



Thank you for choosing North Florida Cataract Specialists and Vision Care for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Our physicians and staff are dedicated to providing you with the highest quality service and care. We will do our very best to make sure your visit is as pleasant and comfortable as possible.

In order to better serve you, we ask that you allow at least 2 hours total for your visit. You can also expect to have your pupils dilated at your appointment. We would like to remind you that any copays, unmet deductibles or coinsurance will be due at the time of your visit. Payment by cash, check, VISA, MasterCard, American Express or Discover is accepted.

We have enclosed our new patient packet for you to fill out and bring with you to your appointment. Please also be prepared to bring the following:

- Glasses and/or contact lens prescription (please bring contact lens box)
- A list of current medications you are using
- A list of medications you are allergic to
- Insurance cards
- Records from your previous doctor (or you can request to have them sent to our office)

We understand that situations may arise that will interfere with your scheduled appointment time and will be happy to assist you in rescheduling. When canceling or rescheduling your appointment, kindly give at least 24 hours notice. Failure to do so may result in a \$50 charge.

If you have any questions or concerns, please do not hesitate to contact our office. We can be reached at 352-373-4300 or 1-800-435-3937. We look forward to providing you with the very best of care!



NORTH FLORIDA
CATARACT SPECIALISTS
AND VISION CARE

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 4313 NW 8th Ave
 Gainesville, FL 32605

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 Tioga, FL 32669

Main Phone: 352-373-4300
Tioga Phone: 352-333-1186
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www.northfloridavision.com

PLEASE PRINT CLEARLY

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ Male Female

Date of Birth: ____/____/____ Age: ____ Social Security #: ____ - ____ - ____
 Month Day Year

- If Patient is a minor: Father _____ DOB: ____/____/____
 Mother _____ DOB: ____/____/____
 Guardian _____ DOB: ____/____/____

Billing Address _____
 City _____ State _____ Zip _____

Phone Numbers: Home () _____ - _____ Work () _____ - _____
 Cell () _____ - _____

Email Address: _____
 (This information will not be sold or shared with any third party.)

Employer: _____ Occupation: _____

Marital Status: Single Married, Spouse's Name: _____ Other _____

Physician or person we may thank for this referral: _____

EMERGENCY CONTACT: Name _____ Phone _____

INSURANCE INFORMATION

Note: A copy of all insurance cards is necessary for our permanent records.

* Primary Insurance: _____ ID: _____

Subscriber: _____ DOB: _____ Relationship: _____

* Secondary Insurance: _____ ID: _____

Subscriber: _____ DOB: _____ Relationship: _____

INSURANCE SIGNATURE ON FILE/LIFETIME MEDICARE SIGNATURE

I request that payment of authorized benefits or other insurance be made on my behalf to North Florida Cataract Specialists and Vision Care for any services rendered. ***I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or non-covered services.*** I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents or any other insurance carrier, any information needed to determine these benefits payable for related services.

My signature below attests to the fact that I have read and do understand the above-mentioned policies. A photocopy of this signature is as valid as an original.

PATIENT/GUARDIAN SIGNATURE _____

DATE _____

HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the following person(s) to have access to my protected health information; example: spouse, son, daughter, parents, etc. I have listed his/her name(s) and relation to me.

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

OPTIONAL I understand that I have the right to restrict the amount of information that the above individual(s) receive. The following are restrictions I would like to place:

- May we leave a message on your HOME answering machine if there is no answer?
 Yes No Do not have an answering machine
- **If there any any changes to the above stated information, it is the patient or guardian's responsibility to inform North Florida Cataract Specialists and Vision Care in writing.**

I hereby acknowledge that I have been presented with a copy of North Florida Cataract Specialists and Vision Care's Notice of Privacy Practices & authorize the above listed person(s) access to my protected health information.

Patient's Signature: _____

If minor, Guardian's Signature: _____

Patient's Name (Printed): _____

Witness: _____ Date: _____

REFRACTION POLICY

A refraction (procedure code 92015) is the part of the exam that evaluates any visual changes and the possible need for an eyeglass and/or contact lens prescription. There is a \$40 charge for this service. **This fee is not covered by most *medical insurance plans* and is due at the time of service.** Please be aware, although this charge is not covered, it may be necessary to perform a refraction to help determine visual changes related to medical conditions.

There is an *additional* charge of \$50-\$75 for **contact lens** measurements, which are a separate procedure (procedure code 92310). This charge will be determined based on the type of contact lens you may need, i.e. spherical, toric or multifocal. These charges are not covered by insurance. The contact lens fitting fee is required to be paid at the time of service along with any insurance copays, deductibles or co-insurances.

Patient's Signature

Date

CONTACT LENS POLICY

All contact lens prescriptions are good for **ONE** year.

All patients new to contact lenses must participate in an "I&R" training to learn how to insert and remove contact lenses properly. This training must be completed within **30 days** of your initial exam.

There will be a **90 day** grace period to finalize your prescription. If not successfully completed, a fee of \$50 will apply after 90 days.

