Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. Our philosophy of care governs everything we do for you.

Please bring the following to your appointment:

- Insurance co-pay, if applicable.
- All medical insurance cards.
- Updated list of medications.
- Most recent contact and/or glasses prescription.
- Attached paperwork filled out, signed and dated.

We **do not** participate with any vision plans, but we do participate with most **MEDICAL** insurance plans. We will bill your Medical insurance accordingly:

- **MEDICAL** insurance covers medical health issues affecting your eyes.

- **VISION** plans usually have out of network benefits that you the subscriber can submit a claim to for reimbursement of materials for glasses or contacts, based on your out of network allowances.

BAYSIDE EYE CENTER FINANCIAL POLICY

Insurance is a contract between you and your insurance company. We accept most plans and will bill them for your services. As a courtesy to you, we will bill your secondary insurance when your primary plan has paid. Bayside Eye participates, as a provider of service, and contracts with each plan to establish reasonable charges. If your plan denies payment, it becomes your responsibility to pay the fee for service. We adjust rates to the in-network fee. Please update us of any change in insurance coverage. Claims that are not paid by the carrier on file within 90 days of service are transferred to you for payment. Be sure to show us your insurance cards on your first visit of the current year or at any time you make a change.

What IS covered under your Medical insurance?

Dr. Lang is an Optometric Physician. He treats the medical conditions that affect the eye. Your medical plan is for these conditions and are considered for payment under your coverage. Some diagnostic testing requires a small percentage of coinsurance and would be billed to you in addition to your copay.

What IS NOT covered under your MEDICAL insurance?

ROUTINE CARE: Refractions ($49.00) for glasses and contact lens services ($$). These are paid by you at the time of service.

COPAYS: Your contract with your insurance plan requires that you pay your copay at the time of service. We accept cash, checks and credit card payments. We will verify your copay when possible if it is not stated on your card.

DEDUCTIBLES: Medicare deductible is $183.00 for the 2018 calendar year. If we are the first doctor you see, this is due at the time of service. Very few secondary's pay the Medicare deductible for their members.

I have read and understand the financial policy of Bayside Eye Center.

Patient Signature: _____ Date: _____

Print Patient Name: _____

We send out a monthly statement once your insurance has paid. Timely payment of the statement is anticipated. An additional 5% finance charge will be added to your balance for each additional 30 day period until paid in full

Medical History Questionnaire

Name: _____ Date: _____/_____/_____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (if applicable): _____ Occupation: _____

Birth Date: _____/_____/_____ Social Security #:_____/_____/_____ Last Eye Exam: _____

Name of Medical Doctor: _____ Dr. Phone #: _____

Email: _____ Last Medical Exam: _____

Hobbies: _____

Medical History

Do you have any allergies to medications: ☐ No ☐ Yes If yes, explain: _____

_____

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

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Are you pregnant and/or nursing? ☐ No Yes ☐

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other_____	☐	☐	☐	_____

Social History ***This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.***

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long: _____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (SKIN)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular /Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered **YES** to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____ _____

Doctor's Signature **Date**

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accountability Act (HIPAA), Bayside Eye Center can use your protected health information for treatment, payment and health care operations.

a. **Treatment** - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
b. **Payment** - We may use and disclose your health information to obtain payment for services we provide you.
c. **Health care operations** - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

I, _____ authorize release of my medical information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Situations

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

- **You have the right to receive confidential communications regarding your protected health information.**
- **You have the right to inspect and copy your protected health information.**
- **You have the right to amend your protected health information.**
- **You have the right to receive an account of disclosures of your protected health information.**
- **You have the right to a paper copy of this notice of privacy practices.**

Legal Requirements

Bayside Eye Center is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information

For further information about Bayside Eye Center privacy policies, please contact our offices and Dr. Todd Lang at the following addresses or phone numbers:

Bayside Eye Center
314 N. Tamiami Trail, Punta Gorda, FL 33950
Phone: 941.637.0202
Fax: 941.637.0425

I request that payment of authorized insurance benefits be made to Dr. Todd B. Lang, or services rendered by Bayside Eye Centre. I authorize release of medical or other information needed by any health insurance company to determine benefits for services provided by Dr. Lang.

