## Registration : Lake City Eye Physicians

| Date | Account ID | Chart ID | Other ID | Internal Use |
|---|---|---|---|---|
| | | | | |

### Patient Information

| Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Age | Social Security # |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Address | Home: | How did you hear of us? |
|---|---|---|
| Address 2 | Work: | |
| | Cell: | |
| | Email: | |

| City | State | Zip Code | Employer Name & Address | Occupation |
|---|---|---|---|---|
| | | | | |

| Emergency Contact | Phone | Pharmacy | Pharmacy Phone |
|---|---|---|---|
| | | | |

**Physician** **Family Physician** **Referring Physician**

| Medical Insurance | Name & Address | Policyholder | Relationship | Policy ID | Group ID |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

### Guarantor (Person to be billed, if different than patient)

| 1 Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Social Security # |
|---|---|---|---|---|---|---|
| | | | | | | |

| Address | Home: | Work: | Email: |
|---|---|---|---|
| | | | |

| City | State | Zip Code | Employer Name & Address | Occupation |
|---|---|---|---|---|
| | | | | |

| 2. Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Social Security # |
|---|---|---|---|---|---|---|
| | | | | | | |

| Address | Home: | Work: | Email: |
|---|---|---|---|
| | | | |

| City | State | Zip Code | Employer Name & Address | Occupation |
|---|---|---|---|---|
| | | | | |

### HIPAA Approved Contacts

| 1. Last Name | First Name | Middle | Gender | Birthdate | Social Security # | Relationship |
|---|---|---|---|---|---|---|
| | | | | | | |

| Address | City | State | Zip Code | Home: | Cell: | Work: |
|---|---|---|---|---|---|---|
| | | | | | | |

| 2. Last Name | First Name | Middle | Gender | Birthdate | Social Security # | Relationship |
|---|---|---|---|---|---|---|
| | | | | | | |

| Address | City | State | Zip Code | Home: | Cell: | Work: |
|---|---|---|---|---|---|---|
| | | | | | | |

### Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Lake City Eye Physicians , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

| Signature | Signature Date |
|---|---|
| X | |

**Lake City Eye Physicians**
621 SW Baya Drive, Suite 101
Lake City, FL 32025
Phone: 386-754-6616
Email: Drcole@coleoptics.com

**Please attach all pertinent insurance ID cards for photocopying.**

# Patient History Form

Today's Date_____

Patient Name_____ Patient Date of Birth _____

**Medical History**

Are you allergic to any medications? ❒ No ❒ Yes (describe)_____

Please list any current medications (with dosage) you are taking (including over-the-counter eye drops, vitamins or supplements, aspirin and oral contraceptives). _____

_____

_____

List any major injuries, surgeries and/or hospitalizations you have had and date(s). _____

_____

*Have you had any of the following:*

❒ Crossed eyes ❒ Lazy eye ❒ Drooping eyelid ❒ Eye infection

❒ Eye injury ❒ Eye Surgery ❒ Glaucoma ❒ Cataracts ❒ Macular degeneration

*Do you or have you ever experienced any problems in the following areas?*

| System Constitutional | No | Yes |
|---|---|---|
| Fever/Weight loss/Gain | N | Y |
| **Integumentary** | | |
| Eczema | N | Y |
| Psoriasis | N | Y |
| Cancer | N | Y |
| **Neurological** | | |
| Headaches | N | Y |
| Migraines | N | Y |
| Seizures | N | Y |
| Multiple Sclerosis | N | Y |
| Cancer | N | Y |
| **Ear/Nose/Throat** | | |
| Allergies/Hay Fever | N | Y |
| Sinus Congestion | N | Y |
| Chronic Cough | N | Y |
| Dry Throat/Mouth | N | Y |

| Endocrine | No | Yes |
|---|---|---|
| Non-insulin Dependent Diabetes | N | Y |
| Insulin Dependent Diabetes | N | Y |
| Thyroid Dysfunction | N | Y |
| Hormonal Dysfunction | N | Y |
| **Respiratory** | | |
| Asthma | N | Y |
| Chronic Bronchitis | N | Y |
| Emphysema | N | Y |
| Cancer | N | Y |
| **Vascular/Cardiovascular** | | |
| High Blood Pressure | N | Y |
| High Cholesterol | N | Y |
| Stroke | N | Y |
| Heart Disease | N | Y |
| **Lymphatic/Hematological** | | |
| Bleeding Problems | N | Y |

