SCHWARTZ EYE ASSOCIATES

1378 SE 17th Street, Fort Lauderdale, FL 33316 ●Tel: (954)467-6227 ●Fax: (954) 467-1488 Schwartzeyedoc@gmail.com

Date:_____ Gender: ○ male ○ female

Name:_____ Date of Birth:_____Age:_____

Home address:_____

City:_____State:_____Zip:_____

TELEPHONE NUMBERS:Home:_____Cell:_____Work:_____

Employer:_____Occupation:_____

Email Address:_____

How did you hear about us?_____

Do you have **DAVIS VISION** or **EYEMED VISION PLAN**?_____

Do you have **MEDICAL INSURANCE**? ○ YES ○ NO Company:_____

Vision Plans cover "well vision" exams. Any medical history or diagnosis that can affect the eyes will result in the visit being billed to your medical insurance.

Date of Last Eye exam:_____ Previous Eye Doctor: _____

Last Physical Exam:_____ Primary Care Physician:_____

OCCUPATIONAL VISION CONCERNS

Do you perform extensive up-close work? ○ yes ○ no

Does your job require safety glasses? ○ yes ○ no

Are you outdoors all or much of the time? ○ yes ○ no

How much time do you spend on a computer daily? ○ None ○ 3-6 hours ○ more than 6 hours

CURRENT EYEWEAR STATUS

Glasses worn: ○ never ○ constantly ○ for distance ○ or reading

Do you wear bifocals? ○ yes ○ no Trifocals? ○ yes ○ no Progressives (no line)? ○ yes ○ no

OVER

MEDICAL/EYE HISTORY

Do you have any allergies to medications? O **yes** O **no if Yes, explain** _____

List any medications taken (including oral contraceptives, over the counter medications, and home remedies):

MEDICAL INFORMATION Do you currently have any problems in the following areas?

DIABETES	YES	NO	BLURRED VISION	YES	NO
HIGH BLOOD PRESSURE	YES	NO	EYE SURGERY	YES	NO
HEART DISEASE	YES	NO	EYE INJURIES	YES	NO
THYROID DISEASE	YES	NO	GLAUCOMA	YES	NO
ASTHMA	YES	NO	CATARACT	YES	NO
RHEUMATOID ARTHRITIS	YES	NO	MACULAR DEGENERATION	YES	NO
HEADACHES	YES	NO	FLOATERS/FLASHERS	YES	NO
ALLERGIES/HAY FVER	YES	NO	ITCHY EYES	YES	NO
ELEVATED CHOLESTEROL	YES	NO	DRY EYES	YES	NO
HIV	YES	NO			

If you answered "yes" to any of the above or have a condition not listed, please explain

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Family History: Please note any family history for the following conditions?

Disease/Condition			**If History in family, list relationship to you**
DIABETES	YES	NO	_____
HIGH BLOOD PRESSURE	YES	NO	_____
GLAUCOMA	YES	NO	_____
CATARACT	YES	NO	_____
MACULAR DEGENERATION	YES	NO	_____
HEART DISEASE	YES	NO	_____

CONTACT LENS USE

Years worn:_____ O soft O rigid Do you sleep in your contacts O YES O NO

Brand of contact lens:_____Solution Brand_____ age of contacts _____

SOCIAL HISTORY:

Do you drive? O YES O NO If yes, do you have visual difficulty when driving? O YES O NO

If yes, please describe_____

Do you use tobacco products? O YES O NO If yes, how much and for how long?_____

Do you drink alcohol? O YES O NO If yes, how much?_____

SCHWARTZ EYE ASSOCIATES POLICIES AND PROCEDURES

I understand that while my medical insurance may confirm benefits, confirmation of benefits does not mean that the insurance company will pay the doctor and that I am responsible for any unpaid balance. Initial _____

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, prior authorization requirements or any other type of benefits limitation for the service I receive. I agree to make payment in full. Initial _____

MEDICAL INSURANCE vs. VISION INSURANCE

Medical Insurance: When a medical condition or diagnosis is present such as Cataracts, Diabetes or any other condition related to the health of your eyes, it is necessary for the doctor to provide you with a comprehensive ocular health examination. In this case, we will file a claim to your health insurance carrier. Most carriers will pay a portion of the some diagnostic tests needed to determine, diagnose and treat medical conditions related to your ocular health.