I certify that I assume full responsibility for all physician charges rendered to the above named patient, including but not limited to deductibles, co-insurance and any other amounts not covered by my insurance carrier.

I certify that if I am enrolled in any HMO, PPO, or any other health maintenance organization that requires any type of referral or authorization it is my responsibility to provide such information to Bayside Eye Centre.

I understand that if Dr. Lang provides medical services and proper authorization is not obtained, I am responsible for payment if insurance is denied due to lack of prior authorization.

PROVIDERS OF MEDICAL BENEFITS ARE NOT REQUIERD TO WAIT FOR PAYMENTS FROM INSURANCE COMPANIES, INSURANCE CLAIMS, AND ARE FILED OUT OF COURTESY, NOT BY LAW.

Responsible Party Signature: _____ Date:_____

Witness: _____

HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the privacy of your protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice.

I am in receipt of the notice of privacy practices.

Patient Signature: _____ Date:_____

Dilation Procedure

The Florida Board of Optometry has adopted regulation 59V.3.010, which requires all patients to have a dilated eye exam upon their initial visit. If you have not previously been dilated under our care, we would then be required to perform this service. The dilating drops will require at least 20-30 minutes to take effect before the retina could be thoroughly evaluated. Without dilation, the presence of retinal holes, tears, diseases or systemic conditions affecting the eyes (i.e. diabetes, hypertension) may not be detected. We recommend accordingly.

The effects of dilation often include blurry vision at distance and near as well as increased light sensitivity, which may last 3-4 hours. Some people may find difficulty operating a motor vehicle.

Please check one of the following statements after reading and understanding all aspects of the dilation procedure.

_____I understand the above paragraph and elect to have my eyes dilated.

_____I understand the about paragraph and elect to NOT have my eyes dilated.

Patient Signature: _____ Date:_____

Name:

BAYSIDE EYE CENTER

Your eyesight is priceless and we are here to protect it!

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.

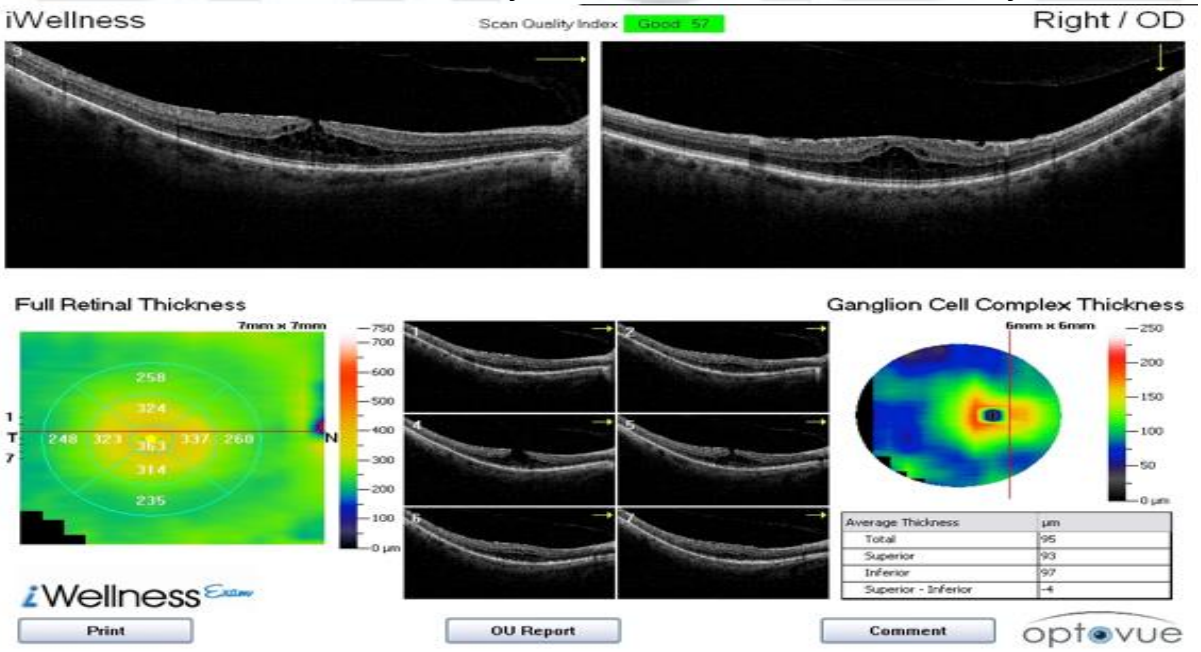
The ¿WellnessExam™ is a quick, non-invasive scan that allows our doctor to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable.

