



11151 East SR 70 - Lakewood Ranch FL 34202 (941) 739.5959
10060 US Hwy 301 N—Parrish FL 34219 (941) 304.2015

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 for Lakewood Ranch or
(941) 304-2016 for Parrish

Please call if any questions arise.
Thank you for choosing our office for
your eye and vision 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Home Phone		Work Phone	Cell Phone
E-mail Address			Social Security No. <i>(For insurance & record keeping only)</i>
Employer			Occupation
Employment Status: <input type="checkbox"/> Part time <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled			
Guarantor Full Name/Person Responsible For Payment			Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian
Communication Preference: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Text <input type="checkbox"/> E-mail			Is "Texting" okay for confirming appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Whom may we thank for referring you to us: <input type="checkbox"/> Insurance list <input type="checkbox"/> EC Observer Ad <input type="checkbox"/> Online advertising <input type="checkbox"/> Close location/drive by <input type="checkbox"/> Doctor, friend or family-Name _____			
<p>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.</p>			
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 <u>Insured</u> : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Legal Guardian
Policy Holder / Insured's Date of Birth			Insured's Employer Name



Name _____

Date _____

Do you currently have any of the following conditions?

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

Race: American Indian Alaskan Native Asian African American /Black Hispanic Native Hawaiian/Pacific Islander Caucasian /White
Ethnicity: 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
- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Retinal detachment | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Strabismus (eye turn) |
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> 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
- | | | | | |
|-----------------------------------|--|---|--|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Strabismus (eye turn) | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Retinal detachments | <input type="checkbox"/> 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 patient

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 or 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 _____

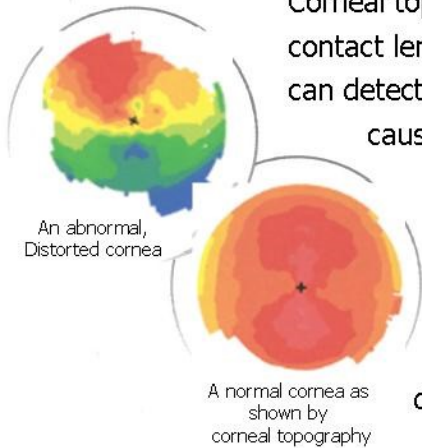


Understanding Your Contact Lens Care & Professional Fees

“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.

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.

“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.

“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.

Medical Insurance & Vision Plans

Medical Insurance covers medical visits to the **Eye Doctor**

Optometrists are “eye specialists” whose services are covered under **Medical Insurance**

Please **Check** which type of exam you wish to have and **Sign** below.

MEDICAL EYE EXAMINATION

- Medically-oriented exam
- Billed towards your medical insurance plan
- Includes vision analysis for eyeglasses unless the visit is problem focused
- Diabetic eye exams including retinal evaluation
- Also provides assessment of *cataracts, glaucoma, macular degeneration, allergies, red eyes, flashes, floaters, eye pain, infections, injury, etc.*
- The doctor may write a prescription for a medication
- Contact lens evaluations/prescriptions will be an additional copay/fee. Fees will be subject to the terms of your plan’s benefit coverage

➔ **YES, I will use my medical insurance for today’s visit.**

ROUTINE EYE EXAMINATION

- Routine vision check
- Billed towards your vision plan or routine benefit
- Includes vision analysis for eyeglasses
- Screening for eye disease
- If disease or disorder is found, your future visits will be billed to your medical insurance plan
- No medication prescriptions will be written
- Contact lens evaluations/prescriptions will be an additional copay/fee. Fees will be subject to the terms of your plan’s benefit coverage

➔ **YES, I will use my vision plan for today’s visit.**

Signature _____ Date _____

When a Vision Plan audit is performed and it is discovered a patient’s visit was not a wellness vision check up, but rather the visit was because of medical signs/symptoms like burning, itching, dryness, cataracts, glaucoma, diabetes, the vision plan will deny the claim and the patient will have to pay the full amount of the visit.

You are responsible for co-pays, co-insurance, deductibles and or non/covered services.

DIGITAL RETINAL IMAGING

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 \$34 and will be added to your co-pay at the time of your visit.

