Lake Lazer Eye Center

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

Last Name_____ First Name_____ M.I._____

DOB_____ SSN_____ Gender_____ Marital Status: M S W D

Race: African American/Black American Indian/Alaskan Native Caucasian/White Native Hawaiian/Pacific Islander Other Decline to Answer

Ethnicity: Hispanic/Latino Non Hispanic/Latino Decline to Answer

Home Address_____ City_____ State____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

Employment Status: Active Duty Military Full-Time Part-Time Retired Self-Employed Student Full-Time Student Part-Time Unemployed

Employer_____ Employer Phone_____

Family Physician_____ Physician Phone_____

How did you hear about us?/Referred by_____

Emergency Contact_____ Phone_____

CURRENT MEDICATIONS (include regularly used OTC medications)

_____

_____

PRIMARY INSURANCE - Please provide insurance card(s) with this completed form

Policy Holder's Name_____ Policy Holder's DOB_____

Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Insured's ID#_____

Policy Group ID#_____ SSN_____

Policy Holder's Relationship to Patient_____ Do you have Medicare Coverage?_____

SECONDARY INSURANCE

Policy Holder's Name_____ Policy Holder's DOB_____

Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Insured's ID#_____

Policy Group ID#_____SSN_____

Policy Holder's Relationship to Patient_____ Do you have Medicare Coverage?_____

(over)

Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments and/or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays and/or deductibles are expected at the time of service. If this fee is not covered by insurance it will be your responsibility.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Lake Lazer Eye Center of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment and/or devices at the rate not to exceed Lake Lazer Eye Center's usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his/her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits.

Release of Information:

I hereby authorize Lake Lazer Eye Center to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment and/or devices received by the patient. I also authorize Lake Lazer Eye Center to release the medical records or the patient to the patient's referring physician or family physician indicated on this form.

Financial Responsibility Agreement by Other than Patient's Legal Representative:

I agree to accept financial responsibility for the goods and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefits, and Release of Information provisions above.

HIPAA Acknowledgement:

By signing below, I acknowledge that I received a copy of Lake Lazer Eye Center's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted on the website and that any revised Notice of Privacy Practices will be made available.

I HAVE READ AND AGREE TO THE TERMS ABOVE:

_____

Patient or Legal Representative (print)

_____ _____

Patient or Legal Representative Date

I, _____ give Lake Lazer Eye Center permission to leave telephone messages. This will remain in effect until you rescind it in writing.

Lake Lazer Eye Center

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

NOTICE TO ALL PATIENTS

Our office appointment policy is listed below. We thank you for your cooperation.

1. We request 48 hours notice for cancellation or rescheduling of an appointment. This allows us to provide care to other patients waiting for an appointment. We will give you a reminder call at least 2 days prior to your appointment.
2. **Appointments that are missed, cancelled or rescheduled with less than 48 hours prior to the date and time of the appointment are subject to a $25 charge.**
3. **APPOINTMENTS FOR PROCEDURES (i.e. LASIK, LID SURGERY, AMNIOTIC MEMBRANE OR ANY OTHER SURGERY) THAT ARE MISSED, CANCELLED OR RESCHEDULED LESS THAN 5 BUSINESS DAYS PRIOR TO THE DATE AND TIME OF THE APPOINTMENT ARE SUBJECT TO A $250 FEE.**
4. If your insurance requires a referral, it is your responsibility to provide it at the time of your appointment. If the referral is not available, you will need to reschedule or be responsible for the payment of charges.
5. While visiting our office, we ask that you refrain from using your cell phone as it affects our equipment.
6. Please bring an updated medication list with you to your appointment.
7. We require that all patients show photo ID and insurance cards at each visit. This is to prevent insurance fraud.
8. Please bring sunglasses and have a driver available when you schedule your dilated eye exam. If you are being followed for contact lens issues, please bring them with you.
9. Prescriptions are sent electronically. Please bring in your preferred pharmacy information with you.
10. Lake Lazer Eye Center performs eye exams and procedures *that fall under the **medical** insurance*
11. *category*. We also offer exams for glasses and contact lenses which fall under the *umbrella of **vision** insurance*. Vision insurance does **NOT** cover an exam if you are having problems that are related to an eye disease – this is only covered under medical insurance just as if you had a medical problem with any other part of the body. Conversely, your medical insurance will not cover a routine exam for eyeglasses/ contact lenses unless you have a vision rider.

