FLORIDA VISION OPTIQUE

Patient Last Name _____ First Name _____ M.I. ____

Address: _____ City _____ State _____ Zip. _____

Social Security Number _____ Date of Birth _____

☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address _____ Primary Care Physician _____

Phone Number - Home _____ Cell _____ Work _____

Emergency Contact - Name _____ Phone Number _____ Relationship _____

Employer _____ Occupation _____ Student? _____ School. _____ Grade __

How did you hear about us?

☐ Previous Pt ☐ Insurance ☐ Website ☐ Facebook ☐ Walking by office

☐ Friend/Family _____ ☐ Doctor's Office _____ ☐Other _____

RESPONSIBLE PARTY INSURED

Policy Holder Name. _____ Date of Birth _____ Relationship to Insured _____

Medical Insurance _____ Member ID Number _____ Vision Insurance _____ Member ID Number_____

MEDICAL HISTORY

Family Health History: Do you or anyone in your immediate family have the following?

	You	Family		You	Family		You	Family
Glaucoma	☐	☐	High Blood Pressure	☐	☐	Thyroid	☐	☐
Cataracts	☐	☐	Macular Degeneration	☐	☐	Migraines	☐	☐
Lazy Eye	☐	☐	Heart Problems	☐	☐	Diabetes	☐	☐
Cancer	☐	☐	High Cholesterol	☐	☐	List any Other	☐	☐
						_____		

If you are diabetic, when were you diagnosed? _____ Last blood sugar level? _____ Last Physical Exam _____

Describe any previous surgery, injury, or infections to your eyes _____

Do you smoke? ☐ Frequency?_____ Do you drink alcohol?☐ Frequency_____

Please list any medications you are taking (including eye drops, nonprescription, vitamins, birth control)

(Continue on back if needed): _____

Do you have any drug allergies? If so, please list: _____

Do you have seasonal/environmental allergies?____ Are you pregnant or planning to become pregnant?_____

Are you interested in talking to the doctor about LASIK? _____

Do you wear:

☐Contact lenses If so, list brand: _____ ☐ Glasses

Do you want to renew a contact lens prescription today? _____

If not currently wearing contact lenses, do you want an evaluation for one today? _____

Last Eye Exam _____ Doctor _____

FLORIDA VISION OPTIQUE

Please list all medications, including over the counter and vitamins, you are currently taking, including strength, dosage and frequency:

Patient Name: _____ Date: _____

Name, location and phone number of preferred pharmacy: _____

_____

Medication	Strength	Dosage	Frequency

RAFAEL A. DIAZ O.D.
NICHOLE L. HRUBAN O.D.

Florida Vision Optique

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS INSURANCE INFORMATION, FINANCIAL AGREEMENT

Patient Name (Printed): _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Florida Vision Optique, for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated as a Secondary Insurance (in Item 9 of the HCFA 1500 claim form or electronically transmitted), my signature authorizes releasing the information to the insurer shown. Florida Vision Optique, accepts the charge determination of Medicare and I am responsible for coinsurance, deductibles and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to Florida Vision Optique for services furnished to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

DILATED EXAMINATIONS: In the event the doctor has to dilate or parch my eye, I am aware that I may experience blurry vision, light sensitivity, and or decreased depth perception. For this reason, it is suggested that you have someone to drive you home.

FINANCIAL AGREEMENT: I agree that in return for the services provided by Florida Vision Optique, I will pay my account at the rime service is rendered or will make financial arrangements satisfactory to the practice. If my account is sent to collection, I will be responsible for the existing outstanding balance along with a 35% collection agency's fee. If further action is required, then I will also be responsible for any attorney fees as established by the court. In case of a check being returned, there will be a service charge of $25. Most insurances require you to pay co-payments and deductibles. These are due, if known, at the time of service as well as any non-covered services. It is understood that I am primarily responsible for the payment of any services not covered by my insurance.

