ST LUCIE EYE

Welcome to the St Lucie Eye Family!

We look forward to greeting you as a new patient. Having served our community for over 50 years, we are here to help you achieve your best vision and the best in personalized care.

As a multi-specialty practice, we are committed to the best in comprehensive ophthalmology with the latest advances in **cataract surgery, glaucoma treatment, macular degeneration and dry eye management.** Each of our three locations in **Ft Pierce, Port St Lucie** and **St Lucie West** are staffed with full-time optical departments that provide expert fitting of eyeglasses.

As a new patient, there are several important forms for you to review and complete before your visit; **New Patient Information, Medical History, Insurance Authorization, Refraction Policy** and **HIPPA** privacy form. Please bring **completed forms**, your **current medications** (including eye drops), **eyeglasses**, **photo ID** and **insurance identification** to your appointment.

Your appointment will **include pupil dilation** and **last approximately 90 minutes or more**. You may experience blurred vision, sensitivity to light, and difficulty driving or reading for up to 6 hours after dilation. Please bring **sunglasses** to protect your eyes and consider having a **driver** if you are particularly sensitive.

Thank you for entrusting us with your eyecare! We will do our absolute best to make sure your visit is comfortable and informative. Should you have any questions about your appointment or our services, please call our **Scheduling Manager, Estefani Infante (772) 461-2020.**

We look forward to seeing you soon!
Staff and Physicians of St Lucie Eye

****Special Precautions**
*At this time, we **no longer require** masks for patients. Our staff continues to wear masks and clean surfaces. Due to waiting room capacity, the **St Lucie West** location may have limited seating on occasion. If this occurs, we may ask that **only patients** be seated in the **St Lucie West location** until space is available. We apologize for any inconvenience.*

ST LUCIE EYE

NEW PATIENT INFORMATION

Welcome to our Practice!

Please complete the following forms and return to the receptionist. We will photocopy your photo ID and Insurance Cards when you arrive. We look forward to serving you!

First Name: | Last Name: | Mid Initial: | Date:

Street Address: | City:

State: | Zip: | Date of Birth: | Age:

Email Address: | Home phone:

Cell Phone: | Work Phone:

Occupation: | Employer:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Gender: ☐ Male ☐ Female

Name of Spouse: | Emergency Contact: | Phone:

Referring Physician: | Primary Care Physician:

Pharmacy/Location | Primary Language Spoken:

How did you hear about us?

☐ Neighbor/Friend ☐ Internet Search ☐ Publication/Directory ☐ Website ☐ Physician ☐ Other

Please Complete if Under 18 Years of Age or a Student

Father's Name: | Employer:

Mother's Name: | Employer:

ST LUCIE EYE

MEDICAL HISTORY AND INTAKE FORM

REASON for visit. Briefly explain any current eye problems.

Do You Wear Glasses? ☐ Yes ☐ No Number of Years:

Do You Wear Contacts? ☐ Yes ☐ No Number of Years:

Have you or any of your family members been diagnosed with any of the following eye diseases?

☐ Glaucoma ☐ Cataract ☐ Diabetes ☐ Macular Degeneration ☐ Blindness

Please answer the following questions about your Medical Status and History:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)
☐ Yes ☐ No If YES, Please explain:

2. Have you ever had any surgery?
☐ Yes ☐ No If YES, Please explain:

3. Have you ever been hospitalized?
☐ Yes ☐ No If YES, Please explain:

4. Do you take any medications?
☐ Yes ☐ No If YES, Please list:

5. Do you have any food or drug allergies?
☐ Yes ☐ No If YES, Please list:

6. Do you smoke?
☐ Yes ☐ No If YES, How much:

7. Do you drink alcohol?
☐ Yes ☐ No If YES, How much:

8. Any recent changes in employment conditions?
☐ Yes ☐ No If YES, Please explain:

9. Are you employed?
☐ Yes ☐ No If YES, How many hours per week:

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ST LUCIE EYE

MEDICAL HISTORY AND INTAKE FORM

10. Have you had a FLU Vaccine?
☐ Yes ☐ No If YES, When:

11. Have you had a PNEUMONIA Vaccine?
☐ Yes ☐ No If YES, When:

Review of Systems: Please check if you have any of the following conditions with a brief explanation.

☐ Yes ☐ No Chronic fever, unexpected weight loss/gain, fatigue

☐ Yes ☐ No Ear/Nose/Throat (hearing loss, sinus, sore throat)

☐ Yes ☐ No Heart (chest pain, irregular heartbeat)

☐ Yes ☐ No Respiratory (shortness of breath, wheezing, coughing)

☐ Yes ☐ No Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)

☐ Yes ☐ No Urinary (pain or discomfort, blood in urine)

☐ Yes ☐ No Skin (rashes, excessive dryness)

☐ Yes ☐ No Musculoskeletal (muscle ache, joint pain, swollen joints)

☐ Yes ☐ No Neurological (numbness, weakness, headaches, paralysis)

☐ Yes ☐ No Psychiatric (depression, anxiety)

ST LUCIE EYE

REFRACTION POLICY

WHAT IS A REFRACTION TEST?

REFRACTION is an eye test performed during a comprehensive eye exam that measures the eye's focusing ability at all distances. The refraction test not only determines if you need corrective lenses, but also enables your physician to track the overall health of your eyes.

