Vision Specialists of Central Florida
1495 W. State Rd 434
Longwood, FL 32750
Phone: 407-332-8255
Fax: 407-332-5769

Last Name: _____ First Name: _____ MI _____

Address: _____ City_____ State: _____ Zip: _____

Phone Home: _____ Cell: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Gender: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Primary Language: □ English □ Spanish

Race/Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino
□ Native Hawaiian or other Pacific Islander □ White □ Other

Email Address: _____

Communication Preference: Email Postal Telephone: Texting □ Yes □ No

If patient is a minor, Responsible party

Name: _____ Relationship_____ Phone: _____

Primary Medical Insurance: _____

Policy Holder's Name: _____ DOB: _____

Member ID# _____ Relationship to Policy Holder: _____

Secondary Medical Insurance: _____

Policy Holder's Name: _____ DOB: _____

Member ID# _____ Relationship to Policy Holder: _____

Vision Insurance: _____

Policy Holder's Name: _____ DOB: _____

SS# _____-_____-_____ Relationship to Policy Holder: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Address: _____

Medical Eye History

Patients name: _____ Date: _____

Date of last eye exam: _____/_____/_____ By Dr. _____

Have you ever worn glasses? [ ] Yes [ ] No How are they used? [ ] Distance [ ] Near [ ] Constant

Do you wear contact lenses now? [ ] Yes [ ] No
Type worn? [ ] Daily Wear [ ] Disposable [ ] Extended Wear [ ] Astigmatism [ ] Gas Permeable

Are you interested in contact lenses? [ ] Yes [ ] No

What is the reason for your visit today? (Please check all that apply.)

___ General Check-Up
___ Lost or Broken Glasses
___ Blurred Distance Vision
___ Blurred Near Vision
___ Poor Night Vision
___ Other (explain)

___ Problem with Present Contacts
___ Eyes Burn or Itch
___ Pain in the Eyes
___ Flashes of Light
___ Spots or Floaters

___ Headaches
___ Double Vision
___ Lazy Eye
___ Crossed Eye
___ Color Vision Problems

_____

_____

Do you or any family member have . . .

	SELF	FAMILY
Glaucoma.....	[ ] Yes [ ] No	[ ] Yes [ ] No
Cataracts.....	[ ] Yes [ ] No	[ ] Yes [ ] No
Diabetes.....	[ ] Yes [ ] No	[ ] Yes [ ] No
Migraine Headaches.....	[ ] Yes [ ] No	[ ] Yes [ ] No
Retinal Detachments.....	[ ] Yes [ ] No	[ ] Yes [ ] No
High Blood Pressure.....	[ ] Yes [ ] No	[ ] Yes [ ] No
Heart Trouble.....	[ ] Yes [ ] No	[ ] Yes [ ] No
Kidney Trouble.....	[ ] Yes [ ] No	[ ] Yes [ ] No

Other Illnesses or Surgeries: _____

_____

Do you have any problems with any of these systems? (Please circle)

Cardiovascular Endocrine (Glands) Allergic/Immune Ear/Nose/Throat
Respiratory Blood/Lymph Gastrointestinal Musculoskeletal
Nervous Mental Genitourinary Integument (Skin)

Do you use any of the following: (Please circle) Cigarettes/Tobacco Alcohol Social Drugs

Have you had any eye surgery, eye injury or eye infections? If so, list the type and date:

_____

_____

_____

Are you allergic to any medications? [ ] Yes [ ] No

If so, please list:

_____

Please list all medications you are currently taking:

_____

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About your Insurance/Financial Policies

INSURANCE

There are two types of insurances that will help pay for your eye care services and products. You may have both and our practice accepts both, vision care plans (such as VSP and EyeMed) and medical insurance (such as Blue Cross/Blue Shield and Medicare).
Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye diseases. Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICE IS RENDERED

We accept cash, personal checks, Care Credit, MasterCard, Visa, Amex, and Discover. Returned checks are subject to a service charge of $35.00 or 10% of the face value of check, whichever is greater, and you lose your privilege to write check in our office.

INSURANCE POLICY

It is your responsibility to update any changes in insurance policies. Failure to do so will proceed to a denial and we will not refile, making you responsible for any leftover balance. We will file supplemental insurances. If we are participating with your HMO plan, we will file your insurance claim. You are responsible for all applicable copays, due at the time of service.

CANCELLED APPOINTMENTS

No show/no call appointments and cancelations less than 24 hours before your appointment will be charged **$65.00**, and you may be discharged from the practice after the third no show.

CHILDREN OF DIVORCED PARENTS

Payment is due at the time of service, no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT

Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover (for example, refraction)

REFRACTION

What is refraction? Refraction is the portion of your eye exam where your prescription is determined for glasses and/or contact lenses. A phoropter is put in front of your eyes and the technician or doctor will ask you which image looks better "one or two".
Is it necessary? YES. If you are referred for a cataract evaluation, considering a change in glasses/ contact lens, or to properly diagnose and give you a prescription.
Why is it separate from my normal exam? Several years ago, in an effort to trim costs, Medicare decided glasses did not fall under the window of health. Most insurance companies followed Medicare's leads.
What is the cost? Our practice charges **$50.00** for the refraction. Contact lens fitting or adjustment is a separate fee which is not covered by your medical insurance and not included in the refraction fee.
Who pays? The patient is responsible at the time of service for the refraction fee. This fee is applicable even if your new prescription has not changed from your current prescription.

We must emphasize that as your medical providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED**. Unpaid accounts over 30 days are subject to a $10.00 late fee each month the balance remains unpaid. Any balance on accounts 90 days or more, including those that insurance has not paid, collection action will be taken. If it becomes necessary to collect any sum due through an attorney, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. I hereby authorize said assignee to release all information necessary to secure payments for medical services rendered to myself or dependents. Should my insurance deny payment, I acknowledge and understand that I am responsible for all of the services rendered to me or any member of my family. I have been notified that some services may be considered not medically necessary or non-covered. I acknowledge and accept liability for payment of these services. I have read and agree the above policies.

_____
Patient Name

_____
Signature

_____
Date

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HIPPA/ Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood Vision Specialists of Central Florida's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice.

Information Release:

Please list the individuals with whom we may discuss details of your medical care. Please give full name, relationship, and list any information you do not want shared:

_____

_____

_____

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____