Vision Plans: Vision coverage through most vision plans is mainly designed to determine the prescription for glasses or contact lenses ONLY. This does not include a detailed exam of the health of the eye or any diagnostic tests needed to determine medical conditions. If you have Diabetes, Cataracts, Macular Degeneration, use medications that have potential ocular side effects, Glaucoma or any other medically related eye condition, your medical insurance is PRIMARY and your vision insurance is secondary. Under no circumstances does vision insurance cover any exams requiring medical treatment of the eye or a prescription for medication.

Co-Payments & Deductibles: Co-payments will be collected at the time of service. If you have not met your deductible, we will collect the insurance allowable. Each insurance company has a different amount allowed per service or office visit and we will estimate what the insurance allows and collect that amount. If we overestimate, we will refund you that amount after all the insurance has cleared. If we underestimate, you will be billed for the balance.

Refraction: Refraction is a procedure incorporated into an ocular exam and used to determine your best possible vision. It is considered a “non-covered” service by Medicare and most major medical insurance companies. You are asked to pay the refraction fee at the time of service. We strive to provide excellent eye care in an ever changing health care environment. We are happy to discuss any questions you may have..

MEDICAL RECORDS

I certify that I or my dependents have medical insurance coverage/vision coverage. I assign directly to SCHWARTZ EYE ASSOCIATES, all insurance benefits for services rendered. I authorize the use of my signature on all claims submitted to the insurance company I have listed above. SCHWARTZ EYE ASSOCIATES may use my healthcare information and may disclose such information to the above named insurance company and their agents for the purpose of

obtaining payment for services and determining insurance benefits.
Payment in full for service and products are due at the time services are rendered or ordered. I understand and agree that, regardless of my insurance status, I am totally responsible for any balance on my account for professional services rendered. I understand that my insurance carrier my pay less than the actual bill for services. I agree to be held responsible for the payment of all services rendered on behalf of me or my dependents. If any amount due for services or products in not paid within 60 days of initial charge, the responsible party agrees to pay all costs for collecting or attempting to collect payment of the amount due.

- I MAY REQUEST A COPY OF SCHWARTZ EYE ASSOCIATES HIPPA "NOTICE OF PRIVACY PRACTICES" ALTHOUGH IT IS DISPLAYED IN THE OFFICE.
- I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED TODAY AND FOR ALL CHARGES MY MEDICAL INSURANCE OR VISION INSURANCE PLAN .DOES NOT PAY, INCLUDING BUT NOT LIMITED TO DEDUCTIBLE, COPAYS AND OR SERVICES NOT COVERED.
- IT IS MY RESPONSIBILITY TO KNOW WHAT MY INSURANCE COVERAGE IS.
- PROFESSIONAL FEES ARE NOT REFUNDABLE.
- THE INFORMATION I HAVE PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____

SIGNATURE

Schwartz Eye Associates

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About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Medical insurance (**Medicare, BCBS, AETNA, CIGNA & UNITED HEALTHCARE**).
2. Vision care plans **(Davis Vision & Eyemed).**

- **Vision care** plans only cover **routine vision** exams along with eyeglasses and contact lenses. Vision plans only cover a **basic health screening** for eye disease. They do not cover diagnosis, management or treatment of eye conditions.
- **Medical insurance** must be used if you have any **eye health problem or systemic health problem** that has **ocular complications**. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member.

I have read and agree with these policies.

Patient signature (parent if child) _____ Date _____