LAKEWOOD FAMILY EYE CARE
11151 East SR 70 - Lakewood Ranch FL 34202

Patient Registration Packet

WELCOME!

In order to cut any possible waiting time down,
please print our patient registration packet.
Fill it out and fax it back to (941) 756-1925.

Alternately, you can fill out your information online on our patient portal. This can be found at https://my.mveportal.com/Patients/18961.

Please call us at (941) 739-5959 if any questions arise.
Thank you for choosing our office for
your eye and vision care.

VISION SOURCE
SIGNATURE EYE CARE

PATIENT REGISTRATION

Thank you choosing Lakewood Family Eye Care!
Please take a moment to fill out the information below as completely as possible.

Today's Date: _____

Patients First Name		Middle Initial	Last Name
Local Address			City, State & Zip Code
Date of Birth	Age	Sex: ☐Male ☐ Female	Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed
Home Phone		Work Phone	Cell Phone
E-mail Address			Social Security No. *(For insurance & record keeping only)*
Employer			Occupation
Employment Status: ☐Part time ☐Full Time ☐Retired ☐Unemployed ☐Disabled			
Guarantor Full Name/Person Responsible For Payment			Relation to Patient: ☐Self ☐Spouse ☐Mother ☐Father ☐Legal Guardian
Communication Preference: ☐Home Phone ☐Cell Phone ☐Text ☐E-mail			Is "Texting" okay for confirming appointments? ☐Yes ☐No

Whom may we thank for referring you to us:

☐Insurance list ☐EC Observer Ad ☐Online advertising ☐Close location/drive by ☐Doctor, friend or family-Name_____

If you are coming in to have a **medical complaint, problem or condition addressed (Example: eye infections, itchy eyes, dry eyes, cataracts, floaters, diabetes, glaucoma, trauma)** **we are required to bill your medical insurance** for your eye exam. **Most often, we can still check your vision and measure you for glasses** even though we are evaluating a medical problem and billing your medical plan. You will be responsible for applicable copays and refraction fees. Vision plans, (**i.e., VSP, Eyemed**) do not cover eye exams in which significant medical complaints are addressed. If you are coming in for a **routine vision exam** to have your glasses or contact lenses updated, **we will bill your vision plan.**

Vision Insurance Co. Name	Vision Insurance ID / Contract Number
Medical Insurance Co. Name	Medical Insurance ID / Contract Number
Policy Holder / Insured's Full Name	Patient's relation to Insured: ☐Self ☐Spouse ☐Child ☐Legal Guardian
Policy Holder / Insured's Date of Birth	Insured's Employer Name

Lakewood Family Eye Care—Medical History Form

Name _____ **Date** _____

Do you currently have any of the following conditions?

	NO	YES	Please CIRCLE or LIST specific condition:
Allergies/Autoimmune	☐	☐	.....allergies, rheumatoid arthritis, Lupus _____
Respiratory problems	☐	☐	.....asthma, COPD, emphysema, chronic bronchitis _____
Ear/nose/throat problems	☐	☐	.....sinus problems, hearing loss, ear infections _____
Heart/Cardio problems	☐	☐	.....high blood pressure, high cholesterol, irregular heart beat, congestive heart failure _____
Constitutional problems	☐	☐	.....fever, recent weight loss or gain, fatigue _____
Endocrine problems	☐	☐	.....diabetes, thyroid, kidney _____
Gastrointestinal problems	☐	☐	.....heartburn, IBS, vomiting, diarrhea _____
Genitourinary problems	☐	☐	.....pain, blood in urine, discomfort, discharge _____
Infectious problems	☐	☐	.....HIV, hepatitis, tuberculosis _____
Skin problems	☐	☐	.....rashes, dryness, eczema _____
Musculoskeletal problems	☐	☐	.....aches, joint pain, swelling, osteoarthritis _____
Neurologic problems	☐	☐	.....headaches, numbness, weakness _____
Psychiatric problems	☐	☐	.....depression, anxiety, bipolar_____

Non-eye related surgery: _____

Race: American Indian Alaskan Native Asian African American /Black Hispanic Native Hawaiian/Pacific Islander Caucasian /White

Ethniciity: Hispanic or Latino Native Hawaiian or Pacific Islander Non-Hispanic Other

