LAKE EYE ASSOCIATES

A US EYE COMPANY

Patient Name: _____

DOB: _____

Person Number: _____

# Patient Demographics

## Patient Information

Date:

First Name: MI: Last Name:

Gender: ☐ Female ☐ Male DOB: SSN:

Address: City: State: Zip:

Home Phone: ( ) - ☐ Primary Mobile Phone: ( ) - ☐ Primary

Work Phone: ( ) - ☐ Primary Other Phone: ( ) - ☐ Primary

Email: *Providing an email address will allow for access to the patient portal.

Which method do you prefer to receive appointment reminders? ☐ Text ☐ Email

Is it ok for members of Lake Eye staff to leave messages? ☐ Yes ☐ No

## Responsible Party Information (Guardian/Guarantor)

First Name: Last Name: Phone: ( ) -

Address: ☐ Same as patient City: State: Zip:

## Physician/Referral Information

How did you hear about us?

☐ Billboard/Building Signage ☐ Magazine ☐ Physician Referral ☐ Television

☐ Event ☐ Newspaper ☐ Radio ☐ Website

☐ Friend/Family Referral ☐ Online Review ☐ Self

☐ Google/Online Search ☐ Other ☐ Social Media

Referring Physician: City/State:

## Demographic Information

Race: ☐ Black/African American ☐ Asian ☐ White

☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Decline to provide

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic/Latino ☐ Decline to state

Marital Status: ☐ Married ☐ Single ☐ Other Language: ☐ English ☐ Spanish ☐ Other _____

## Emergency Contact

First Name: Last Name: Relationship:

Phone 1: ( ) - Phone 2: ( ) - Allowed to talk about: ☐ Medical ☐ Non-Medical

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# Patient Demographics

## Insurance Information

Please provide the front desk staff with your identification and insurance cards.

**Primary** Insurance: Policy Number:

Policy Holder Name: Relationship: ☐ Spouse ☐ Other ☐ Child

Policy Holder Address: ☐ Same as patient Zip:

Phone: ( ) - DOB: Gender: ☐ Female ☐ Male

**Secondary** Insurance: Policy Number:

Policy Holder Name: Relationship: ☐ Spouse ☐ Other ☐ Child

Policy Holder Address: ☐ Same as patient Zip:

Phone: ( ) - DOB: Gender: ☐ Female ☐ Male

**Vision** Insurance: Policy Number:

Policy Holder Name: Relationship: ☐ Spouse ☐ Other ☐ Child

Policy Holder Address: ☐ Same as patient Zip:

Phone: ( ) - DOB: Gender: ☐ Female ☐ Male

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# Medical History

## Ocular History

What problems are you having with your eyes? _____

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

Do you wear contact lenses? ☐ Yes ☐ No If yes, ☐ Hard Lenses ☐ Soft Lenses x _____ years

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

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

List any eye surgeries, procedure or injuries ☐ None

| **Eye** Surgery/Procedure/Injury | Eye | Date | Surgeon |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Medical History

List any major medical conditions or injuries (i.e. diabetes, heart attack, cancer, etc.) ☐ None

## Surgical History

☐ None

| Surgery | Date | Surgery | Date |
|---|---|---|---|
| | | | |
| | | | |

## Allergies

List any allergies to medications ☐ None

| Allergen | Reaction | Allergen | Reaction |
|---|---|---|---|
| | | | |
| | | | |

## Medications

List all medications, including vitamins and supplements that you are currently taking ☐ None

| Medication Name | Dosage | Frequency | Medication Name | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Family History

Has any person, related by blood had any of the following: ☐ Adopted

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

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Person Number: _____

# Medical History

## Social History

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

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

Have you fallen 2 or more times or 1 time with injury in the past year? ☐ Yes ☐ No

## Review of Systems

### Cardiovascular ☐ Negative

☐ Chest Pain
☐ Heart Attack
☐ Heart Disease
☐ Hypertension
☐ Heart Attack
☐ Hypercholesterolemia
☐ Irregular Heart Beat
☐ Racing Pulse

Other:_____

### Constitutional ☐ Negative

☐ Appetite Changes
☐ Chills
☐ Fatigue
☐ Feeling Sick
☐ Fever
☐ Night Sweats
☐ Weight Loss
☐ Weight Gain

