Welcome!

We want to extend our personal greetings and a very warm welcome to our practice. For 40 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.** If you do not bring your completed forms with you, you will be asked to fill them out again before being seen.

- Please arrive 15 minutes prior to your scheduled appointment time so that we may process your paperwork and scan your insurance cards.

- 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 wear **contact lenses** you will be scheduled for a *separate appointment for a contact lens evaluation*. Contact lens prescriptions will not be renewed during your complete exam with the physician.

- *Please be aware that we allow a 15 minute window for late arrivals. If you arrive beyond that window your appointment will have to be rescheduled to a later date***.**

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 of Lake Eye Associates

LAKE EYE ASSOCIATES

Account:

Patient Information		
Patient's Full Legal Name:		
Date of Birth:	**Age:**	**Gender:**
Social Security Number:	**Marital Status:** (please circle) Married • Widowed • Single • Other	
Preferred Language: (please circle) English • Spanish • Other	**Retired:** ☐ Yes ☐ No	**Employer:**
Race: (please circle) White • African American • American Indian Asian • Decline • Other	**Ethnicity:** (please circle) Not Hispanic or Latino • Latino • Decline • Other	
Driver's License Number:	**License State:**	
Patient Home Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	
Work Phone:	**Additional Contact:**	
Email:		
Spouse's Full Legal Name:		
Spouse's Phone Number:	**Spouse's Date of Birth:**	
Spouse's Social Security Number:		

If Patient is a Minor Please Complete		
Person Responsible or Guardian:		
Date of Birth:	**Social Security Number:**	
Phone Number (if different):		
Home Address (if different):		
City:	**State:**	**Zip Code:**

LAKE EYE ASSOCIATES

Emergency Contact Other than spouse		
Name:	**Relationship:**	**Phone Number:**

Medical Release Please indicate the names of those individuals with whom we may discuss your medical and non – medical information.	
Name:	
Relationship:	**___ Non – Medical ___ Medical**
Name:	
Relationship:	**___ Non – Medical ___ Medical**

Primary Insurance Information	
Insurance Carrier:	**Policy Holder:**
Social Security #:	**Date of Birth:**
Secondary Insurance Information	
Insurance Carrier:	**Policy Holder:**
Social Security #:	**Date of Birth:**
Vision Plan Information	
Insurance Carrier:	**Policy Holder:**
Social Security #:	**Date of Birth:**

Please provide the receptionist with your driver's license and insurance cards so a copy can be added to your file.

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE

___Family/Friend
___Internet
___Billboard
___Insurance Directory
___Referring Physician
___Seminar/Screening
___Newspaper/Publication
___Yellow Pages
___Workman's Comp
___Florida Hospital Waterman
___Leesburg Regional Medical Center
___Villages Regional Medical Center

Name of referring physician: _____

LAKE EYE ASSOCIATES

FINANCIAL POLICY

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 or most insurances. **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 United Healthcare M Plus *(with referral & authorization from PCP)* 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.**

No Show 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, Discover, American Express and Care Credit.

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

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 Notice of Privacy Policy and Financial Policy

I acknowledge that I have reviewed Lake Eye Associates Notice of Privacy Practices and Financial Policy. I understand that copies of these policies are available in all Lake Eye Associates locations, www.lakeeye.com and on my patient portal.

Signing below indicates that you acknowledge and authorize the notices and policies listed above;

_____ _____

PRINTED NAME OF PATIENT OR REPRESENTATIVE DATE

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Patient Portal

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you register for the Patient Portal you will be allowed the following:

- Ability to update your contact information
- Request appointments and cancellations
- Exchange results between staff and patient
- Request prescription refills
- View your medical summary, treatment history and visitation dates
- Receive reminders through your email

Online communications should never be used for life threatening emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or our office.

Reminders for Patient Portal:

- Your password is case sensitive.
- You will be receiving reminders via email. Please make security adjustments to your email to receive our emails.
- If you forget your password, you may request another by using the password reset option
- After you are finished accessing the Patient Portal be sure to logout and close your browser to reduce the risk of someone else accessing your private information.
- The portal is provided as a courtesy service for our patients. There is no service fee. If the patient abuses or misuses the Patient Portal, we reserve the right to terminate the patient's account.
- Our hours of operation are 9:00am - 5:00pm Monday-Friday. We encourage you to use the portal at any time; Please be aware that messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- The portal will be available to the parent or guardian if patient is under 18.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications. Secure messages and information can only be read by someone who knows the right password to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:
The secure message must reach the correct email address, therefore it is imperative that our practice has your correct email address on file and that you inform us of any changes. Only the correct individual, or someone authorized by that individual, must have access to the message. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly access the portal and change it.

Please initial if you are an established patient with Lake Eye Associates and have logged into the Patient Portal within the last 12 months _____

Patient Portal Acknowledgement and Agreement
I acknowledge that I have read and fully understand this consent form, regarding my Patient Portal. I understand the risks associated with online communications between my physician and myself.