| Gastrointestinal | No | Yes |
|---|---|---|
| Crohn's | N | Y |
| Colitis | N | Y |
| Ulcer | N | Y |
| Digestive | N | Y |
| **Genitourinary** | | |
| Genitals/Kidney/Bladder | N | Y |
| **Allergy/Immunological** | | |
| Drug Allergy | N | Y |
| Environmental Allergy | N | Y |
| Rheumatoid Arthritis | N | Y |
| Lupus | N | Y |
| **Psychiatric** | | |
| Depression | N | Y |
| Panic Disorder | N | Y |
| Schizophrenia | N | Y |
| **Pregnant/Nursing** | N | Y |

**Your Eye Symptoms** – *Do you (patient) experience any of the following?*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Blurred Vision | N | Y | Flashing Lights | N | Y | Seeing Rings Around Lights | N | Y |
| Distorted Vision | N | Y | Painful Eyes | N | Y | Color Vision Difficulties | N | Y |
| Double Vision | N | Y | Gritty/Sandy Eyes | N | Y | Depth Perception Problem | N | Y |
| Red Eyes | N | Y | Aching Eyes | N | Y | Losing Place While Reading | N | Y |
| Watery Eyes | N | Y | Drawing/Pulling | N | Y | Night Vision Problems | N | Y |
| Itchy Eyes | N | Y | Dizziness | N | Y | Extreme Light Sensitivity | N | Y |
| Burning Eyes | N | Y | Excessive Squinting | N | Y | Discharge From Eyes | N | Y |
| Dry Eyes | N | Y | Other _____ | | | Floating Spots | N | Y |

**Family History** – *Has anyone in the patient's family (blood relative) had any of the following?*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cataracts | N | Y | Glaucoma | N | Y | Heart Disease | N | Y |
| Cornea Disease | N | Y | Lazy Eye | N | Y | Diabetes | N | Y |
| Crossed Eyes | N | Y | Macular Degeneration | N | Y | High Blood Pressure | N | Y |
| Retina Disease | N | Y | Cancer | N | Y | Other _____ | | |

**Social History** *This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.*

❒ Yes, I would prefer to discuss my Social History Information directly with the doctor.

Occupation: _____

Do you drive? N Y If yes, do you have visual difficulty while driving? _____
If yes, please describe: _____

Do you use tobacco? N Y If yes, type/amount/how long? _____

Do you drink alcohol? N Y If yes, type/amount/how long? _____

**Hobbies/Recreation/Sport** – Please mark the boxes that apply to you.

❒ Boating/fishing ❒ Gardening ❒ Photography ❒ Sewing ❒ Card playing ❒ Golf ❒ Racquetball/Handball
❒ Flying ❒ Music ❒ Crafts ❒ Hunting ❒ Skiing ❒ Swimming/Scuba

Do you wear: ❒ glasses ❒ contact lenses

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ No ❒ Yes

How often do you replace your contact lenses? ❒ Daily ❒ 1-2 Weeks ❒ Monthly ❒Quarterly ❒ Yearly ❒ Other _____

What brand of contact lenses do you wear? _____

Please provide any additional information you would like to add: _____

*The information provided is true and complete to the best of my knowledge.*

| Patient Signature (or Guardian if patient is a minor) | Date |
|---|---|
| Name of Person Completing Form (if not patient) | Relationship to Patient |

**For Office Use Only**

Review date _____ ☐ Changes ☐ No Changes Provider signature _____
Review date _____ ☐ Changes ☐ No Changes Provider signature _____

***Provider: Keep original signed form in patient's file***

# LAKE CITY EYE PHYSICIANS

## FINANCIAL POLICY

**PATIENT NAME:**_____ **DATE OF BIRTH:** _____

**PAYMENT POLICY:** Payment co-payments and deductibles are due and payable in full at the time services are provided.

**PATIENTS WITH INSURANCE:** We will bill your primary and secondary insurance carriers for you. Your agreement with your insurance carrier is private; we do not regularly investigate why a carrier has not paid or why payment was less than anticipated. If an insurance carrier has not paid within 60 days, you will be responsible for the balance due.

