DVANCED Eye Care Center

PORT ST LUCIE
2710 SW PORT ST LUCIE BLVD
PORT ST LUCIE , FL 34953
T: 772.878.1414
F: 772.878.0118

FORT PIERCE
4976 S 25TH ST
FORT PIERCE, FL 34981
T: 772.460.8487
F: 772.460.0225

Welcome to our Office

Name:_____ **Date of Birth:**____/_____/_____
(Last, First, Middle Initial) *(Month, Day, Year)*

Address:_____
(Street, City, State, Zip Code)

Preferred Language:_____ **Sex**:_____ **Weight**:_____ **Height**:_____

Cell Phone:_____ **Home/Alternate Phone**:_____

Email:_____ **Occupation**: _____

Date of Last Eye Exam: _____ **By Whom?**: _____

Primary Care Physician:_____

Reason for today's exam:_____

Primary Insurance Name and ID#_____

Secondary Insurance _____

Consent To Treat Minor Children

I, _____, parent or legal guardian of _____, born_____, do hereby consent to any medical care and the administration of anesthesia (eye drops) determined by a physician to be necessary for the welfare of my child. This authorization is effective from the date of signature until revoked in writing.

_____ _____

Patient/Legal Guardian Signature **Date**

Information Regarding Dilating Drops

Dilating eye drops are used to enlarge the pupils of the eyes to allow your doctor to examine the inside of your eye. Dilating drops may cause blurred vision and make bright lights bothersome. You may elect to defer dilation and schedule to a later date.

By signing below, I hereby authorize the physicians and/ or assistants as designated by the providers, to administer dilating drops when deemed necessary to examine my eyes

_____ _____

Patient/Legal Guardian Signature **Date**

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Alternative Contact/Preferred Method of Communication Form

Patient Name_____

We take your medical confidentiality very seriously. We will not and cannot release information without your written authorization. This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____I do **NOT** authorize anyone to receive information regarding my medical care.

_____I authorize my physician and the employees of this clinic to speak with:

1. _____ (Name), my **_____(Relationship to patient),** their phone number is: **_____,** regarding my:

_____ **MEDICAL CARE AND TREATMENT** (including Test Results)
_____ **APPOINTMENTS AND ACCOUNT/BILL**

2. _____ (Name), my **_____(Relationship to patient),** their phone number is: **_____,** regarding my:

_____**MEDICAL CARE AND TREATMENT** (including Test Results)
_____**APPOINTMENTS AND ACCOUNT/BILL**

Electronic Communication Consent ___ **Yes** ___ **No**

In order to electronically communicate with you or anyone you designate, we are required to have your written permission. Communication may be in the following forms: Home Phone/Answering Machine, Cell Phone: Voicemail, Cell Phone Text-Messaging, E-mail, Mail, or Work Phone.

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.
I agree that should I desire to revoke this authorization, I will give written notice.

_____ _____
Patient/Legal Guardian Signature **Date**

Health Insurance Portability and Accountability Act (HIPAA)

Advanced Eye Care Center is committed to being responsible stewards of our patients' protected health information. By signing this form, I consent to the use or disclosure of my protected health information by Advanced Eye Care Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of Advanced Eye Care Center. A Copy of the HIPPAct can be obtained through inquiry at reception.

_____ _____
Patient/Legal Guardian Signature **Date**

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Assignment of Benefits and Lifetime Authorization

I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Advanced Eye Care Center. I request the payment of authorized Medicare, Medicaid or other commercial insurance benefits be made on my behalf to Advanced Eye Care Center for services provided to me by Advanced Eye Care Center. I authorize any holder of medical information about me to release to my insurance company or the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agreed to accept the charge determination of the Medicare contractor.

