NORTH FLORIDA
CATARACT SPECIALISTS
AND VISION CARE

Thank you for choosing North Florida Cataract Specialists and Vision Care for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Our physicians and staff are dedicated to providing you with the highest quality service and care. We will do our very best to make sure your visit is as pleasant and comfortable as possible.

In order to better serve you, we ask that you allow at least 2 hours total for your visit. You can also expect to have your pupils dilated at your appointment. We would like to remind you that any copays, unmet deductibles or coinsurance will be due at the time of your visit. Payment by cash, check, VISA, MasterCard, American Express or Discover is accepted.

We have enclosed our new patient packet for you to fill out and bring with you to your appointment. Please also be prepared to bring the following:

- Glasses and/or contact lens prescription (please bring contact lens box)
- A list of current medications you are using
- A list of medications you are allergic to
- Insurance cards
- Records from your previous doctor (or you can request to have them sent to our office)

We understand that situations may arise that will interfere with your scheduled appointment time and will be happy to assist you in rescheduling. When canceling or rescheduling your appointment, kindly give at least 24 hours notice. Failure to do so may result in a $50 charge.

If you have any questions or concerns, please do not hesitate to contact our office. We can be reached at 352-373-4300 or 1-800-435-3937. We look forward to providing you with the very best of care!

Gregory D. Snodgrass, M.D.
Gerald G. Hazouri, M.D.

NORTH FLORIDA
CATARACT SPECIALISTS
AND VISION CARE

Patricia L. Bailey, O.D.
Kimberly M. Broome, O.D.
Christa M. Morris, O.D.

PLEASE PRINT CLEARLY

Today's Date: _____

**PATIENT INFORMATION**

Patient Name: _____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____
Month Day Year

- If Patient is a minor: Father _____ DOB: _____/_____/_____
  Mother _____ DOB: _____/_____/_____
  Guardian _____ DOB: _____/_____/_____

Billing Address _____
City _____ State _____ Zip _____

Phone Numbers: Home ( ) _____-_____ Work ( ) _____-_____
Cell ( ) _____-_____

Email Address: _____
(This information will not be sold or shared with any third party.)

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married, Spouse's Name: _____ ☐ Other _____

Physician or person we may thank for this referral: _____

**EMERGENCY CONTACT:** Name _____ Phone _____

**INSURANCE INFORMATION**
Note: A copy of all insurance cards is necessary for our permanent records.

* Primary Insurance: _____ ID: _____

Subscriber: _____ DOB: _____ Relationship: _____

* Secondary Insurance: _____ ID: _____

Subscriber: _____ DOB: _____ Relationship: _____

**INSURANCE SIGNATURE ON FILE/LIFETIME MEDICARE SIGNATURE**

I request that payment of authorized benefits or other insurance be made on my behalf to Gregory D. Snodgrass, M.D., Gerald G. Hazouri, M.D., Patricia L. Bailey, O.D., Kimberly M. Broome, O.D., or Christa M. Morris, O.D. for any services rendered. ***I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or non-covered services.*** I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents or any other insurance carrier, any information needed to determine these benefits payable for related services.

My signature below attests to the fact that I have read and do understand the above-mentioned policies. A photocopy of this signature is as valid as an original.

**PATIENT/GUARDIAN SIGNATURE** _____
**DATE** _____

**HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the following person(s) to have access to my protected health information; example: spouse, son, daughter, parents, etc. I have listed his/her name(s) and relation to me.

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

*OPTIONAL* I understand that I have the right to restrict the amount of information that the above individual(s) receive. The following are restrictions I would like to place:

_____

_____

- May we leave a message on your HOME answering machine if there is no answer?
  ☐ Yes ☐ No ☐ Do not have an answering machine

- **<u>If there any any changes to the above stated information, it is the patient or guardian's responsibility to inform North Florida Cataract Specialists and Vision Care in writing.</u>**

I hereby acknowledge that I have been presented with a copy of North Florida Cataract Specialists and Vision Care's Notice of Privacy Practices & authorize the above listed person(s) access to my protected health information.

**Patient's Signature:** _____

If minor, Guardian's Signature: _____

Patient's Name (Printed): _____

Witness: _____ Date: _____

# REFRACTION POLICY

A refraction (procedure code 92015) is the part of the exam that evaluates any visual changes and the possible need for an eyeglass and/or contact lens prescription. There is a $40 charge for this service. **This fee is not covered by most *medical insurance* plans and is due at the time of service.** Please be aware, although this charge is not covered, it may be necessary to perform a refraction to help determine visual changes related to medical conditions.

There is an *additional* charge of $50-$75 for **contact lens** measurements, which are a separate procedure (procedure code 92310). This charge will be determined based on the type of contact lens you may need, i.e. spherical, toric or multifocal. These charges are not covered by insurance. The contact lens fitting fee is required to be paid at the time of service along with any insurance copays, deductibles or co-insurances.

_____ _____

Patient's Signature Date

# CONTACT LENS POLICY

All contact lens prescriptions are good for **ONE** year.

All patients new to contact lenses must participate in an "I&R" training to learn how to insert and remove contact lenses properly. This training must be completed within **30 days** of your initial exam.

There will be a **90 day** grace period to finalize your prescription. If not successfully completed, a fee of $50 will apply after 90 days.

