InFocus Family Eyecare

Patient Information

First Name _____ MI _____

Last Name_____

Street _____

City_____State_____

Zip code_____

Email Address _____

Cell Phone _____

Home Phone_____

Preferred Contact: Email / Cell / Home/ Work

Date of Birth ____/____/____ Age ____

Sex M F

Patient's SSN_____

Employer (or School) _____

Occupation (or Grade) _____

Spouse/Parent/Partner _____

What is the major purpose of this visit?

_____

_____

NEW PATIENTS ONLY!!!!

Who may we thank for referring you to our office?
Name of friend or relative

If not referred, how did you hear about our office?

- Doctor
- Insurance List
- Sign/ Building
- Magazine/ Newspaper
- Hometown News
- Website
- Other

Insurance Information

Primary Medical Insurance

_____

Subscriber Name _____

Secondary Medical Insurance

_____

Subscriber Name _____

Vision Insurance _____

Subscriber Name _____

Lifestyle Questions

Do you…. (Check if your answer is "YES")

__ work at a computer?
__ have interest in contact lenses?
__ spend time outdoors? ____ hours per week
__ have prescription sun wear?
__ prefer not to wear glasses at times
__ want info on Laser Vision Correction?
__ have more than 1 pair of current RX eyewear?

Date of Last Eye Exam_____

By Whom? _____

Have you ever tried Contacts? __ **Y** __ **N**

Do you currently wear Contact Lenses? __ **Y** __ **N**

What Brand? _____

Are you satisfied with the vision & comfort of your contact lenses? __ **Y** __ **N**

Do you sleep in your contacts? __**Y** __ **N**

Are you satisfied with your current bifocal/ progressive lenses? __ **Y** __ **N**

Have you used transition lenses? __ **Y** __ **N**

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Patient Medical History

Name of Primary Care Doctor _____
Date of Last Physical Check-Up_____

Current Medication List (RX or over the counter)

(List eye drops, vitamins & Birth Control Pills)

_____

_____

_____

Allergies to medications? __ Y __ N
If yes, list them

_____

_____

Please list any surgeries and dates if applicable

_____

_____

_____

Do you use cigarettes/ tobacco? __ Y __ N
If yes, how often? _____

Do you drink alcohol? __Y __ N

Have you ever been diagnosed or treated for any of the following health problems?

- □ Allergies _____
- □ Blood/ Lymph _____
- □ Cancer_____
- □ Diabetes _____
- □ Ears/ Nose/ Throat _____
- □ High Blood Pressure _____
- □ Kidney _____
- □ Neurological _____
- □ Respiratory _____
- □ Arthritis _____
- □ Cholesterol _____
- □ Digestive _____
- □ Endocrine _____
- □ Genitourinary _____
- □ Integumentary _____
- □ Muscle/ Bone _____
- □ Psychological _____
- □ Thyroid _____

Patient Eye History

Have you ever experienced, been diagnosed or treated for any of the following?

- □ Blurry vision
- □ Trouble seeing at night
- □ Sun Sensitivity
- □ Cataracts
- □ Glaucoma
- □ Headaches
- □ Uncomfortable glasses
- □ Burning
- □ Macular Degeneration
- □ Itchiness
- □ Retinal Detachment
- □ Grittiness
- □ Eye Infections
- □ Lazy Eye
- □ Eye Injury
- □ Floaters/ Spots
- □ Flashes
- □ Dryness
- □ Other eye disorders_____

Family Medical/ Eye History (Check all that apply)

Is there a family medical history of any of the following?
(Mother's or Father's side)

- □ Blindness _____
- □ Cataracts_____
- □ Corneal problems _____
- □ Diabetes_____
- □ Glaucoma_____
- □ Heart Disease _____
- □ Lazy Eye_____
- □ Macular Degeneration _____
- □ Retinal Problems _____

Signature of Patient or Guardian

_____

Date _____

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FAMILY EYECARE

RECORDS REQUEST FORM

Date: _____Patient Name: _____

Address:_____

Date of Birth: _____

To:_____

_____

"I request your office release all patient records including medical findings, lab reports and treatments to Dr. Masuga. I hereby release you, my practitioner, from any laws governing the disclosure of confidential or privileged information. You are also authorized to communicate orally or in writing any information regarding the requested information."

- o Spectacle Prescription
- o Contact Lens Prescription
- o All Previous Eye Exam Records/Diagnostic Testing
- o Medication List

Please send information to our office via Fax or Mail:

8120 Lakewood Main St Suite 101
Lakewood Ranch, FL 34202
Fax (941) 718-4926

Patient Signature _____

Notice to Patient:
You have the right to **receive** a copy of this authorization.

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Contact Lens Prescription Signed Acknowledgment Form

Included below is important information to review prior to receiving your contact lens prescription.

