Southwest Orlando EyeCare
Your Vision Is Our Focus

Last Name: _____ M.I. ____ Name: _____Date: _____
Occupation: _____ Address: _____
Social Security #:_____ City: _____ State: _____ Zip Code: _____
Email: _____ Phone: Home: _____ Cell: _____
Race: _____ Work: _____
Date of Birth: _____ ☐ **M** ☐ **F** Date of last eye exam: _____
Reason for visit: _____
How were you referred to our office: _____
Preferred form of communication (Please circle): Phone Email Text

List of any medications you currently take (prescription and over-the-counter)_____
_____
Are you allergic to any medications? **YES NO**
If YES, list the medications:_____
List all major illness (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):_____
List any surgeries you have had (cataract, appendectomy):_____
_____

Do you ***currently*** have any problems in the following fields? If YES, please circle or add additional information.

	YES	NO		YES	NO
EYES: poor vision, eye pain, tearing, redness, etc.			**FEMALES**: Are you pregnant? Nursing?		
PSYCHIATRIC: anxiety, depression, insomnia			**CARDIOVASCULAR**: high BP, racing pulse, etc.		
ENDOCRINE: diabetes, hypothyroid, etc.			**SKIN**: pimples, warts, growths, rash, etc.		
MUSCLES, BONES, JOINTS: joint pain, stiffness, swelling, cramps, arthritis, etc.			**BLOOD/LYMPH**: bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.		
GASTROINTESTINAL: upset stomach, diarrhea, constipation, hernia, ulcers, etc.			**ALLERGIC / IMMUNOLOGY**: sneezing, swelling, redness, itching, hives, lupus, etc.		
RESPIRATORY: congestions, wheezing, short of breath, etc.			**GENITAL, KIDNEY, BLADDER**: painful urination, frequent urination, impotence, yellow jaundice, etc.		
NEUROLOGICAL: numbness, headache, seizures, paralysis, etc.			**EARS, NOSE, THROAT**: hard of hearing, stuffy nose, earache, cough, dry mouth, etc.		

FAMILY HISTORY (Mother, Father, Grandparents, Siblings):

Has any member of your family had these diseases? (Circle all that apply) **YES NO**
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease: _____

SOCIAL HISTORY:

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Are you interested in Lasik? **YES NO**
Have you ever had a blood transfusion? **YES NO**
Do you drink alcohol? **YES NO** If **YES**, how much? _____
Do you smoke? **YES NO** If **YES**, how much? _____ How many years? _____

INSURANCE & PHARMACY INFORMATION:

Ins. Provider:_____ Group#:_____
Insured Name: _____ Ins. ID #: _____
Insured Date of Birth:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent
Pharmacy:_____ Phone #:_____

Southwest Orlando EyeCare
Your Vision Is Our Focus

DR. JOHN NOWELL & DR. BENJAMIN KONYNENBELT

Retinal Imaging

Digital Retinography System (DRS). The DRS captures a digital image of the retina, the portion of the eye responsible for seeing. Since every patient's eyes are unique, this image provides a baseline for comparison as the doctor monitors your eye health through the years. Having this done yearly allows the doctor to know exactly when and how your eyes are changing and if further treatment is needed. It is completed in a matter of seconds and provides instant results that will be reviewed with you today!

iWellness Optical Coherence Tomography (OCT) The iWellness OCT is the newest technology in retinal imaging. It uses near infrared light to capture a 3D image of retina, allowing the doctor to access a portion of the eye impossible to evaluate using standard examination techniques. This advanced test detects ocular diseases such as glaucoma, macular degeneration, or diabetic retinopathy before they would be visible during a routine eye exam. As with most conditions, early detection is key in properly treating eye disease. The results are instantaneous and will be reviewed with you today!

To help us provide a higher quality of care to our patients we recommend these tests to all patients. In most cases, these advanced tools are not covered by insurance.

- ○ I elect the DRS imaging. ($40)
- ○ I elect the iWellness imaging ($40)
- ○ I elect to have both with the bundle discount ($60 total)
- ○ I decline testing.

Contact Lens Evaluation

Annual contact lens evaluations are not included in a routine eye exam and may not be covered by insurance. Payment will be required at the time of service for all contact lens evaluations. The fee for the annual evaluation is based on the complexity and type. The usual and customary fee range is $95 to $160. All contact lens progress exams will be covered without charge for 90 days. Additional fees may apply.

