LAKE CITY EYE PHYSICIANS

Patient Medical History Record

Please answer the following questions about your medical history:

1. Have you ever been treated for any medical conditions? (e.g., diabetes, high blood pressure, arthritis, asthma, lung disease, kidney stones, stroke, TIA, cancer, heart disease, bleeding, etc.) YES NO
If yes, please explain: _____

_____

2. Have you ever had any eye disease: (e.g., glaucoma, cataract, wandering or "lazy eye," retinal detachment) YES NO
If yes, please explain: _____

_____

3. Have you ever had surgery? YES NO
If yes, please provide date and reason: _____

_____

4. Have you ever been hospitalized? YES NO
If yes, please provide date and reason: _____

_____

5. Do you take any medications? YES NO
Please list: _____

_____

6. Do you have any food or drug allergies? YES NO
Please list: _____

7. Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
Please list: _____

_____

8. Do you smoke? If yes, how much? _____

9. Do you drink alcohol? If yes, how much? _____

10. Developmental (pediatric patients only): Premature? _____ Birth weight? _____ Normal milestones? _____

11. Are you currently breast feeding? YES NO

12. Are you or could you be pregnant? YES NO

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS:	*YES*	*NO*	*EXPLAIN:*
Heart Problems (chest pain, irregular heart beat)			
Respiratory Problems (shortness of breath, wheezing, coughing)			
Chronic Fever, Unexpected Weight Loss/Gain, Fatigue			
Ear/Nose/Throat Problems (hearing problems, sinus problem, sore throat)			
Gastrointestinal Problems (heart burn, abdominal pain, diarrhea, vomiting)			
Urinary Problems (pain or discomfort, blood in urine)			
Skin Problems (rash, excessive dryness)			
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)			
Neurological Problems (numbness, weakness, headaches, paralysis)			
Psychiatric Problems (depression, anxiety)			
Endocrine Problems (hot or cold intolerance, excessive thirst)			
Hematological Problems (easy bleeding, lymph node enlargement)			
Allergic/Immunological Problems (hay fever, frequent infections)			

PATIENT SIGNATURE: _____ **DATE:** _____

LAKE CITY EYE PHYSICIANS
REAVES C. COLE, O.D.
Board Certified Optometric Physician
621 SW Baya Drive, Suite 101, Lake City, FL 32025 TEL: 386.754.6616 FAX: 386.754.6615

LAKE CITY EYE PHYSICIANS

Patient Ocular History Record

Please answer the following questions about your ocular medical history:

Patient Name: _____ Birth Date: _____ Age: _____

School (if student): _____ Grade: _____

Employer: _____ Occupation: _____

If under 21, Father's Name: _____ Mother's Name: _____

Name of Last Eye Doctor: _____ Approximate Date of Visit: _____

Do you wear eyeglasses? No ____ Yes ____ For: Distance ____ Near ____ Full-Time ____ Part-Time, for What?

Do your eyeglasses have: Anti-Glare Coating ____ Tint: ____ Solid ☐ Sun Activated ☐ Thin & Light Material ____

Do your eyeglasses require special lenses (Progressive, Bi-Focal, etc): _____

Do you wear contact lenses? No ____ Yes ____ Type: Soft ☐ Hard (gas permeable) ☐ Disposable ☐ Toric ☐

Have you worn contact lenses in the past? No ____ Yes ____ When? _____ Do you sleep in your lenses? ____

Do you have now, or have you ever, had: (please mark R for recent or P for in the past)?

_____ Distance Blur _____ Near Blur ____ Watery Eyes ____ Itchy Eyes ____ Black Outs/Vision Loss

_____ One Eye Blurred _____ Dry Eyes: ____ Both Eyes ____ One Eye

_____ Frequent Loss of Place While Reading ____ Macular Degeneration ____ Glaucoma: How Long? ____

_____ Double Vision (Seeing 2 Images) ____ Cataracts? ____ Surgery? Right ☐ Left ☐ When? _____

_____ Poor Reading Comprehension ____ Optic Neuritis ____ Shimmering/Geometric Lights

_____ Fluctuating Vision ____ Floating Spots ____ Flashing Lights? Right ☐ Left ☐

_____ Color Vision Problems ____ Iritis/Uveitis ____ Eye Injury: What?

_____ Droopy Eyelids: Right ☐ Left ☐ ____ History of A Turning Eye? Right ☐ Left ☐ When? _____

_____ Eye Pain ____ Surgery To Straighten An Eye: Right ☐ Left ☐ When? _____

_____ Eye Strain ____ Patching An Eye: Right ☐ Left ☐ When? _____

Anything else about your eyes that we should know?

_____

_____

Are there any hobbies or specialty areas at home/work in which you have specific visual needs (ie, reading, reading music, using a computer, working overhead, target shooting, playing golf, scuba diving, sewing, needlepoint, etc.) Please list so we can better assist you in seeing more efficiently. _____

_____

Patient Signature: _____ **Date:** _____

Patient E-mail Address: _____

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

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: / Work: / Cell:	How did you hear of us?
Address 2	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.

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 $25 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

LAKE CITY EYE PHYSICIANS

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPTIONS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Lake City Eye Physicians, LLC, (The Practice), in order to carry out treatment, payment, or health care operations. The patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such notice prior to signing this consent form.

The Practice reserves for itself the right to change the term of its Notice of Privacy Practices at any time if the practice does change the terms of its Notice of Privacy Practices, the patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such request restrictions; however, if the Practice does agree to patients requested restriction(s); such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and Patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the patient:

_____

_____

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate space below):

_____ Via e-mail to the Patient's designated e-mail address which is:

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the patient's name, social security number, and unique personal identifier)

At all times, the Patient retains the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action in the reliance on the consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign the consent form. If Patient (or authorized representative) signs this consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of the revocation (except to extent that the Practice is required by law to treat individuals.)

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

DATE **TIME** AM/PM

_____ _____

SIGNATURE OF PATIENT (or Authorized Representative) **PLEASE PRINT NAME**

_____ _____

Please explain representative's relationship to Patient and include a description of representative's Authority to act on behalf of the Patient: _____

_____

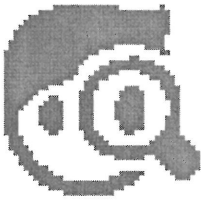
Why do we need your medical card?

A WellVision Exam combines a comprehensive vision evaluation with a very important diagnostic medical eye exam.

Vision Evaluation

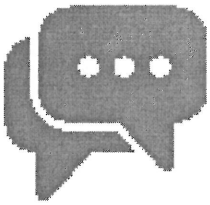
Your vision exam is an integral piece of your overall health and typically involves:

- Refractive Exam
- Dilation
- Prescription for glasses or contact lenses



Your eye doctor also provides important input about your overall health, and can diagnose eye conditions like:

- Diabetic Retinopathy
- Cataracts
- Macular Degeneration
- Glaucoma



We may ask for your medical ID card to bill your medical insurance, in addition to your vision insurance. The care provided by your eye doctor leads to continued quality vision, and can also help identify health conditions that are often first detected through an eye exam.