Signature: _____Date: _____

FLORIDA VISION OPTIQUE

HIPAA Notice of Privacy Practices Acknowledgment Form

To adhere to many changes in government guidelines regarding health care reform and identity theft protection we are required to get a photo ID on every patient we provide services to. Please be assured that any information provided to our office will never be released to any party unless you have given us written permission to do so. A copy of our entire HIPAA Privacy Policy is located on the wall or you can request a copy from our staff. It is your right to refuse to give us any of this information. However, services may be restricted. By signing below, you are acknowledging that you understand this information.

Name (Printed) _____ Date_____

Signature_____

Authorization to use or Disclose Protected Health Information

In order to protect our patients' privacy, Florida Vision Optique will not discuss or release any information regarding our patients without their written authorization. Should you wish to authorize Florida Vision Optique to discuss your account or medical information with someone other than yourself, please indicate the permission below.

I authorize Florida Vision Optigue to discuss my personal medical and account history with the following individuals:

Name _____ Relationship _____Phone _____

Name _____ Relationship _____Phone _____

**In an effort to increase co-management and continued care with other physicians we do send exam results to primary care physicians.

Signature_____ Date_____

OUR OFFICE REFRACTION POLICY
Advance Beneficiary Notice

During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. A refraction is also done when you need an old prescription checked, or a yearly update of your prescription This is a necessary and essential portion of your eye exam. This test is not always covered by medical insurance but covered by routine vision plans if eligible.
It is considered a separate procedure.

Most medical insurance companies, including Medicare, classify this as a "Non-Covered,, service and require that patients be responsible for payment.

Our fee effective 01/01/2021 at Florida Vision Optique for this service is $65.00, required at time of service. The only exception will be if we are aware that your insurance company has paid for this procedure in the past. **I have read and understood that the refraction is a "non-covered" service, meaning my medical insurance will not cover any portion of the $65.00 fee and I am responsible for payment at the time the test is administered.**

Signature_____ Date_____

FLORIDA VISION OPTIQUE

CONTACT LENS EVALUATIONS

The glasses prescription you receive from Florida Vision Optique is not a contact lens prescription.
A contact lens evaluation is a separate part of the eye examination. All contact lens patients will need this evaluation yearly if you plan to continue to wear or purchase contact lens. The evaluation is not covered by medical insurance except when medically necessary. If you have a vision plan it may have an allowance or discount for the evaluation as part of your contact lens benefits. The fee for this service is based on the type of contact lens you wear; single vision, astigmatism, mono vision or multi-focal and includes three months of follow up. If you have any questions, please feel free to ask.

I have read and understand that the contact lens evaluation is a separate part of the examination and I would like to wear contact lenses or update my contact lens prescription.

Signature_____ Date_____

Contact Lenses Trial Policy

Trial Contact Lenses are now being limited by most major contact lens companies in proportion to the number of retail boxes that we purchase therefore we need to institute a trial lens policy.

1) New patients and new contact lens evaluations will get a free pair or several pairs to facilitate the evaluation process during the initial three month period. This is unchanged from our past policies.

2) Trials provided after the initial evaluation period will be provided with a $15 processing fee. This fee also applies to patients who are not our clients and who present a prescription while out of town, on vacation, etc.

3) Patients requesting trials for new lenses other than what they have been fit for and after the initial three month evaluation period are also subject to refitting and evaluation fees.
Example: Patient wants to try a bifocal, toric or mono vision contact lenses.

4) Patients with vouchers for "Free Trial Pairs" from manufactures are always subject applicable professional fees like examinations, refraction, and contact lens evaluation fees.

5) Patients who purchase contacts from our office may have this fee waived at the doctor's discretion.

Please remember that processing and handling trials requires substantial staff time and handling costs.
This fee represents a small portion of that time.

Signature_____ Date_____

I am not interested in contact lens/evaluation, please sign below:

Signature_____ Date_____

FLORIDA VISION QPTIOUE

FINANCIAL POLICIES

It is no longer an easy task to interpret each individual insurance policy due to many changes in insurance. Although we try to stay aware of these changes, it is not always possible.

Our office is unique in the fact that Florida Vision Optique can see patients under medical and vision plans.
It is your responsibility to tell us which plan you are using. Once a claim has been submitted to your medical or vision insurance we will not be able to make any changes.