Other:_____

### Endocrine ☐ Negative

☐ Cold Intolerance
☐ Excess Thirst
☐ Heat Intolerance
☐ Hair Loss
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Pre-Diabetes
☐ Low Blood Sugar
☐ Thyroid Disease

Other:_____

### Gastrointestinal ☐ Negative

☐ Abdominal Pain
☐ Constipation
☐ Diarrhea
☐ Digestive Disease
☐ Nausea
☐ Upset Stomach
☐ Vomiting

Other:_____

### Genitourinary ☐ Negative

☐ Blood in Urine
☐ Difficulty with Urination
☐ Frequent Urination
☐ Frequent Infections
☐ Incontinence
☐ Kidney Disease
☐ Kidney Stones
☐ Prostatitis

Other:_____

### Hematology ☐ Negative

☐ Anemia
☐ Blood Clots
☐ Easy Bruising
☐ Excessive Bleeding
☐ Sickle Cell
☐ Swollen Lymph Nodes

Other:_____

### HENT ☐ Negative

☐ Difficulty Swallowing
☐ Dry Mouth
☐ Ear Ache
☐ Hay Fever
☐ Hearing Loss
☐ Ringing in Ears
☐ Sinus Pain

Other:_____

### Integumentary ☐ Negative

☐ Dry Skin
☐ Eczema
☐ Itching
☐ Psoriasis
☐ Rash
☐ Rosacea
☐ Skin Cancer

Other:_____

### Musculoskeletal ☐ Negative

☐ Arthritis
☐ Back Pain
☐ Cramps
☐ Joint Pain
☐ Muscle Aches
☐ Muscle Stiffness
☐ Muscle Weakness
☐ Painful or Swollen Joints

Other:_____

### Neurological ☐ Negative

☐ Alzheimer's
☐ Dementia
☐ Dizziness
☐ Headaches
☐ Memory Loss
☐ Numbness or Tingling in Body
☐ Seizures or Convulsions
☐ Stroke
☐ TIA
☐ Tremor

Other:_____

### Psychiatric ☐ Negative

☐ ADD
☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Depression
☐ Mood Swings

Other:_____

### Respiratory ☐ Negative

☐ Asthma
☐ COPD
☐ CPAP
☐ Cough
☐ Wheezing
☐ Shortness of Breath
☐ Sleep Apnea

Other:_____

## Primary Care Physician Information

Primary Care Physician: _____ City/State: _____

## Pharmacy Information

Preferred Pharmacy: _____ Phone Number: _____

Address: _____ City: _____ State: _____

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# Financial Agreement and Assignment of Benefits

Lake Eye Associates (LEA) are privately-owned medical facilities that provide medical services on a fee-for-service basis. LEA relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. LEA receives no federal, state or other third-party funding; as such, LEA does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

For the convenience of our patients, LEA participates with most medical insurance companies and vision plans. LEA will submit claims for all medically necessary services to your insurance company. Please note that payment is ultimately due from you if your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, non-participating status, etc. If we do not participate with your medical or vision insurance(s), we will provide you with an itemized receipt so that you may file with your insurance company for any out-of-network benefits to which you may be entitled.

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore, coinsurance percentages cannot always be accurately calculated for pre-payment. A LEA statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

***Please note that LEA medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.***

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom LEA will seek reimbursement for medical services, prohibit the routine discounting of published fees, "insurance-only billing" or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) LEA and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e., cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc.), LEA accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

LEA does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

LEA is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

For your convenience, LEA accepts cash, check, money order and credit cards. In addition, LEA offers financing options through third party vendors.

**I understand all the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Lake Eye Associates. I hereby authorize the provider and its employees, agents, and assignees, to contact me via e-mail, text message and to my cellular device.**

**I hereby assign all medical / surgical benefits to Lake Eye Associates, for services rendered to me by the medical providers contracted under Lake Eye Associates and request that payment of authorized benefits be made to assignee on my behalf. I authorize release of any medical information as may be required by Medicare and / or my other health insurance company to determine my benefits and issue payment to assignee for related medical claims.**

**My signature below constitutes my Financial Agreement, Assignment of Benefits, and Lifetime Signature Authorization.**

| **Patient Name Printed** | **Patient / POA Signature** | **Date** |
|---|---|---|

***Failure to honor your financial obligations to LEA in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care.***

LAKE eye ASSOCIATES

A US EYE COMPANY

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# Refraction Policy

**WHAT IS A REFRACTION?**

It is important to understand that the refraction is an essential part of your comprehensive eye examination. A refraction is a diagnostic test that allows the doctor to determine if your eyes are working together correctly, what your best possible vision is, and if the cause of your blurry vision is due to a need for glasses or other ocular condition. A refraction is necessary to provide an accurate glasses/contact lens prescription. Additionally, it is necessary for insurance to determine if you qualify for certain procedures such as cataract surgery.

