WELCOME TO EYE CARE OF SOUTHWEST FLORIDA: PATIENT REGISTRATION

DATE:__________________

Last Name:__________________________________ First:__________________________ MI_____ DOB_________________

Preferred Name / Nickname:____ □ Male □ Female

Local Address:____ City:__________________ ST:_____ Zip:____________

E-mail address:____ SS#:____________________________________

Cell Phone #:_______________________________________ Home Phone #:_______________________________________

Marital Status: □ Single □ Married □ Divorced □ Widowed

Northern Address: ____ City:______________ ST:_____ Zip:__________

The State of Florida requires that we gather the following information (please check the appropriate box):

Race:
- □ American Indian or Alaskan Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Other Pacific Islands
- □ White
- □ Other Race
- □ Decline to answer

Ethnicity:
- □ Not Hispanic or Latino
- □ Hispanic or Latino
- □ Unknown
- □ Decline to answer

Preferred Pharmacy:_________________________________ Location:______________________ Phone #:_____________

Emergency Contact Name:____________________________ Relationship:___________________ Phone #:_____________

INSURANCE INFORMATION (We will copy the front/back of your insurance cards)

□ If you are working, Employed by: ____

□ Retired – If retired, is Medicare your primary insurance? □ Yes □ No

PRIMARY Medical Insurance: _________________________________ ID# ____

SECONDARY Medical Insurance: ______________________________ ID# ____

VISION Insurance: ____ ID# ____

RESPONSIBLE PARTY (If patient is responsible, check here □)

Last name:_______________________________________ First:___________________________ SS#:__________________

Relationship to patient:________________________ Phone #:_____________________ □ Home □ Cell

I hereby authorize Eye Care of Southwest Florida to disclose my Protected Health Information (PHI) to the noted individuals:

Name:____ Relation:____

Name:____ Relation:____

VISUAL AND MEDICAL HISTORY:

Reason for today's visit: □ Glasses exam □ Contact Lens exam □ Red Eyes □ Other:

Glasses currently worn: □ Distance Only □ Near Only □ Bifocal □ Trifocal □ Progressive □ Computer

Date of last eye exam:__________________ Name of Doctor: ____

Are you interested in learning about **Lasik Surgery**? □ Yes □ No

Date of last medical exam:________________ Name of Doctor:____

Medications you are currently taking (including over-the-counter): ____

____

Please list any drug allergy: ____

Seasonal allergy: □ Yes □ No

Do you smoke? □ Yes □ No Smoking frequency: ____

Please check the following that apply to you and/or your immediate family members:

	SELF	FAMILY (List Relationship)		SELF	FAMILY
Cancer	_____	_____	Eye Injury	_____	_____
Diabetes	_____	_____	Floaters/Flashes	_____	_____
High Blood Pressure	_____	_____	Double Vision	_____	_____
Thyroid	_____	_____	Headache	_____	_____
Arthritis	_____	_____	Lazy Eye	_____	_____
Heart Disease	_____	_____	Cataract	_____	_____
Respiratory Problems	_____	_____	Glaucoma	_____	_____
Kidney Disease	_____	_____	Retinal disease	_____	_____
High Cholesterol:	_____	_____	Macular Degeneration	_____	_____
Other:	_____	_____	Eye Surgery	_____	_____

Do you have: Dry Eyes? □ Yes □ No Itchy Eyes? □ Yes □ No Excess Tearing? □ Yes □ No

Do you skip lines or lose your place when reading? □ Yes □ No Do you get car sick/motion sickness? □ Yes □ No

CONTACT LENS INFORMATION:

Do you currently wear contact lenses? □ Yes □ No If yes, what type?____

How often do you replace your contact lenses?___________________________ Do you sleep in your contacts? □ Yes □ No

Are you interested in contacts you can sleep in up to: **7 days?** □ Yes □ No

Are you interested in bifocal/multifocal contact lenses? □ Yes □ No

FINANCIAL POLICY: It is the policy of Eye Care of Southwest Florida, LLC to file insurance on your behalf. Filing a claim is not a guarantee of payment. Your insurance policy is a contract between you and your insurance company; we are not a party to this contract. Although we verify your benefits, please be aware that some, and perhaps all, of the services provided may be non-covered services under your vision/medical insurance. All personal and health information obtained is kept private and confidential except as required or permitted by the law for billing your insurance company for payment of services. Co-pays, Deductibles and Co-insurance are required billing fees per the contract with your insurance company.

*If you do not inform us that you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.

*I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.

*I agree this office with no exceptions will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits.

*We will begin your custom glasses order immediately after receipt of payment. All glasses are custom crafted for each patient's unique visual needs. All glasses lenses are tailored to fit the frame which patient selected.

Cancellations on glasses will not be permitted. Patients may not switch frames after their order has been processed. REFUNDS ARE NOT AN OPTION. ALL PRESCRIPTION EYEGLASS LENS REMAKES MUST BE MADE WITHIN 30 DAYS OF ORDER DATE. AFTER 30 DAYS YOU WILL BE CHARGED FOR NEW LENSES.