Height: _____feet _____ inches Weight _____ lbs

Please list any medications you take? (Include eye medications) _____

_____

_____

_____

_____

Please list any drug allergies: _____

Do you currently have, or been diagnosed with any of the following conditions: (PLEASE CHECK) ☐ None

☐ Retinal detachment ☐ Glaucoma ☐ Cataracts ☐ Strabismus (eye turn)

☐ Amblyopia (lazy eye) ☐ Macular degeneration ☐ Diabetic retinopathy ☐ Dry Eye Syndrome

Any past trauma to the eye? ☐ Yes ☐ No Nature of injury _____

Have you had any eye surgery such as cataract surgery, laser surgery or eye muscle surgery? If so , please list procedure and year performed. ☐ No

RT _____ LT _____

Do you have a family history of any of the following: ☐ No

☐ Glaucoma ☐ Strabismus (eye turn) ☐ Macular degeneration ☐ Retinal detachments ☐ Cancer / Melanoma

Do you drink alcohol?	No	Occasionally/Socially	1 / day	2-3 / day	4+/ day
Do you smoke?	No	Occasionally/Socially	1/2 pk / day	1pk / day	2 pk / day

Primary Physician's Name _____ Pharmacy _____

Are you planning to get new glasses today? ☐ Yes ☐ No ☐ Only if prescription changes

Are interested in LASIK / Laser vision correction? ☐ Yes ☐ No

Advisement: Please be advised, our doctor dilates your pupils as a part of a complete eye health examination. This is not an optional part of the exam. This may cause light sensitivity and temporary blurry vision. Caution should be taken when driving. Protective sunglasses are available.

PATIENT AUTHORIZATION

Authorization to Release Protected Health Information (PHI)

I hereby authorize Lakewood Family Eye Care 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
Name of Authorized Person	Relationship	Daytime Phone Number

Patient's / Patient's Legal Representative

Name (print):_____Signature:_____Date:_____

If signed by Representative, state relationship to patient:

_____

PAYMENT POLICY & NOTICE OF PRIVACY PRACTICES

Third party insurance information must be given at least 24 hours in advance so that we may obtain prior authorization and verification of benefits or you will be considered self-pay.

Payment is due the date when services are rendered. If we are billing insurance, you will be responsible for your **co-pays, refraction, co-insurance and/or deductibles**. You will be responsible for the remainder of your examination if your insurance does not pay within **45 days.**

NO SHOW FEE: Please give us 24 hours advance notice if you cannot make your appointment. A No-Show fee will be charged if you do not make your appointment and fail to give us advanced notice.

PRIVACY POLICY: By signing below, I acknowledge that I have viewed or have been given a copy of Troy L. Bedinghaus, O.D., P.A.'s Notice of Privacy Practices. A copy of our Notice of Privacy Practices is posted in the reception/waiting area of our office.

Patient or Patient representative _____ Date _____

INSURANCE AGREEMENT

PLEASE READ CAREFULLY: *If you are coming in to have a medical complaint, problem or condition addressed (Example: eye infections, itchy eyes, cataracts, dry eyes, floaters, diabetes, glaucoma, trauma)* ***we are required to bill your medical insurance*** *for your eye exam.* ***Most often, we can still check your vision and measure you for glasses*** *even though we are evaluating a medical problem and billing your medical plan. You will be responsible for applicable co-pays and refraction fees. Vision plans,* ***(i.e., VSP, Eyemed)*** *do not cover eye exams in which significant medical complaints are addressed. If you are coming in for a routine vision exam to have your glasses or contact lenses updated,* ***we will bill your vision plan. By signing below, you give us permission to bill your medical plan or vision plan depending on the reason for the visit.***

I hereby authorize the physician to release any information required to process this claim. If the physician is accepting insurance, I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions.

Patient or Patient representative _____ Date _____

SIGN BELOW ONLY IF YOU HAVE MEDICARE PART B FOR YOUR HEALTH PLAN

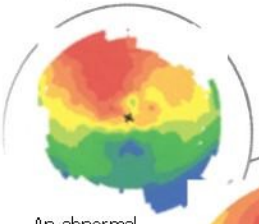
I request that payment of authorized Medicare benefits be made to Troy L. Bedinghaus, O.D., P.A. for services rendered to me by him. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits. I understand my signature request that payment be made and authorizes release of medical information necessary to pay this claim. If other health insurance is listed in item 9 of the CMS 1500 or elsewhere, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Troy L. Bedinghaus, O.D., P.A. agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

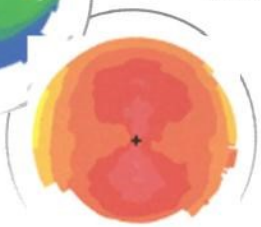
Understanding Your Contact Lens Care & Professional Fees

"What are contact lens professional fees for?"