During refraction, you'll look through a special device called a Phoroptor that contains lenses of varying strengths. You'll be asked to identify which lenses make the chart appear more or less clear. Most people know this as the familiar phrase "which is better, one or two".

The rest of the comprehensive exam, or **MEDICAL EYE EXAM**, determines the presence of medical disorders or conditions that affect your eye's health. Both the **medical eye exam and the refraction are absolutely necessary for your doctor to fully evaluate the health of your eyes and your visual system.**

THE COST OF REFRACTION:

While refraction is an essential component of a comprehensive eye exam, the fees for refraction testing are **not covered by most medical insurances.** Medicare and most insurers do not pay for this vital portion of the eye exam and only pay for the medical eye exam component. The **refraction** has been made the **patient's responsibility.**

ACKNOWLEDGEMENT:

I have read the above information and understand that refraction is a routinely non-covered service and is paid in addition to insurance co-pays and deductibles. **Contact lens exams, including prescription changes are also non-covered services**.

I accept responsibility for payment of the REFRACTION FEE, which is $40 at the time of service. This fee is charged only once per year.

PATIENT SIGNATURE	**DATE**

As a courtesy, **St Lucie Eye will file an insurance claim for the refraction test and reimburse you if your insurer covers the cost.

ST LUCIE EYE

NO-SHOW POLICY

Thank you for trusting your care to St Lucie Eye. When you schedule an appointment with us, we set aside enough time to provide you with high quality, personalized care. This time is just for you.

Should you need to cancel or reschedule your appointment, please contact our office as soon as possible and **no later than 24 hours** prior to your scheduled appointment. This allows us enough time to schedule other patients who may be waiting for an appointment. Please review our patient no-show policy below:

St Lucie Eye No-Show Appointment Policy

- Any established patient who **fails to show for an appointment** and has not contacted us to cancel or reschedule will be considered a No-Show and will be **charged a $25.00 fee.**
- Any established patient who fails to show a **second time** will be charged a $25.00 fee.
- Any established patient who fails to show a **third time** will be **charged a $50.00 fee**.
- These fees are charged to the patient, not the insurance company, and are due prior to the patient's next visit.

As a courtesy, we will make reminder calls for your appointments. If you do not answer to confirm, cancel or reschedule your appointment, we will leave a message on your answering machine that will serve as a confirmation of your appointment. If you receive a confirmation call and we leave a message, but you fail to show, the above policy remains in effect.

If you have opted in to receive text or email reminders, please respond with the option to confirm or reschedule. If you receive a text or email reminder and you do not respond and fail to show for your appointment, the above policy remains in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office. You may **contact St Lucie Eye 24 hours a day, 7 days a week** at the phone number below. Should it be after business hours or on a weekend, you may leave a message or speak with the answering service.

I have read and understand the No Show Policy and agree to its terms.

PATIENT SIGNATURE	**DATE**

(772)461-2020 | stlucieeye.com

ST LUCIE EYE

PATIENT FINANCIAL RESPONSIBILITY AND INSURANCE ASSIGNMENT AUTHORIZATION

- I accept full responsibility for the payment of services rendered to me and agree to pay for them in full at the time of service unless other arrangements have been made in advance with the office.
- I authorize treatment of myself or minor child.
- I understand and agree that health insurance policies are an arrangement between MYSELF and INSURANCE CARRIER. Insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.
- I understand that co-pays are due in full at time of service.
- The REFRACTION test involves measuring the eye's visual acuity and is not a covered benefit under Medicare and most medical insurance companies. However, your physicians at St Lucie Eye feel that refraction is a necessary part of your comprehensive examination.

I understand the above statements and understand that I am responsible for any non-covered, out-of-pocket services and co-pays due at time of service.

Patient Signature (Parent Signature if a Minor)

Date

INSURANCE AUTHORIZATION AND RELEASE

- **RELEASE OF INFORMATION:** I authorize any physician examining and or treating me to release to any third party (Medicare, BCBS of FL, etc.) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
- **PHYSICIAN INSURANCE ASSIGNMENT:** I authorize payment directly to the physician examining or treating me for services as described but not to exceed the reasonable and customary charge for these services.
- **MEDICARE/MEDICAID:** I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim.
- **I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.**

This assignment will remain in effect until revoked by me in writing.

Patient Signature (Parent Signature if a Minor)

Date

Subscriber Signature (If Different from Patient)

ST LUCIE EYE

HIPAA RIGHT OF ACCESS FORM: 45 C.F.R.

I direct my healthcare and medical services providers and payers to disclose and release my protected health information as described below to:

Name | Relationship

Name | Relationship

Name | Relationship

HIPAA INFORMATION TO BE DISCLOSED ON REQUEST OF PERSONS NAMED ABOVE
(Check either A or B)

☐ A. Disclose my complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment and billing for all condition) OR

☐ B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate)

- ☐ Mental Health Records
- ☐ Communicable Diseases (Including HIV/AIDS
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Other (please specify)

FORM OF DISCLOSURE

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL (Check one)

- ☐ All past, present and future periods

OR

- ☐ Specified date or event , unless I revoke it.

(**NOTE:** You may revoke this authorization in writing at any time by notifying your health care provider.

Name of Individual Giving this Authorization | Date of Birth

Signature of Individual Giving this Authorization | Today's Date