I also request that the payment of any authorized secondary insurance made on my behalf to Advanced Eye Care Center or any physician of that group, for services provided to me. I authorize any holder of medical information about me to release to my medigap insurer or other commercial payer (where applicable) and any information needed to determine these benefits payable for related services. **I understand I am responsible for any deductible, copay, coinsurance and or any non-covered procedures.**

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Financial Agreement and Assignment of Benefits

We are delighted that you have chosen Advanced Eye Care Center. Your understanding of our financial policies is important to our relationship. If you have questions or concerns about any of the information below please discuss this with our team.

Insurance

Advanced Eye Care Center participates with Medicare and most major medical insurance companies. As a courtesy to you, we will submit all medically necessary services to your insurance company. If we do not participate in your network, you will be responsible for a larger portion, or possibly the entire bill. The insurance company makes the final determination of your eligibility and benefits. You will be responsible for any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance company pays you directly, you are responsible for payment.

Co-Pays, Co-Insurance and Deductibles

We expect our patients to present a current insurance card at each visit. All copayments, co-insurance and previous balances are due at the time services are rendered, unless otherwise arranged. We accept cash, check, Visa, MasterCard, Discover, and we also have financing options available.

Referrals and Pre-Authorizations

If your insurance company requires a referral and/ or preauthorization, we will do our best to obtain it for you. You are responsible for making sure that the referral and/or preauthorization is obtained. Failure to obtain it may result in significantly lower payment from the insurance company, and the remaining balance will be your responsibility.

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Self-Pay Accounts

- Patients without insurance coverage
- Patients covered by insurance plans in which Advanced Eye Care Center does not participate
- Patient without an insurance card on file with us.

It is your responsibility to know if our office participates in your plan. We require self pay patients to pay for services rendered at the time of the appointment please let us know if you have questions period we are here to help you!

Refraction Service Fees *(*Note: If you are using your routine vision insurance this does not apply.*)*

To determine the need for corrective lenses the examiner will complete the refraction portion of your exam. This is an important part of your eye examination and must be done in order to write any eyewear prescription. The refraction will be routinely performed on a yearly basis.

Medicare and **most medical insurances** will **not** cover the routine refraction portion of your exam. We are required by Medicare to charge separately for the refraction as it is a non-covered service.

*****You have the right to refuse the refraction portion of your examination but keep in mind that we will not will not be able to write you a current prescription without completing the refraction. *****

The refraction fee is **$50.00*** and we will collect this fee at the end of your office visit along with any other non-covered services or co-payments according to your insurance plan.

Patient acknowledgement

I have read the above information concerning the refraction, and understand that it is a non-covered routine vision service. I accept financial responsibility for the $50.00 charge and acknowledge it is due the day of the visit along with any copayment, deductible, or coinsurance there may be separate from and not part of the refraction fee.

_____ _____

Patient/Legal Guardian Signature **Date**

Please use this space for any additional information

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COMPLETE MEDICAL HISTORY

1. Do you wear glasses? Y N If so how long? _____
2. Do you wear contact lenses? Y N If so, which brand? _____
3. Do you drink? Y N If so how much? _____
4. Do you smoke? Y N If so how much? _____
5. Do you experience headaches? Y N If so how frequently? _____
6. Do you work in front of a screen for more than 5 hours a day? Y N
7. Do you work outside for more than 2 hours a day? Y N

Do you, or any of your immediate family members have/had the following?:

Blindness _____ Eye Surgery_____

Cataracts_____ Degenerative Myopia_____

Corneal Diseases_____ Retinitis Pigmentosa_____

Glaucoma_____ Usher Syndrome_____

Macular Degeneration _____ Retinal Disease_____

Thyroid Disease_____ Cancer _____

Immune Deficiency _____ Chronic Inflammation_____

Blood Disorders _____ Arthritis_____

Sjögren's syndrome_____ Psychiatric Disorders _____

Diabetes (include type) _____ If "self" What was your last A1C? _____

High Blood Pressure_____ High Cholesterol _____

Please list any allergies _____

What Medications are you currently taking, and how much?:

Please use this space for any additional information, medical history, surgeries or pertinent information:

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