**HOW MUCH IS THE REFRACTION?**

Despite the importance of this test, refraction (CPT code 92015) is deemed a non-covered service by Medicare and most private insurances. Since it is a non-covered service, we are required to charge you for this service. **The fee for a refraction is $65.00 and is due at the time of service in addition to any co-payment your plan may require.** Should your plan pay us for the refraction, we will reimburse you accordingly.

**WHAT IS OUR POLICY?**

In order to provide the very best eye care, our policy is to perform a refraction for all new patient and annual comprehensive exams, anytime vision significantly decreases and before cataract surgery. You do have the option to decline this service. Please notify the technician/physician **PRIOR** to the exam if you do not want this service. **It is important to understand that if you decline, we may not be able to determine the cause for your decrease in vision and you will not receive a glasses prescription.**

**The refraction fee is due and payable whether or not you receive a written glasses prescription.** Sometimes an underlying condition can produce an unreliable prescription or the change in vision is not significant enough to warrant the cost of purchasing new glasses. However, the fee covers the doctor's and technician's time and effort in achieving this process.

I have read the refraction policy and understand that the refraction is a **non-covered** service. I accept full financial responsibility for the cost of this service in addition to any co-payments or deductible.

Patient Signature: _____ Date: _____

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Person Number: _____

# HIPAA Acknowledgement and Authorization

**Consent to Use and Disclose PHI & Acknowledgement of Receipt of Notice of Privacy Practices:**

General consent to use and disclose personal health information to carry out treatment, payment for treatment and health care operations.

With my signature below, I give LEA permission to disclose my personal health information as necessary to carry out treatment, obtain payment for treatment provided to me and to carry out its health care operations.

A complete description of how LEA will use and disclose my personal health care information can be found in its Notice of Privacy Practices which has been made available to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices may be revised at any time by LEA and that I may view changes to the Notice of Privacy Practices at their website at www.LakeEye.com or by requesting a printed copy of revision from the Compliance department in writing. I hereby acknowledge that I have received, and have had the opportunity to ask questions regarding, a copy of the LEA Notice of Privacy Practices.

I have the right to request restrictions regarding how my personal health information is used or disclosed in the course of carrying out treatment, obtaining payment for treatment provided to me and carrying out health care operations. I may request restrictions by filling out the appropriate form which will be provided to me upon request. LEA is under no obligation to implement any of the restrictions that I may request but will be bound by any restrictions that it agrees to implement.

I understand that I may revoke this consent at any time notifying LEA in writing, except to the extent that action has been take in reliance on it.

Patient's Legal Representative/Patient's Signature: _____ Date: _____

If signed by Representative, state relationship to patient: _____

**Authorization to Release Protected Health Information (PHI):**

I hereby authorize LEA to release my PHI to the following person(s) and understand that I may revoke this authorization in writing at any time. I understand that such disclosures may include, but not be limited to, discussing my medical condition(s) and treatment(s) with individuals that accompany me to my appointments and / or are responsible for my care-giving, leaving voice mail messages regarding appointments and / or balances due on my account, and any emergency situation which may arise in the course of my care.

| Name of Authorized Person | Relationship | Daytime Phone Number |
|---|---|---|
| | | |

| Name of Authorized Person | Relationship | Daytime Phone Number |
|---|---|---|
| | | |

Patient's Legal Representative/Patient's Signature: _____ Date: _____

If signed by Representative, state relationship to patient: _____

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**Documentation of Good Faith Efforts (To be completed if patient unable or unwilling to sign above):**

On this day, patient presented for treatment and was provided a copy of the LEA's Notice of Privacy Practices. Although a good faith attempt was made to obtain a written Acknowledgement of Receipt and Authorization to Release, signatures were not obtained because:

_____ Patient / Legal Representative refused

_____ Patient / Legal Representative unable due to medical disability

_____ Emergency medical condition required immediate attention (signature to be obtained at next appointment)

Printed Name of LEA Employee: _____

Signature of LEA Employee: _____ Date: _____