The Center for Disease Control and Prevention (CDC) makes clear, "Contact lenses can provide many benefits, but they are not risk-free. Especially if contact lens wearers don't practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment."

The CDC recommends the following for contact lens wearers:

-Schedule a visit with your eye doctor at least once a year.

-Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.

-Understand that eye infections that go untreated can lead to eye damage or even blindness. The

Food and Drug Administration (FDA) indicates:

- "To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional."

Symptoms of Eye infection include:

-Irritated, red eyes

-Worsening pain in or around the eyes-even after contact lens removal

-Light Sensitivity

-Sudden blurry vision

-Unusually watery eyes or discharge

Sign below to acknowledge and consent that you will be provided **with** an electronic copy of your contact lens prescription at the completion of your contact lens fitting.

Patient Signature: _____Date: _____

Acknowledgement of Pupil Dilation
I understand that Florida Board of Optometry requires optometrists to perform a dilated exam of the retina during the patient's comprehensive exam. I understand that the optometrist recommends it to evaluate the internal health of my eyes more thoroughly. Please indicate your preference:

____ I wish to be dilated today if necessary (Required for New Patients)

____ I would like to discuss the dilation with the Doctor

____ I refuse the dilation and agree to release InFocus Family Eyecare of all legal responsibility

OCT Retinal Imaging
The Ocular Coherence Tomographer, also known as the OCT Retinal Exam, is a scanning digital image of the retina, macula, and optic nerve. It allows the Doctor to better diagnose, treat, and follow changes to the retina over time. The OCT Retinal Exam can be billed to some insurance carriers, while other carriers recognize it as a "non-covered service," meaning the patient will be responsible for the charges. Dr. Brad and Ashley Masuga highly recommend this imaging for all patients once a year. The out-of-pocket fee for the retinal imaging exam is: $45.00

____ I wish to have the retinal OCT Retinal Exam

____ I wish to discuss the OCT Retinal Exam with the Doctor

____ I refuse the OCT Retinal Exam

****PLEASE NOTE: Payment is required at the time of service****

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payment of medical payments to InFocus Family Eyecare for any services rendered to me by any doctors of InFocus Family Eyecare.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, co-insurance, and referrals. I am responsible for obtaining any required referrals, and in absence as such, I will be held responsible for the cost of services provided.

Acknowledgement of HIPAA:
I acknowledge that I received a copy of InFocus Family Eyecare's Notice of Privacy Practices (HIPAA).

Signature of Guarantor _____ Date: _____

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Medical Insurance - Explanation of Coverage

About Your Insurance
There are two types of health insurance that will help cover eye care services and optical products; you may have both types. InFocus Family Eyecare accepts most medical insurance plans such as Medicare, Blue Cross/Blue Shield, Aetna, United Health Care etc. InFocus Family Eyecare is out-of-network with vision plans such as VSP, Eyemed and Spectera.

Medical insurance must be used for medical eye care involving the diagnosis, management, and treatment of eye health conditions such as diabetes, dry eye, glaucoma, cataracts, eye infections, etc. Depending on the insurance plan, patients will be responsible for their deductibles, co-pays, and non-covered services as allowed by the insurance contract.

Vision Plans may contribute toward routine visits and eyewear products such as glasses and contact lenses. They do not cover medical eye care. If you have both types of insurance, you may be able to use your medical insurance towards your exam services, and your out-of-network vision benefits towards your eyewear and/or contact lenses.
If your vision plan has out-of-network benefits, we will discuss your coverage options and coordinate benefits in order to reduce any out-of-pocket patient expense.

Fees that are not paid by your insurance will be billed to the patient. As a reminder, health insurances do not cover all procedures; even some that your health care provider may feel are necessary for you. Please ensure you understand your insurance coverage so that you can make an informed decision about your care.

Refraction Fee
A refraction is a portion of the exam that evaluates a patient's vision and determines if a vision correction is needed to improve sight. When using your medical insurance, the refraction is considered a "non-covered service" and will be billed directly to the patient. The refraction fee is $45.00

Out of Network Plans
Patients who have an out-of-network vision plan or medical plan may be able to use their benefits for exam services and eyewear materials. Patients will be required to pay for any services and materials they receive during their visit. For the convenience of the patient, InFocus Family Eyecare will then bill the vision or healthcare insurance provider. Once the claim has been processed by the insurance company, the patient will receive a reimbursement check in the mail.

We ask all patients to please provided our team with insurance cards for both medical and vision plans. This will allow us to bill the appropriate carrier and reduce any out-of-pocket costs. We are required to have your medical insurance and/or Medicare Card on file for future billings to your insurance. We will always notify you for approval before we bill any insurance plan.

Signing below indicates that you understand this notice and agree to the terms:

Signature of Guarantor _____ Date: _____