PATIENTS INITIALS________

REFRACTION: Is a diagnostic test used to determine your best corrected vision. Most **MEDICAL** insurances **DO NOT COVER** this procedure. If your insurance does not cover your refraction, you will be asked to pay a fee of $40.00

PATIENTS INITIALS________

DILATION: A dilated examination allows Dr. Sagona to see the entire inside of your eye by using eyedrops. These drops cause your pupils (the black areas in the center of the eyes) to open wider (dilate). With the pupils dilated, Dr. Sagona has a better view of the lens (the clear part of the eye behind the pupil that light travels through) and the retina (the back lining of the eye that contains the optic nerve and the only visible blood vessels in the body). I hereby make the following choice: Please check one

- ○ I agree to dilation today.
- ○ I refuse the dilation and understand that I am releasing Dr. Sagona, O.D. from any liability.
- ○ I refuse the dilation today and understand that I am responsible for rescheduling my dilation.

  ***If rescheduled within 30 days there will be no additional charges.*

PATIENTS INITIALS________

CONTACT LENSES: Contact lens exam/fitting and boxes are **NOT** included with comprehensive eye exam. Contact lens exam/fitting is an additional service which includes exam, fitting, training and trial contact lenses. Contact lens exam/fitting and contact lens boxes may be covered at a specific benefit amount according to your insurance. This applies towards provider's fee and the purchase of your lenses. If your contact lens benefits have been exhausted the **contact lens fitting exam and contact lens box fees will be billed to you.**

ALL FOLLOW-UP EXAMS MUST BE COMPLETED WITHIN 30 DAYS.

AFTER 30 DAYS YOU WILL BE CHARGED A CONTACT LENS EXAM FEE; AFTER 60 DAYS YOU WILL BE CHARGED FOR REFRACTION AND CONTACT LENS EXAMS FEE. AFTER 180 DAYS YOU WILL CHARGED A COMPREHENSIVE AND CONTACT LENS EXAM FEES.

REFUNDS ARE NOT AN OPTION ON CUSTOM CONTACT LENS ORDERS

PATIENTS INITIALS_______

ELECTIVE TESTS NOT COVERED BY INSURANCE

1. **VISUAL FIELD TESTING:**

This screening checks for visual field defects, both in central and peripheral areas. Visual field screening can assist the doctor in early detection of glaucoma, optic nerve disease, visual related neurological diseases, and possible causes of headaches.
******_**The fee for this procedure is $35.00 ($100 Discount). Please check one and sign below.**_

______ I **DO** consent to having a visual field performed.

______ I **DO NOT** wish to have a visual field screening performed. I release Dr. Sagona from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

2. **FUNDUS CAMERA PHOTOS:**

The word "fundus" describes the inside or back of the eyeball. A fundus photo would contain an image of the center of the very back inner wall of the eye: the retina. The optic nerve, macula and main retinal blood vessels are common structures seen in a fundus photo. Fundus photography is very useful to document the natural state of the back of the eye in order to give the retinal specialist a future reference to compare with during follow-up visits. It is important to document the findings of most retinal diseases and conditions, especially diabetic eye disease findings, macular degeneration, epi-retinal membranes, macular holes and retinal tears and detachment.
******_**The fee for this procedure is $39.00 ($87 Discount). Please check one and sign below.**_

______ I **DO** consent to having fundus photos performed.

______ I **DO NOT** wish to have fundus photos performed. I release Dr. Sagona from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

3. iWellness Exam™:

Vision threatening diseases such as glaucoma, macular degeneration and diabetic retinopathy often have no outward signs or symptoms in the early stages, so our practice has begun using state-of-the-art technology to assess the health of your eyes. The iWellness Exam™ is a quick non-invasive scan that allows Dr. Sagona to see beneath the surface of your retina. This unique technology can help Dr. Sagona detect vision threatening and systemic diseases in their very early stages, when they are most treatable. As part of your pre-exam testing, our technician will perform the iWellness Exam™ which Dr. Sagona will review with you during your examination today.
*****The fee for this procedure is $39.00 ($40 Discount). Please check one and sign below.

______ I **DO** consent to having iWellness Exam™ preformed.

______ I **DO NOT** wish to have iWellnes Exam™ preformed. I release Dr. Sagona from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

*****We strongly believe in the early detection and treatment of all ocular disease and conditions and strongly recommend all patients to have all 3 procedures performed. ********If you choose to have all 3 tests performed, an additional courtesy discount will be applied. Total for all 3 tests will be $99.00 total ($14 Discount, Total Savings $241). ******

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Signature (Patient/Legal Guardian) Date

Effective date of notice: 01/01/2017

NOTICE OF PRIVACY PRACTICES

EYE CARE OF SOUTHWEST FLORIDA, LLC

Jill Sagona, O.D.
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Naples, FL 34110
P: 239-631-6451
F: 239-631-6455
eyecareswfl@gmail.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call, text, email or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, text, email or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, text, and/or leave you a reminder voicemail on your cell and/or home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eye Care of Southwest Florida, LLC's Notice of Privacy Practices. Please retain copy for your records.

Patient name (Please Print): ____

Signature____ **Date** ________________