Patient's Signature

Date

Why is there a Contact Lens Fitting fee?

This fee covers the extra tests performed by the doctor along with any necessary follow-up visits and trial lenses. These procedures are only done on patients that wear contacts; it is in addition to the services provided during the annual eye exam.

Why doesn't my insurance cover that fee?

Insurance companies view most contact lenses as elective vision correction. In rare occasions, insurance companies may consider contacts as medically necessary and cover a portion or all of a contact fitting, such as those for patients with conditions like keratoconus. Most insurance companies take the position that if your vision can be corrected with glasses, then contacts are not medically necessary and therefore are not covered as extensively as glasses and your annual eye exam. If you believe that should change, then we urge you to contact your insurance company and discuss the matter with them.

How much is the Contact Lens Fitting fee and how is that determined?

There are different levels of charges based on several factors. The doctor can only determine the exact level of the fitting after completing the exam, because that is when all of the patient's needs have been assessed. Those factors include:

1. The complexity of the fit: Many options for vision correction exist and have varying levels of complexity in order to determine the optimal Rx. These options include spherical lenses (what many patients are most familiar with), toric lenses for astigmatism, monovision, and multifocal lenses
2. Patient's ocular health: The condition of the eyelids, conjunctiva, cornea, and tear film all affect the optimal contact lens material, shape, and care. Even your general health and any conditions you might have can affect ocular health; these must be taken into consideration as well.
3. History of previous eye surgeries or injuries: corneal irregularities or eye sensitivity can be brought on by eye surgeries or injuries. In these cases more care may be required in order to prevent irritation or complications.
4. New patient vs. established patient: New patients require longer appointments, because there is more history to collect and options to discuss. Established patients still have a lengthy appointment but our doctors have a previous knowledge of the patient and any conditions they might have, which makes the process quicker.

Signature: _____

Date: _____

REVIEW OF SYSTEMS: (Please mark all that apply)

CONSTITUTIONAL SYMPTOMS:

Fever _____
Weight Loss/Gain _____
Weakness _____
SOB _____
Numbness _____
Swelling _____
Coughing _____
Aches / Pains _____

CARDIOVASCULAR:

Hypertension _____
Heart Attack _____
Stroke _____
Congestive Heart Failure _____
Coronary Artery Disease _____
Angina _____
Heart Murmur _____
Arrhythmia _____
Peripheral Vascular Disease _____

PULMONARY DISEASE:

Asthma _____
Emphysema _____
Tuberculosis _____
Bronchitis _____
COPD _____
Sleep Apnea _____

MUSCULOSKELETAL:

Osteo Arthritis _____
Rheumatoid Arthritis _____
Fibromyalgia _____
Polymyositis _____
Gout _____

GASTROINTESTINAL:

Crohns disease _____
Liver Problems _____
Irritable Bowel _____
Reflux _____
Hiatal hernia _____

OTOLARYNGOLOGIC:

Sinusitis _____
Ear Infection _____

GENITOURINARY:

Prostate _____
Kidney _____
Urinary Tract Infection _____
Bladder Problems _____
Flomax or its generic _____

HEMATOLOGIC/LYMPHATIC:

Anemia _____
Sickle Cell _____
Bleeding _____

ENDOCRINE:

Diabetic (ID) | (NID) _____
Type ____ Year ____
Hypoglycemia _____
Hypo Thyroid _____
Hyper Thyroid _____
Pituitary Tumor _____
Cholesterol _____

INTEGUMENTARY:

Rosacea _____
Dermatitis _____
Cancer _____

ALLERGIC/IMMUNOLOGIC:

Seasonal Allergies _____
Lupus _____
HIV _____
AIDS _____

PSYCHIATRIC:

Anxiety _____
Depression _____
Manic-Depressive _____

NEUROLOGIC:

Epilepsy _____
Parkinsons _____
Dementia _____
TIA's _____
MS _____
Bells Palsy _____
Myasthenia Gravis _____
Migraines _____
Meniere's _____
Brain Tumor _____

OPHTHALMIC:

Glaucoma _____
Amblyopia _____
Strabismus _____
Cataracts _____
ARMD _____
Trauma _____
Retinopathy _____
Iritis _____
Cornea _____
Retinal Disease _____

EYE SURGERY/LASERS:

FAMILY HISTORY:

Glaucoma Y N
Diabetes Y N
Cataracts Y N
ARMD Y N

GENERAL SURGERIES:

SOCIAL HISTORY:

Do you smoke? Y N
If yes, #packs per day: _____
When did you start? _____

Have you ever smoked: Y N
When did you stop? _____

Cessation counseling done? Y N

Do you drink? Y N
Drinks per day: _____

Do you take recreational drugs: Y N
If yes, what and how long:

Occupation: _____

Have you had any recent unexplained medical problems? Y N

Comments: _____

Initial date of review: _____ Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____

Patient Name: _____ DOB: _____ Acct: _____