You are responsible for providing us with your correct address, telephone number, photo ID and insurance ID cards. Incomplete or incorrect information may result in non-payments and you will be responsible for any balance due.

If we participate with your insurance, under the terms of your contract with your insurance company, we must collect any deductible, coinsurance and/or co-pay at the time of service. U you are unable to provide us with that payment, we reserve the right to reschedule your appointment.

I agree that in return for the services and/or materials provided by Florida Vision Optique, I will pay my account at the time service and/or materials are rendered or will make financial arrangements satisfactory to the practice. Any balance passed onto you by your insurance company after your claim has been processed Is due within 30 days. Failure to pay may ultimately result in your account being turned over to a collection agency.

If my account is sent to collections, I will be responsible for the existing balance along with 35% collections agency fee. If further action is required, then I will also be responsible for our attorney fees as established by the court It is understood that I am primarily responsible for the payment of any services not covered by my insurance.

In the case of a check being returned for non payment we will charge a fee of $25.
Orders placed for ophthalmic materials must be paid in advance or a minimum of 50% deposit with balance due upon dispensing. For your convenience, we do accept all major credit cards, including Care Credit.

Spectacle orders: We will process your custom spectacle order immediately. For this reason, we are unable to cancel any order. All spectacle lenses are custom crafted for each padent with their unique prescription and custom sized to flt the frame you select. Therefore, patients may not switch frames after lenses have been edged. For all these reasons, refunds are not possible.

Patients who are not satisfied with their vision in their new glasses will have the prescription adjusted at the doctor's discretion.

Progressive lens wearers who cannot adapt to their lenses have 60 days to have lenses remade Into their choice of lined bifocals, single vision, or trifocal lenses at no additional charge, There are no refunds on progressives.

PLEASE READ THE ABOVE CAREFULLY AND SIGN BELOW STATING THAT YOU UNDERSTAND OUR POLICIES AND THE CONDITIONS OF FILING YOUR INSURANCE.

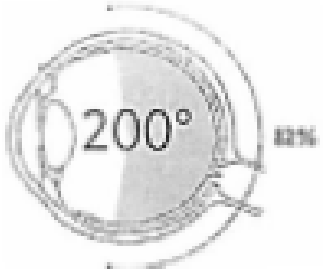
Signature_____Date_____

OPTOMAP

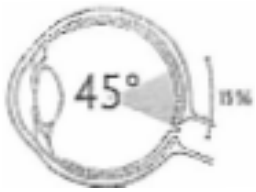
Florida Vision Optique is pleased to provide the most advanced technology for eye health screening. During your comprehensive eye exam, a thorough screening of the retina is critical to determine the health of your eye. When detected early, most retinal conditions and other diseases, can be treated successfully. Optomap captures a digital image of your retina. When used in addition to traditional exam techniques, it can significantly improve the doctor's ability to detect abnormalities from eye disease, changes that take place, and general diseases, such as diabetes and high blood pressure. Optomap is not a substitution for dilation and dilation may still be required.

Optomap Benefits:

- Quick, safe, and efficient screening for children and adults, with no side effects.
- In most cases, dilation may not be required.
- Provides you and your family the best standard of care. We are able to help many of our patients discover potentially sight-threatening diseases such as glaucoma, and macular degeneration.
- Up to 82% of your retina captured in one scan, as compared to 1 0-1 5% with traditional methods.



With Optomap ultra-wide field retinal imaging



Without Optomap

Our doctors highly recommend this procedure for all of our patients as part of their comprehensive eye exam.

The additional cost of $40, for including Optomap in your exam is not generally covered by vision or health plan benefits.* The cost is the responsibility of the patient at the time of the exam and can be paid for with an (FSA) flexible spending account or (HSA) health savings account.

*If it is a covered benefit, we will submit for reimbursement.

CONSENT FORM

By signing this form, you are consenting to have the Optomap Retinal Scan performed as part of today's eye exam. Please check one:

☐ YES, I understand the benefits of Optomap Retinal Scan and I would like to include it in my comprehensive exam.

☐NO, I do NOT want the Optomap Retinal Scan today.