**NON-COVERED SERVICES:** Any care not paid for by your existing insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

**MISSED APPOINTMENTS:** In all fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments or you may be charged a $50 missed appointment fee.

**PAST DUE BALANCES:** All unpaid balances will be forwarded to a Collection Agency in the event of non-payment. If your account is sent to a collection agency, you will be responsible for all collection costs.

**REFUND & RETURNS:** No refunds of payments made via cash, check, visa, mastercard, discover or amex will be provided due to eyewear being custom-made for the patient. See our posted return policy for further details.

***By signing this form I have been made aware of Dr. Reaves Cole & Lake City Eye Physicians/Cole Optic's financial policy.***

SIGNED: _____ DATE: _____

## MEDICARE PATIENTS

I request payment of authorized Medicare benefits be made either to me or on my behalf to LAKE CITY EYE PHYSICIANS/ REAVES C. COLE, OD for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

PATIENT'S NAME (Please Print): _____

PATIENT'S SIGNATURE: _____

PATIENT'S MEDICARE NUMBER: _____ DATE: _____

## ASSIGNMENT OF INSURANCE BENEFITS

Patient's with insurances please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits, to which I am entitled, private insurance, and any other health plans, to LAKE CITY EYE PHYSICIANS/ REAVES C. COLE, OD. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by above insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

PATIENT'S SIGNATURE: _____ DATE: _____

# LAKE CITY EYE PHYSICIANS

## Financial Responsibility and Benefit Utilization Policy

### For Patients with Health/Vision Benefit Plans

As a Primary Health Care Provider, we will ***bill all examination services to your medical insurance carrier.*** Claims for glasses, contact lens fitting fees, and contact lens materials will be billed to your vision plan. If a claim for examination services is denied by your medical insurance carrier, the services may be covered by your vision plan; however, there are no guarantees your vision plan will be accepted as payment for a primary care medical eye examination. Please present your current major medical insurance card and vision benefit card at the time of your visit.

If we determine that we have a working relationship with your vision and/or your health insurance company, we will bill your health and/or vision benefit carrier directly. At the time of service, you are responsible for payment of non-covered charges such as co-payments, deductibles, and overages—most of which have been established by your benefit carrier(s).

As we have no control over your insurer's payment schedule or interpretation of their responsibility, and because our agreement is with you—not your vision or health benefit company—if we do not receive reimbursement from your benefit company in 45 days, we must seek payment from you.

PATIENT SIGNATURE: _____

PATIENT PRINTED NAME: _____ DATE: _____

LAKE CITY EYE PHYSICIANS
REAVES C. COLE, O.D.
*Board Certified Optometric Physician*

# OPTICAL POLICIES & WAIVER FORM

**Dispensing of Prescription Eyewear:**
Prescription eyewear / glasses are a medical device. Cole Optics and Lake City Eye Physicians cannot dispense a pair of glasses without the patient present. Frames must be adjusted and fit to the patient, in addition to instruction on proper use is sometimes indicated (Ex: progressive lenses).

PT INITIALS: _____

**Returns/Refunds/Damage to Prescription Eyewear:**
Every pair of glasses ordered from Cole Optics/Lake City Eye Physicians are custom-made. Therefore, it is not Cole Optics' policy to accept returns on any product that has been ordered/used. We are happy to service all our products and back up with a warranty for quality and workmanship from the manufacturer. Warranties cover against manufacturer's defects under normal wearing conditions and do not cover for accidental breakage, abuse, or loss. Warranties are in effect only for the duration offered by the manufacturer.

PT INITIALS: _____

**Re-Use of An Old Frame / Limitations on Liability:**
Cole Optics cannot be responsible for breakage when we reuse a patient's old frame to manufacture and insert new lenses. We will use the utmost care if we accept a patient's frame, but in a small percentage of cases the frame parts or material will be worn or brittle to the point that it will not support a new lens. Older frames are usually discontinued by the manufacturer and replacement parts are not available. If a patient's frame breaks during our handling, the purchase of a new frame is the patient's expense. It is at the discretion of the optician if a frame can be reused. Additionally, we are not responsible for lost, broken, or damaged frames or lenses by the lab.