As a contact lens wearer, additional tests are done for you that are necessary to make sure your eyes are healthy, that your lenses fit properly, and to ensure that you are seeing as well as possible. Contact lens professional fees are for the extra testing, our doctor's expertise and the time taken by the staff and doctor each year to properly evaluate your contact lenses. Writing a prescription for your contact lenses places a certain amount of responsibility for the health of your eyes on the doctor. As result, your eyes and the fit of the lenses need to be checked annually.



An abnormal, Distorted cornea



A normal cornea as shown by corneal topography

Corneal topography is one example of a test done for contact lens wearers. With this computerized data we can detect any undesirable changes of the cornea caused by wearing contact lenses.

A second test uses the microscope to examine the fit of the contact lens and to assess the quality and quantity of your tears. Thirdly, pupil size is measured. Last, prescription measurements are done differently than those for glasses.

"What types of additional tests are needed?"

"Isn't this part of my annual eye exam?"

These contact lens related tests are done in addition to the eye examination. These are procedures that only need to be done for contact lens wearers, not for patients who do not wear contact lenses.

"How much does it cost?"

Depending on the type of lenses you wear and the complexity of your case, it costs anywhere from $30 to $170 annually for the contact lens evaluation fee.

"Doesn't my insurance cover contact lens professional fees?"

It depends on your plans coverage. Many insurance plans cover a routine eye exam which determines your glasses prescription and evaluates your eye health. Contact lens services are separate procedures often not covered by insurance.

Will Your Eye Exam today be...

ROUTINE OR MEDICAL?

Please read and <u>choose the examination</u> type you would like the doctor to perform today.

☐ COMPREHENSIVE *ROUTINE* EYE EXAM

A **routine well-patient eye exam** includes a <u>vision analysis</u>, a refraction to update your eyeglass or contact lens prescription, a dilated eye health evaluation & digital retinal Imaging. Medical eye problem visits will be scheduled for another appointment. No topical or oral drug prescriptions will be written during this type of exam. Your vision plan will deny the claim if you have medical problems addressed.

Your vision plan (i.e., EYEMED, VSP, VISION SOURCE SAVINGS PLAN etc.) will be billed.

<u>*ESTIMATED* patient responsibility:</u>

Exam Co-pay $_____ + DRI ___<u>$24</u>___ = _____*

(If you wear contact lenses, you will also be responsible for the contact lens evaluation fee which varies between **$40-$350** depending on complexity. Most will range between **$40-$110**)

☐ COMPREHENSIVE *MEDICAL* EYE EXAM

A **medically-oriented eye exam** includes all of the above but the <u>reason for the visit</u> is medical in nature (i.e., diabetes, allergies, cataracts, glaucoma, macular degeneration, infections, injury, dry eye syndrome.) These conditions require <u>more responsibility</u> and require a <u>higher level of medical decision making</u> by the doctor. We can still check you for glasses or contact lenses even though we are evaluating a medical problem in most cases.

Your regular medical/health insurance carrier (i.e., AETNA, BCBS, MEDICARE etc.) will be billed.

<u>*ESTIMATED* patient responsibility:</u>

Exam Co-pay $_____ + Refraction ___<u>$30</u>___ + DRI ___<u>$24</u>___ = _____*

(If you wear contact lenses, you will also be responsible for the contact lens evaluation fee which varies

Digital retinal imaging (DRI) is a procedure consisting of capturing an image of the inside of the eye using the ultra-wide view EIDON Confocal Retinal Scanner. It does not replace dilation of the pupils but it compliments and adds to the dilated retinal exam to better assist the doctor in viewing the eye anatomy in a unique way for proper diagnosis of eye disease.

Insurance companies allow us to charge a fee for the test but do not reimburse for routine digital retinal imaging.

The fee for routine digital retinal imaging (DRI) is a nominal $24 and will be added to your co-pay at the time of your visit

We perform

DIGITAL RETINAL IMAGING

as a part of our

comprehensive eye exam

_____ _____ _____

Printed Name Signature (Guardian if minor) Date