REMINDER: If you elect to have dilation only or if dilation is required, the side effects include light sensitivity and blurred vision 4-6 hours post the exam.

Patient or Guardian Signature _____ Date _____

FLORIDA VISION

KATZEN Eye Care & Laser Center
A FLORIDA VISION PARTNER

Date: ____/____/____

Patient Name: _____ D.O.B: ____/____/____

Pharmacy Name: _____

Pharmacy Location/Address: _____

Pharmacy Telephone Number: _____ — _____ — _____

Medication Allergies: ☐ Penicillin ☐ Sulfa Drugs ☐ Other:_____

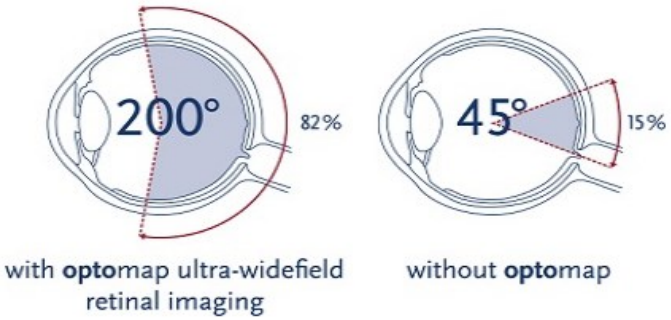
Please list all medications you are currently taking, including over the counter and vitamins. Please document the strength of the medication, the dosage and the frequency.

Medication Name	Strength	Dosage	Frequency

Optomap Consent Form

Your eyes are the window to your health! Your retina is the only place in the body where blood vessels can be seen directly. Early signs of disease such as stroke, heart disease, hypertension, cancer, diabetes, glaucoma and macular degeneration can be seen in your retina. Some of these diseases can be found in the periphery of your retina and remain undetected long before you notice any changes in your vision.

Florida Vision Optique is pleased to provide the most advanced technology for viewing the retina. Optomap allows us to obtain a digital, 200° image of your retina in less than half a second and can be viewed immediately. Under normal circumstances, dilation drops may not be necessary, but your doctor will decide if your pupils need to be dilated depending on the health of your eyes.



Most vision insurances cover the Optomap with a co-pay of $39. This fee can be paid for with an (FSA) Flexible spending account or (HSA) Health savings account.

By signing this form, you are consenting to have the Optomap retinal scan performed as part of today's eye exam.

- ☐ YES! I understand the benefits of the Optomap retinal scan and would like to include it with my exam today.
- ☐ NO, I do NOT want the Optomap retinal scan today.

Patient or Guardian Signature:_____ Date:____/____/____

****REMINDER**: If you elect to be dilated or if dilation is required, the side effects Include light sensitivity and blurred vision 4-6 hours after the exam.

FLORIDA VISION

KATZEN Eye Care & Laser Center
A FLORIDA VISION PARTNER

Date:____/____/____

Name: _____ Date of Birth: ____/____/_____
Last First MI

Primary Care Physician: _____
Referring Doctor: _____
Reason for visit:_____ Last eye exam: ____/____/____

Ocular History

	No	Yes	
Do you wear glasses?	☐	☐	☐ Reading ☐ Distance ☐ Both
Do you wear contact lenses?	☐	☐	☐ Soft ☐ Hard Brand: _____
Do you currently use eye drops?	☐	☐	List: _____
Have you had any previous ocular surgeries?	☐	☐	List:_____
Are you pregnant?	☐	☐	
Are you interested in LASIK?	☐	☐	

Health History

Do you or anyone in your immediate family have the following;

	You	Family		You	Family		You	Family
Glaucoma	☐	☐	Cancer	☐	☐	Thyroid	☐	☐
Cataracts	☐	☐	Hypertension	☐	☐	Migraines	☐	☐
Macular Degeneration	☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐
Amblyopia	☐	☐	Elevated Cholesterol	☐	☐	Other	☐	☐

Social History

	No	Yes	
Do you smoke?	☐	☐	If yes, how frequently? _____
Do you consume alcohol?	☐	☐	If yes, how frequently? _____
Do you use drugs?	☐	☐	