PT INITIALS: _____

**Insurance Frames / "Where Are My Glasses?":**
Cole Optics is not responsible for frames that are lost or damaged by insurance-sponsored labs. In these cases, the lab will be responsible for the replacement or repair of your eyewear. There are no exchanges or returns under any circumstances on jobs done by any of the insurance-sponsored labs. There is often a delay due to the high volume of glasses that these labs make; unfortunately, we have no control over these delays. We will work to keep you informed on your order. If you are unsatisfied, please take it upon yourself to call their laboratory directly to check on your order.

PT INITIALS: _____

**Eyeglasses Prescription Change(s):**
For prescriptions written by other doctor(s): Eyeglass lenses will be remade one time at no charge if the prescribing doctor provides a new prescription in writing within 30 days of dispensing. Rx changes are one free remake or after 30 days will be charged the usual lens price.
For prescription by Lake City Eye Physicians: An office visit to recheck the prescription will be provided and new lenses will be made at no charge within 30 days of dispensing. Recheck visits after 30 days will be charged the usual fee for an exam.
If a Lake City Eye Physicians/Cole Optics prescription is filled elsewhere: An Rx change is needed, we will not be responsible for any changes incurred. Most reputable optical dispensaries all doctor Rx changes at no charge, but this is up to the patient to inquire about such policies in advance of purchase.

PT INITIALS: _____

**Progressive Lens Non-Adapt Policy:**
All progressive addition lenses have a slight optical distortion in the outer portions of the lens, which can make some objects appear bowed or curved, or can cause a feeling of motion when the head is turned. The reading zone of progressive lenses is wide enough for most purposes, but it may appear narrower than other bifocal styles. If you cannot adapt to the progressive addition lenses, we will make new lenses in any other design that you wish, within 30 days of dispensing, at no charge. Since the original lenses were a custom prescription item, there are no refunds of the difference in cost if the remade pair is of lesser value.

PT INITIALS: _____

**Non-Cole Optics Product Adjustments:**
We can provide adjustments at the patient's request, but there is a risk. If the product accidentally breaks, Cole Optics is not liable. It is up to the optician's discretion on what is able to be adjusted. Patients can always return to the place of service/purchase in troubleshooting a frame as well.

PT INITIALS: _____

**Patient (Guardian) Signature:**_____ **Date:** _____

# Lake City Eye Physicians

"Advanced Primary Care for the Eyes"

**Reaves C Cole, OD**

*Board Certified Optometric Physician*

621 SW Baya Drive, Suite 101

Lake City, FL 32025

Phone: 386.754.6616 Fax: 386.754.6615


## Cancellation and No-Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Lake City Eye Physicians reserves the right to charge a fee of $75.00 (or $150 if scheduled for multiple procedures in one day) for all missed appointments ("no-shows") or appointments canceled with less than 24 hours' notice.

**"No-Show" fees** will be billed to the patient. This fee is not covered by insurance and must be paid prior to scheduling your next appointment. Multiple "no-shows" in any 12-month period may result in dismissal from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

***By signing below, you acknowledge that you have received this notice and understand this policy.***

_____ _____

**(Patient Name – Please Print)** **(Patient Date of Birth)**

_____ _____

**(Signature of Patient or Patient Representative)** **(Date Signed)**

LAKE CITY EYE PHYSICIANS

## Lake City Eye Physicians and Cole Optics

621 SW Baya Dr Suite 101 Lake City, FL 32025
(386) 754-6616 • melissa@coleoptics.com
https://www.lakecityeyephysicians.com/home/4524563

### We invite you to participate in our online system. Features include:

- Request Appointments Online
- Receive Text Message Appointment Reminders
- Refer Your Friends Online
- Confirm Appointments via Email
- Submit Patient Satisfaction Surveys

### Please Verify Your Contact Information

| | | |
|---|---|---|
| **Name** | | |
| **Address1** | | |
| **Address2** | | |
| **City** | | |
| **State** | | |
| **Zip** | | |
| **Home Phone** | | |
| **Work Phone** | | |
| **Cell Phone** | | ☐ Opt In to Text Messages |
| **Email** | | ☐ Opt In to Email |

I agree to allow Demandforce to use this information in providing my services.

**Signature** **Date**