As part of your pre-exam testing, our technician will perform the ¿WellnessExam which your doctor will review with you during your examination today.

This test is not covered by your medical insurance, so <u>this will be added into the cost of your visit today.</u>

Any questions you have about ¿WellnessExam and the results of the test can be discussed with the doctor during your examination.

Please mark below that you would like this test done today!



☐ **¿WellnessExam™ *Only - $39.00***

The Benefits of **opto**map® Ultra-wide Digital Retinal Imaging

In our continued efforts to bring the most advanced technology available to our patients, **Bayside Eye Center** offers the **opto**map® digital retinal imaging as part of your comprehensive eye exam. The doctor highly recommends that you have these images taken today. Depending on the results, the doctor will determine whether or not you need to be dilated.

Our staff will discuss the importance of the **opto**map® digital retinal imaging with you during the examination procedure. The procedure is fast, easy and comfortable.

Even if you see clearly now, it doesn't mean your eyes are healthy or that they won't change. That's why it's so important that you choose to have your retinal health documented today.

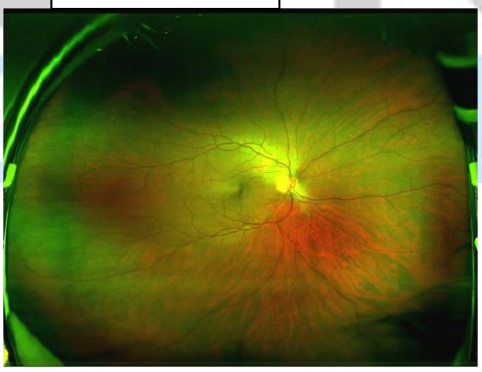
A thorough screening of your retina, or the back of your eye, is critical to verify that your eye is healthy. This can lead to detecting early warning signs of common diseases such as:

Glaucoma	Diabetes	Retinal Tears
Macular Degeneration	Hypertension	even some types of cancer

An **opto**map® provides:

- a scan to confirm a healthy eye or detect the presence of disease early
- a map of the retina, giving your doctor a more detailed and wider view than can be achieved by other means
- the opportunity for you to view and discuss the **opto**map® images of your eye with your doctor
  a permanent record for your medical file, enabling your doctor to make important comparisons

Healthy Retina



Unhealthy Retina

Please mark that you would like this test done ☐ **optomap® *Only- $39.00***

This test is not covered by your medical insurance, so this will be added into the cost of your visit today.

We offer a combination package! For $59.00 you get the iWwellness Exam as well as the Optomap.**Again, neither of these tests are covered by your medical insurance and will be collected at today's visit.**

Any questions you have about **opto**map® and the results of the test can be discussed with the doctor during your examination.

Please mark below that you would like these tests done today!

☐ **iWellnessExam™ *and* optomap®- *Only $59.00***