_____ _____

Patient's Signature Date

## Why is there a Contact Lens Fitting fee?

This fee covers the extra tests performed by the doctor along with any necessary follow-up visits and trial lenses. These procedures are only done on patients that wear contacts; it is in addition to the services provided during the annual eye exam.

## Why doesn't my insurance cover that fee?

Insurance companies view most contact lenses as elective vision correction. In rare occasions, insurance companies may consider contacts as medically necessary and cover a portion or all of a contact fitting, such as those for patients with conditions like keratoconus. Most insurance companies take the position that if your vision can be corrected with glasses, then contacts are not medically necessary and therefore are not covered as extensively as glasses and your annual eye exam. If you believe that should change, then we urge you to contact your insurance company and discuss the matter with them.

## How much is the Contact Lens Fitting fee and how is that determined?

There are different levels of charges based on several factors. The doctor can only determine the exact level of the fitting after completing the exam, because that is when all of the patient's needs have been assessed. Those factors include:

1. The complexity of the fit: Many options for vision correction exist and have varying levels of complexity in order to determine the optimal Rx. These options include spherical lenses (what many patients are most familiar with), toric lenses for astigmatism, monovision, and multifocal lenses
2. Patient's ocular health: The condition of the eyelids, conjunctiva, cornea, and tear film all affect the optimal contact lens material, shape, and care. Even your general health and any conditions you might have can affect ocular health; these must be taken into consideration as well.
3. History of previous eye surgeries or injuries: corneal irregularities or eye sensitivity can be brought on by eye surgeries or injuries. In these cases more care may be required in order to prevent irritation or complications.
4. New patient vs. established patient: New patients require longer appointments, because there is more history to collect and options to discuss. Established patients still have a lengthy appointment but our doctors have a previous knowledge of the patient and any conditions they might have, which makes the process quicker.

Signature: _____

Date: _____

# Patient Medications

Please include over-the-counter, vitamins/supplements and PRN (as needed) medications.

| Medication Name | Strength | # Times Taken Daily | Route | Reason |
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| Allergies | Reactions |
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**Office Use Only:**

| Date Reviewed/Updated | Tech Signature |
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**Name:** _____ **DOB:** _____ **Acct:** _____

## REVIEW OF SYSTEMS: (Please mark all that apply)

**CONSTITUTIONAL SYMPTOMS:**
Fever ____
Weight Loss/Gain ____
Weakness ____
SOB ____
Numbness ____
Swelling ____
Coughing ____
Aches / Pains ____

**CARDIOVASCULAR:**
Hypertension ____
Heart Attack ____
Stroke ____
Congestive Heart Failure ____
Coronary Artery Disease ____
Angina ____
Heart Murmur ____
Arrhythmia ____
Peripheral Vascular Disease ____

**PULMONARY DISEASE:**
Asthma ____
Emphysema ____
Tuberculosis ____
Bronchitis ____
COPD ____
Sleep Apnea ____

**MUSCULOSKELETAL:**
Osteo Arthritis ____
Rheumatoid Arthritis ____
Fibromyalgia ____
Polymyositis ____
Gout ____

**GASTROINTESTINAL:**
Crohns disease ____
Liver Problems ____
Irritable Bowel ____
Reflux ____
Hiatal hernia ____

**OTOLARYNGOLOGIC:**
Sinusitis ____
Ear Infection ____

**GENITOURINARY:**
Prostate ____
Kidney ____
Urinary Tract Infection ____
Bladder Problems ____
Flomax or its generic ____

**HEMATOLOGIC/LYMPHATIC:**
Anemia ____
Sickle Cell ____
Bleeding ____

**ENDOCRINE:**
Diabetic (ID) | (NID) ____
Type ___ Year ___
Hypoglycemia ____
Hypo Thyroid ____
Hyper Thyroid ____
Pituitary Tumor ____
Cholesterol ____

**INTEGUMENTARY:**
Rosacea ____
Dermatitis ____
Cancer ____

**ALLERGIC/IMMUNOLOGIC:**
Seasonal Allergies ____
Lupus ____
HIV ____
AIDS ____

**PSYCHIATRIC:**
Anxiety ____
Depression ____
Manic-Depressive ____

**NEUROLOGIC:**
Epilepsy ____
Parkinsons ____
Dementia ____
TIA's ____
MS ____
Bells Palsy ____
Myasthenia Gravis ____
Migraines ____
Meniere's ____
Brain Tumor ____

**OPHTHALMIC:**
Glaucoma ____
Amblyopia ____
Strabismus ____
Cataracts ____
ARMD ____
Trauma ____
Retinopathy ____
Iritis ____
Cornea ____
Retinal Disease ____

**EYE SURGERY/LASERS:**
_____
_____
_____
_____

**FAMILY HISTORY:**
Glaucoma Y N
Diabetes Y N
Cataracts Y N
ARMD Y N

**GENERAL SURGERIES:**
_____
_____
_____
_____
_____
_____
_____

**SOCIAL HISTORY:**
Do you smoke? Y N
If yes, #packs per day: _____
When did you start? _____

Have you ever smoked: Y N
When did you stop? _____

Cessation counseling done? Y N

Do you drink? Y N
Drinks per day: ____

Do you take recreational drugs: Y N
If yes, what and how long:
_____

Occupation: _____

Have you had any recent unexplained medical problems? Y N Comments: _____
_____
_____

Initial date of review: _____ Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____
Date reviewed / updated: _____ Changes: Y N Tech signature: _____ Dr. signature: _____

Patient Name: _____ DOB: _____ Acct: _____