



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



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: <input type="checkbox"/> Yes <input type="checkbox"/> 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:



Emergency Contact

Other than spouse

Name:	Relationship:	Phone Number:
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Medical Release

Please indicate the names of those individuals with whom we may discuss your medical and non – medical information.

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

Primary Insurance Information

Insurance Carrier:	Policy Holder:
Policy #:	Date of Birth:

Secondary Insurance Information

Insurance Carrier:	Policy Holder:
Policy #:	Date of Birth:

Vision Plan Information

Insurance Carrier:	Policy Holder:
Policy #:	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

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

Name of referring physician: _____



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. Payments can be made online by going to www.LakeEye.com and clicking on **Pay Your Bill** on the top right of the page.

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.



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

Blindness	Relationship _____	Diabetes	Relationship _____
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

<p>CONSTITUTIONAL</p> <p>___ Fatigue ___ Malaise ___ Chills ___ Fever ___ Night Sweats ___ Appetite Changes ___ Weight Changes Other: _____</p> <p>HEENT</p> <p>___ Head Injury ___ Hay Fever ___ Discharge ___ Sinus Pain ___ Decreased Hearing ___ Stuffiness ___ Dry Mouth ___ Sore Throat ___ Earache ___ Tinnitus ___ Dentures ___ Vertigo ___ Difficulty Swallowing Other: _____</p> <p>CARDIOVASCULAR</p> <p>___ Angina ___ Thrombophlebitis ___ Heart Attack ___ Racing Pulse ___ High Cholesterol ___ High BP ___ Low BP ___ Murmur ___ MVP Other: _____</p> <p>RESPIRATORY</p> <p>___ COPD ___ Shortness of breath ___ Wheezing ___ Cough ___ Hemoptysis ___ Asthma ___ Tuberculosis Other: _____</p>	<p>GASTROINTESTINAL</p> <p>___ Diarrhea ___ Constipation ___ Stool Changes ___ Hemorrhoids ___ Indigestion ___ Difficulty Swallowing ___ Nausea/Vomiting Other: _____</p> <p>GENITOURINARY</p> <p>___ Blood ___ Incontinence ___ BPH ___ Kidney Stones ___ Difficult Urination ___ Enlarged Prostate ___ Increased Frequency ___ Frequent UTI'S Other: _____</p> <p>DERMATOLOGICAL</p> <p>___ Rash ___ Lump ___ Itching ___ Dryness Other: _____</p> <p>MUSCULOSKELETAL</p> <p>___ Arthritis ___ Leg Cramps ___ Swelling ___ Back Pain ___ Stiffness ___ Joint Pain ___ Muscle Aches Other: _____</p> <p>PSYCHIATRIC</p> <p>___ Depression ___ Panic Attack ___ Nervousness ___ Anxiety ___ Memory Loss Other: _____</p>	<p>ENDOCRINE</p> <p>___ Thyroid ___ Nervousness ___ Diabetes (Insulin Dependent) ___ Diabetes (Non – Insulin Dependent) ___ Hypoglycemia ___ Goiter ___ Hair Loss ___ Hypothyroid ___ Hyperthyroid ___ Heat/Cold Intolerance Other: _____</p> <p>HEMATOLOGIC</p> <p>___ Ease of Bruising ___ Excessive Bleeding ___ Enlarged Lymph Nodes ___ Anemia Other: _____</p> <p>NEUROLOGICAL</p> <p>___ Alzheimer's ___ Parkinson's Disease ___ Dizziness ___ Paralysis ___ Headaches ___ Seizures ___ Migraine ___ Stroke ___ Neuropathy ___ TIA ___ Tremors Other: _____</p> <p>IMMUNOLOGIC</p> <p>___ Lupus ___ Rheumatoid Arthritis ___ Fibromyalgia ___ Multiple Sclerosis ___ Crohn's ___ AIDS ___ HIV+ Other: _____</p>
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PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone Number: _____
 Address: _____ City: _____ State: _____

Patient Signature: _____



Mark Vocci, M.D.

Scott Wehrly, M.D.

Shelby Terpstra, D.O

Scot Holman, M.D.

Vinay Gutti, M.D.

Dry Eye Questionnaire

Dry Eye Disease is one of the most commonly treated ocular conditions. In order to evaluate and decide the best course of treatment for you, we ask that you complete this questionnaire.

Name: Date of Birth: Age: Date:

1. Questions about EYE DISCOMFORT:

a. During a typical day in the past month, how often did your eyes feel discomfort?

Table with 5 columns: Never, Rarely, Sometimes, Frequently, Constantly. Each column has a checkbox and a number in parentheses (0-4).

b. When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

Table with 6 columns: Never, Not intense at all, Very intense. Each column has a checkbox and a number in parentheses (0-5).

2. Questions about EYE DRYNESS:

a. During a typical day in the past month, how often did your eyes feel dry?

Table with 5 columns: Never, Rarely, Sometimes, Frequently, Constantly. Each column has a checkbox and a number in parentheses (0-4).

b. When your eyes felt dry, how intense was this feeling of dryness at the end of the day, within two hours of going to bed?

Table with 6 columns: Never, Not intense at all, Very intense. Each column has a checkbox and a number in parentheses (0-5).

3. Questions about WATERY EYES:

During a typical day in the past month, how often did your eyes look or feel excessively watery?

Table with 5 columns: Never, Rarely, Sometimes, Frequently, Constantly. Each column has a checkbox and a number in parentheses (0-4).

4. Do you use eye drops for lubrication? Yes No If yes, how often? _____



5. Which brand of artificial tears do you use? _____ Are they preservative free? Yes No
6. How long have you been treated for dry eye disease? Never More than one year Less than one year
7. Do you feel your dry eye is chronic? Yes No Rate the severity of your dry eye on a scale of 1-10: _____
8. Have you or a family member ever been treated for an autoimmune disease? Yes No
9. Report any of the following allergy symptoms: itchy eyes red eyes watery eyes swollen eyes
 congestion runny nose itchy skin asthma
 flakey, red skin dark circles under eyes
10. What would you like to see improve with your dry eyes? _____

Questionnaire score: _____

1a	1b	2a	2b	3	Total

OD: _____ mOSM/L
OS: _____ mOSM/L

A score of 7 or greater indicated order for osmolarity testing