custom product, a refund will not be issued. Any add-ons to the lenses after the lenses have been processed are not eligible for in-house or insurance discounts.
- **Contact Lens Patients:** Additional time and testing is required for the fitting and evaluation for contact lenses so there will be an additional professional fee charged outside of the comprehensive examination fee. Patients have 90 days of follow-up care from the date of the fitting to make any changes in the prescription necessary, any visit after 60 days, a fee will be incurred. A contact lens prescription is only valid one year from the exam date and cannot be filled once expired. Once contacts have been ordered and received by the patient, contact lenses cannot be returned. If the patient desires to take their contact lens prescription elsewhere, Southwest Orlando Eye Care will not be responsible for any warranty on their contact lenses, and all follow-up visits will be charged an additional professional fee.
- Eyeglass and contact lens prescriptions (when requested) are sent at the end of each business day. _____ ***(Initial)***
- **Please acknowledge that:**
    1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party in that contract.
    2. You are responsible for all charges that are denied/not covered by the insurance company. Not all services are covered under.
    3. Although we verify coverage through your insurance company with each patient, verification of benefits is not a guarantee of payment. You must present your insurance card for your records if insurance or any discount plans are being utilized. Only one insurance/discount plan is accepted, per patient, per service.
- **Patient Responsibility Agreement: (Please check one)**
    - ☐ I am receiving services from Southwest Orlando Eye Care through my insurance _____ _____. My insurance company has been contracted and my insurance coverage has been verified.
    - ☐ I am presenting no insurance coverage, and therefore I am financially responsible for all services rendered.
- I authorize release of any information concerning my healthcare and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the Optometrist, otherwise payable to me.
- I have read and understood the above. (Please sign below)

Signature _____ Date_____

Print Name _____

Notice of Privacy Practice

This notice describes how your health information may be used and disclosed. Please review it carefully.

- At Southwest Orlando Eye Care, we have always kept your health information secure and confidential.
- A law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the call.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all your health information when required by law.
- You may request in writing that we not use or disclose your health information as described above.
- As we will need to contact you from time to time, we will use whatever address, telephone numbers, or email address we have on file.
- You have the right to transfer copies of your health information to another practice.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request or sign a records request form regarding the information you are requesting.
- If we change the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at (407)271-8931.

Acknowledgement:
I have received a copy of the Southwest Orlando Eye Care Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

If signing as a parent or guardian, please print the name of the patient below:

_____

NO SHOW POLICY

Patient Name: _____ DOB: _____

Due to the high volume of no shows in the office, we have made some recent changes to our standard policies.

This policy has been updated to be fair to the patients that need an appointment and cannot be seen due to an already booked schedule. Our goal is to provide quality eye care in a timely manner. No shows and late cancellations inconvenience those individuals who need access to timely medical care. This policy enables us to better utilize available appointments for our patients in need of eye care.

Appointment confirmations are done the day before an appointment via text message, email, and/or a phone call from a staff member. This allows for us to reach all patients by at least one means of communication. If a patient is unable to keep the appointment or must reschedule, we need to be given notice more than 24 hours prior to the office visit. Failure to give this notice or to be present at the time of the scheduled appointment without a call cancelling, will result in a **$50 no show fee** added to your account. This fee will be the responsibility of the patient, not the insurance company.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours and in such instances, we will waive the fee upon management approval.

I have read and understand the **NO SHOW POLICY** listed above.

Patient/Parent/Guardian Name: _____

Patient/Parent/Guardian Signature: _____

Date: _____

Staff/Witness: _____ Date: _____

Southwest Orlando EyeCare
Your Vision Is Our Focus

Retinal Imaging

Retinal Imaging: These digital images provide your doctor with a closer look at the inner parts of your eye and help them take note of changes to your eye health and vision sooner. Photos of the back of your eye will show your retina, blood vessels, optic nerve, and macula. This quick and painless test will let your eye doctor detect certain eye or health issues and treat them early to prevent them from becoming severe. Retinal imaging is non-invasive and appropriate for all ages. Eye conditions such as diabetic retinopathy, glaucoma, age-related macular degeneration, and detached retina can be detected with retinal imaging. All our doctors require retinal imaging as part of the annual comprehensive eye exam to know exactly when and how your eyes are changing and if further treatment for any condition is needed. It is completed in a matter of seconds and provides instant results that will be reviewed with you by the doctor.

To help us provide a higher quality of care our providers now require all patients to have retinal imaging completed during their annual eye examination. The cost for this service is $39. In most cases, this advanced test is not covered by insurance, but our practice will bill the retinal imaging to your in-network insurance in any case where it is deemed medically necessary.
I understand that my optometrist requires retinal imaging as a component of my annual eye exam. I will pay the required $39 fee should this service not be covered by my in-network insurance.

_____ _____

Patient/Guardian Signature **Date**

Contact Lens Evaluations

Annual contact lens evaluations are not included in a routine eye exam and may not be covered by insurance. Payment will be required at the time of service for all contact lens evaluations. The fee for the annual evaluation is based on the complexity and type of fit. The usual and customary fee range is $105 to $245. Additional fitting visits will be covered at no charge for up to 90 days. Additional fees may apply.

- ○ I elect to have a contact lens evaluation and agree to pay the fee required. I consent to receive my contact lens prescription electronically.
- ○ I do not wish to have a contact lens evaluation and understand that my exam will not result in a prescription for contact lenses.

_____ _____

Patient/Guardian Signature **Date**