Patient's Secure Email Address _____

_____ _____
Printed Name of Patient or Guardian Date of Birth

_____ _____
Signature of Patient or Guardian Date

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

LAKE eye ASSOCIATES

What problems are you having with your eyes? _____

Date of your **last** eye exam: _____ Referring Physician: _____

OCULAR HISTORY

Do you wear glasses? ☐ Yes ☐ No If yes, how old are your current glasses?_____

Do you wear contact lenses? ☐ Yes ☐ No If yes, hard or soft contact lenses? _____How many years?_____

Have you ever been diagnosed with any of the following? Please check all that apply.

☐ Cataracts
☐ Glaucoma
☐ Macular Hole
☐ Macular Degeneration
☐ Retinal Tear
☐ Retinal Detachment
☐ Corneal Problem
☐ Dry Eye Syndrome
☐ Strabismus (lazy/crossed eye)
☐ Diabetic Retinopathy
☐ Other_____
_____

Have you had any eye injuries? ☐ Yes ☐ No If yes, please explain. _____

_____

Have you had any surgeries, laser procedures or injections to the **eye**? ☐ Yes ☐ No If yes, please list below.

Eye Surgery/Procedure	Eye	Date	Surgeon

MEDICAL AND SURGICAL HISTORY

Please list any major medical conditions and injuries (diabetes, heart attack, cancer, etc.)_____

_____

Have you had any surgeries? ☐ Yes ☐ No If yes, please list below.

Surgery	Date	Surgery	Date

FAMILY HISTORY

Please indicate if any of your immediate family (**Mother**, **Father**, **Sibling**, **Grandparent**, **Child**) has ever been treated for any of the following. If yes, please list the relative's relationship to you. ☐ Adopted

	Relationship		Relationship
Blindness		Diabetes	
Cataract		Thyroid Disease	
Glaucoma		Heart Disease	
Macular Degeneration		Stroke	
Arthritis		Cancer	
Hypertension		Other	

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ Former ☐ Never If yes, how much? _____# of years_____

Do you drink alcohol? ☐ Yes ☐ Former ☐ Never If yes, how much?_____# of years_____

PHYSICIAN INFORMATION

Primary Physician: _____Phone Number: _____Fax Number: _____

Address: _____City: _____State: _____

ALLERGIES

Do you have an allergy to latex? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list the medication and reaction

Allergy	Reaction	Allergy	Reaction

MEDICATIONS

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list all medications (include dosage and frequency)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

REVIEW OF SYSTEMS

CONSTITUTIONAL
___Fatigue
___Malaise
___Chills
___Fever
___Night Sweats
___Appetite Changes
___Weight Changes
Other: _____

HEENT
___Head Injury ___Hay Fever
___Discharge ___Sinus Pain
___Decreased Hearing ___Stuffiness
___Dry Mouth ___Sore Throat
___Earache ___Tinnitus
___Dentures ___Vertigo
___Difficulty Swallowing
Other: _____

CARDIOVASCULAR
___Angina ___Thrombophlebitis
___Heart Attack ___Racing Pulse
___High Cholesterol
___High BP
___Low BP
___Murmur
___MVP
Other: _____

RESPIRATORY
___COPD ___Shortness of breath
___Wheezing
___Cough
___Hemoptysis
___Asthma
___Tuberculosis
Other:_____

GASTROINTESTINAL
___Diarrhea
___Constipation
___Stool Changes
___Hemorrhoids
___Indigestion
___Difficulty Swallowing
___Nausea/Vomiting
Other: _____

GENITOURINARY
___Blood ___Incontinence
___BPH ___Kidney Stones
___Difficult Urination
___Enlarged Prostate
___Increased Frequency
___Frequent UTI'S
Other: _____

DERMATOLOGICAL
___Rash
___Lump
___Itching
___Dryness
Other: _____

MUSCULOSKEKETAL
___Arthritis ___Leg Cramps
___Swelling ___Back Pain
___Stiffness ___Joint Pain
___Muscle Aches
Other: _____

PSYCHIATRIC
___Depression ___Panic Attack
___Nervousness
___Anxiety
___Memory Loss
Other: _____

ENDOCRINE
___Thyroid
___Nervousness
___Diabetes (Insulin Dependent)
___Diabetes (Non – Insulin Dependent)
___Hypoglycemia
___Goiter
___Hair Loss
___Hypothyroid
___Hyperthyroid
___Heat/Cold Intolerance
Other: _____

HEMATOLOGIC
___Ease of Bruising
___Excessive Bleeding
___Enlarged Lymph Nodes
___Anemia
Other: _____

NEUROLOGICAL
___Alzheimer's ___Parkinson's Disease
___Dizziness ___Paralysis
___Headaches ___Seizures
___Migraine ___Stroke
___Neuropathy ___TIA
___Tremors
Other: _____

IMMUNOLOGIC
___Lupus
___Rheumatoid Arthritis
___Fibromyalgia
___Multiple Sclerosis
___Crohn's
___AIDS
___HIV+
Other: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone Number: _____

Address: _____City: _____ State: _____

Patient Signature:_____