

PERSONAL INFORMATION SHEET



Today's Date: _____

Patient's Full Legal Name: _____

Age: _____ Date of Birth: _____ Sex: _____ Number of Children: _____

Marital Status: Married Single Divorced Widow Separated

Patient's Address: _____

City _____ State _____ Zip _____

Patient's Phone Number: Home () _____ Work () _____

Cell () _____

Patient's Social Security Number: _____

If Married, Spouse's Name: _____ Phone Number: () _____

If a minor, Person responsible, or Guardian: _____

Address: _____

City _____ State _____ Zip _____

Phone Number: Home () _____ Work () _____

Cell () _____

Nearest Relative Not Living With You: _____ Phone Number: () _____

Family Physician's Name: _____ Phone Number: () _____

Address: _____ City _____ State _____ Zip _____

*** Reason for Your Visit: _____

Patient's Occupation: _____

Employer's Name: _____

Employer's Address: _____ City _____ State _____ Zip _____

If Workman's Comp. Carrier: _____

Address: _____ City _____ State _____ Zip _____

Contact Person: _____ Phone Number: () _____

Tell us how you heard about us.

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

continued on reverse.....

PATIENT MEDICAL HISTORY

NAME: _____

DATE: _____

What problems are you having with your eyes? _____

Date of **last** eye exam? _____ How old are your current glasses? _____

Have you ever been treated for any eye disease or injury? ___ Yes ___ No *(if yes, please give date and description)*

List all **past major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries**:

List any **surgeries** you have had (including dates): _____

Please list any **medications** you currently take:

Are you **allergic** to any medications? ___ Yes ___ No *(if yes, list the medication)* _____

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

REVIEW OF SYSTEMS	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
CARDIOVASCULAR (blood pressure, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful or frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY AND SOCIAL HISTORY

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

___ Blindness _____	___ Hypertension _____	___ Thyroid Disease _____
___ Cataract _____	___ Heart Disease _____	___ Arthritis _____
___ Glaucoma _____	___ Stroke _____	___ Other heritable disease _____
___ Diabetes _____	___ Cancer _____	

Do you drink alcohol? Yes No If YES, how much? _____ How many years? _____

Do you smoke? Yes No If YES, how much? _____ How many years? _____

Physician's Signature: _____

Date: _____

LAKE EYE

A S S O C I A T E S

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 Ave., Suite 201, Leesburg, FL 34748 (352) 365-2020 fax (352) 728-3322
Villages – 1400 Us Hwy 441 N, Suite 521, Lady Lake, FL 32159 (352) 750-2020 fax (352) 753-0064

LAKE EYE ASSOCIATES

Notice of Privacy Practices

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 you may use to pay for services. For example, your health plan may request and receive information on dates of 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 prompt quality to ensure that our practice is meeting state and federal guidelines and laws designated to protect your healthcare 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 listed above requires your specific 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 the 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 interest 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 practices. We are also required to abide by the privacy policies as 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 revisions, we will provide you with 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 Administrator.

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
(352) 343-2020***

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



Patient #: _____

I, _____, acknowledge that I have received a copy of
Print Patient Name
Lake Eye Associate's Medical Record Privacy Policy and Financial Policy.

Patient Signature

Date

Occasionally, 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LAKE EYE ASSOCIATES

Financial Policy

MEDICARE PATIENTS

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

MEDICAID

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

INSURANCE

We are participating providers for BCBS of Florida/Health Options, 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.**

COPAYS & DEDUCTIBLES

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

AUTHORIZATIONS & REFERRALS

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

VISION PLANS

Currently, VSP and EyeMed Access Plan are the only routine vision plans we accept. You must notify the front desk **prior** to being seen 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 at (352) 589-4755.

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 CHECK

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. 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 PAYMENT METHODS

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