- ○ I elect to have a contact lens evaluation and agree to pay the fee required.
- ○ I do not wish to have a contact lens evaluation and understand that my exam will not result in a prescription for contact lenses

_____ _____

Signature Date

SOUTHWEST ORLANDO EYE CARE

Financial & Insurance Policy:

Thank you for choosing Southwest Orlando Eye Care as your Vision Care Provider. As a part of our services, we try to contain the ever-rising cost of vision care. In an effort to do so, we advise you to read and sign the following financial policy prior to treatment. Patient or responsible party must complete our information and insurance form before seeing the doctor.

- **FULL PAYMENT, CO-PAYMENT, PERCENTAGES AND/OR DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED.** We accept cash, checks, Visa, MasterCard, American Express and Discover. If you are purchasing eye glasses or contacts, you will be expected to pay in full before any orders can be processed.
  _____ (Initial) **NO SHOW POLICY:** A patient is considered a "No Show" if an appointment is missed or cancelled with less than 24 hours notice. When this occurs, Southwest Orlando Eye Care loses the opportunity to care for other patients that wish to be seen. Failure to give 24 hours notice will result in a $100 fee. _____ (Initial)
- **Office Policy:** Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. If your insurance has not paid within 60 days you (the patient) will be notified. Orders are for a custom product. Please make your selection carefully.
- **Minor Patients (under the after of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in **ADVANCE** and we must have parents or guardians written permission prior to treatment of a minor.
- **Returned Checks:** A $50.00 service charge will be applied to your account for returned checks. All returned checks will not be redeposited. All balances must be paid in cash or by credit card. One attempt will be made to collect this debt from the patient, if not collected within 5 days of the returned check; the account will be turned over to our collection agency. We request a copy of your driver's license for your records if you wish to make payments by check.
- **Spectacle Prescription:** If the patient desires to take their spectacle lens prescription elsewhere, Southwest Orlando Eye Care will not be responsible for any warranty on glasses made elsewhere. However, the optician will be happy to check the prescription of your glasses against your prescription given at no charge. If you are not happy with your eyeglasses purchase for any reason we will gladly refund your money within 60 days after you receive your eyeglasses. Frames come with a one year warranty.
- **Contact Lens Patients:** Additional time and testing is required for the fitting and evaluation for contact lenses so there will be an additional professional fee charged outside of the comprehensive examination fee. Patients have 90 days of follow-up care from the date of the fitting to make any changes in the prescription necessary, any visit after 60 days, a fee will be incurred. A contact lens prescription is only valid one year from the exam date and cannot be filled once expired. Once contacts have been ordered and received by the patient, contact lenses cannot be returned. If the patient desires to take their contact lens prescription elsewhere, Southwest Orlando Eye Care will not be responsible for any warranty on their contact lenses, and all follow-up visits will be charged an additional professional fee.
- Eyeglass and contact lens prescriptions (when requested) are faxed at the end of each business day. _____(Initial)
- **Please acknowledge that:**
  1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party in that contract.
  2. You are responsible for all charges that are denied/not covered by the insurance company. Not all services are covered under.
  3. Although we verify coverage through your insurance company with each and every patient, verification of benefits is not a guarantee of payment. You must present a company of your insurance card for your records if insurance or any discount plans are being utilize. Only one insurance/discount plan is accepted, per patient, per year.
- **Patient Responsibility Agreement: (Please check one)**
  - ☐ I am receiving services from Southwest Orlando Eye Care through my insurance _____ _____. My insurance company has been contracted and my insurance coverage has been verified.
  - ☐ I am presenting no insurance coverage, and therefore I am financially responsible for all services rendered.
- I authorize release of any information concerning my healthcare and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the Optometrist, otherwise payable to me.
- I have read and understood the above. (Please sign below)

Signature _____ Date_____

Notice of Privacy Practice

This notice describes how your health information may be used and disclosed. Please review it carefully.

- At Southwest Orlando Eye Care, we have always kept your health information secure and confidential.
- A law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the call.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- You may request in writing that we not use or disclose your health information as described above.
- As we will need to contact you from time to time, we will use whatever address, telephone numbers, or email address we have on file.
- You have the right to transfer copies of your health information to another practice.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request or sign a records request form in regards to the information you are requesting.
- If we change the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at (407)271-8931.

Acknowledgement:

I have received a copy of the Southwest Orlando Eye Care Notice of Privacy Practices.
Returns or cancellations of glasses or contacts are made at the discretion of this office. An in office credit will be issued. Progressive lenses have a non-adapt 90 day warranty, which means we can exchange the lenses for single vision or lined bifocal lenses. Ophthalmic lenses for glasses are custom made for you.

Signature: _____ Date: _____

Print Name: _____

If signing as a parent or guardian, please print the name of the patient below:

_____