Patient Name:_____

Patient's Signature: _____ Date: _____

(over)

Lake Lazer Eye Center

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

RETURN POLICY FOR EYEGLASSES & CONTACT LENSES

All sales of prescription and non-prescription contact lenses, eyeglasses and sunglasses are final. Orders take 7 to 10 business days to arrive.

If, however, there are any discrepancies between the Doctor's prescription and the lenses manufactured by the lab, or between the Doctor's prescription and the actual prescription, any adjustments to the prescription lenses are included at no charge within 60 days.

All orders require at least 50% deposit.

Adjustments for glasses and minor repairs are provided free of charge.

Professional services are nonrefundable.

POLICY FOR PICKING UP EYEGLASSES & CONTACT LENSES

All eyeglasses and contact lenses that have been prescribed, fitted, and purchased by the patient will be kept in the office for a total of one year from the date of purchase. If the patient does not pick up his/her eyeglasses or contact lenses within that year, they shall, by default, become the property of LLEC, and we will no longer be responsible for those eyeglasses or contact lenses.

I have read, understood, and shall abide by all aspects of the policies explained to me above. It has been made known to me that if any or all parts of the above policies are not fully understood by me, for any reason at all, that proper explanation, or translation, is available and ultimately has been provided to me at the time of signing.

Patient Name:_____

Signature:_____ Date:_____

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative: _____

Relationship to Patient:_____

Lake Lazer Eye Center

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

TEAR LAB CONSENT

Millions of people suffer from Dry Eye Disease. Yet in the majority of cases it goes undiagnosed. Often this is because sufferers misunderstand the symptoms.

The following listed are the most common symptoms. Please circle any that may apply.

Redness Burning Itching Watery eyes Fluctuations in Vision Tired eyes

Feeling of sand or grittiness Contact lens discomfort Light sensitivity

If you suffer from two or more of these symptoms you may have Dry Eye Disease and should discuss your symptoms with your physician. People often assume they are caused by external irritants or that they are just part of life. Dry Eye Disease occurs when your eyes do not produce enough tears or produce poor-quality tears. This can happen for several reasons and it's essential you get your tears analyzed by your eye doctor.

Now, thanks to breakthrough technology, patients can be tested in their doctor's office and get objective results immediately. Your eye doctor will take a sample of tears from each eye and use the TearLab to measure osmolarity.

Due to this new technology your insurance does not pay for this testing. The amount for this testing is **$50**, payable at time of service. We will gladly give you a receipt to submit to your insurance.

_____ I would like to have the TearLab testing performed and understand that I am responsible for the cost of this testing.

_____ I decline having this testing, at this time.

Patient Name _____ Date _____

Patient's Signature_____

(over)

Lake Lazer Eye Center

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

Medicare and an increasing number of commercial insurance carriers **do not** cover ***refractions***. *

The **refraction** is the part of your eye exam where the doctor obtains your **eyeglass prescription**.

Please choose an option below:

___ I choose to pay a discounted rate of $75 for my refraction today.

___ I choose to pay $100 for Contact Lens Fit

___ I do **not** want to be refracted today.
(Note: your doctor will be unable to give an eyeglass or contact lens Rx without performing a refraction.)

___ I have routine vision benefits that cover refraction and would like to schedule this appointment for a later date.

_____
Patient Name

_____ _____
Patient Signature Date

*CMS, the department of the federal government that controls Medicare and Medicaid, has decided that refractions are not a payable part of an eye exam. CMS, directly under control of the US Congress, has determined this is a “noncovered” service. That means you have to pay for that portion of the eye exam.