Atlantis VISION CENTER

Today's Date _____

NAME:	DOB:	AGE
ADDRESS:	CITY STATE	ZIP
HOME PH:	CELL PH:	WK PH:
OCCUPATION	EMPLOYER	
PRIMARY CARE PHYSICIAN	HOW DID YOU HEAR ABOUT US?	
WHAT IS YOUR HEALTH INSURANCE?	EMAIL:	

PLEASE CHECK YES OR NO AND CIRCLE ALL THAT APPLY TO YOU

	Do you now or have you ever had:	Yes	If yes, Please Describe:	No
Allergy	Medications, pollen, dust, shellfish, animal dander, molds, etc.			
Cardiovascular	Heart Disease, hypertension, elevated cholesterol, etc.			
Constitutional	Dizziness, weight loss/gain, cold, cough, fever, etc.			
Endocrine	Diabetes, thyroid disease, Crohns, gout, etc.			
Gastrointestinal	Acid reflux, ulcer, colitis, gall stones, etc.			
Genitourinary	Bladder infection, kidney stones, etc.			
Head/ENT	Dry Mouth, ear infection, sinusitis, etc.			
Lymphatic	sickle cell, leukemia, Lymphatic cancer, anemia, etc.			
Immunologic	AIDs, herpes simplex, herpes zoster, mononucleosis			
Immunologic	Sjogrens, Rhuematoid Arthritis, Other (please describe)			
Integumentary	Acne, acne rosacea, psoriasis, lupus, skin lesions, etc.			
Musculoskeletal	Arthritis, myasthenia gravis, osteoporosis, etc.			
Neurological	Bell's palsy, multiple sclerosis, migraines, epilepsy, etc.			
Psychiatric	Alzheimer's, autism, anxiety, depression, ADD, etc.			
Respiratory	Asthma, bronchitis, COPD, pneumonia, lung disease/cancer, etc.			
Cancer	Breast,Prostate, Lung, Skin, Other(Please describe)			

I AM ALLERGIC TO:
List Your Current Medications:
List Current Eye Drops/Meds
Describe any surgeries/ hospitalizations in the past year:

Your Past Eye History	Yes	If yes, please describe	No
Injuries			
Surgery, Laser Treatment			
Prosthesis			
Cataracts			
Glaucoma			
Retina			
Lazy Eye (Amblyopia, Exotropia, Esotropia)			
Macular Degeneration			
Double Vision (Diplopia, Prism)			
Corneal (dry eye, scar, KCS, Keratoconus, Fuch's)			
Contact Lenses			
Nevus/Mole (conjunctiva, choroid, iris, eyelid)			
Floaters			

Please List any other eye problems:

Social History	Yes	If yes, please describe	No
Recreational Drugs			
Alcohol			
Tobacco			

Family History (Blood Relatives):	Yes	If yes, specify who:	No
Diabetes			
High Blood Pressure/Stroke/Heart Problems			
Macular Degeneration			
Glaucoma			
Cataracts			
Cancer			
Other			

For Office Use Only:

History Reviewed:		
Date	MD/OD	Tech

“No Show” and “Late Cancellation” Policy Form

Effective October 19, 2021

Due to the high demand for appointments, Atlantis Vision Center has had to institute a “no show” and “late cancellation” fee.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When a patient no-shows or cancels late, it takes an available time slot away from another patient. No shows and late cancellations delay the delivery of healthcare to other patients.

A “No-Show” is missing a scheduled appointment without notice. A “Late-Cancellation” is canceling an appointment without calling us to cancel within 24 hours of an office appointment. We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

If you are not able to make your appointment, please cancel by calling the office at least 24 hours in advance of your scheduled appointment. Failing to do so will result in a fee being billed to your account, which will be due upon your next visit. You may cancel appointments by calling or texting our office at 321-777-1670. If it is after hours, please wait through the prompt in order to leave a message with our answering service.

All “No Shows” and “Late Cancellations” will be billed as follows:

New/Established patient appointments	$50.00

This fee is for patients who miss their scheduled appointment or do not cancel within the 24-hour period. These fees are not covered by your insurance and you will be responsible for payment.

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

Please Read Before Your Eye Exam

What is a refraction?

A refraction is the vision test that measures a patient's prescription for eyeglasses or contact lenses. The test involves looking through a device called a phoropter to read letters on a chart through lenses of differing strength. During this process, the eye doctor will ask you "Which is better…one or two?". This test is performed as part of a comprehensive eye examination or anytime that your vision drops significantly. The refraction allows for assessment of your current eye health and the detection of eye diseases.

Why is it sometimes necessary?

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription.

Who pays for the refraction?

Even though this is a vital test to the care of your eyes, the refraction is a non-covered service through your medical insurance. Our office charge is $50.00 for the refraction, and you will be asked to pay at the time of your visit. If you wish to forego the refraction, please inform us **BEFORE** we begin doing any testing of your eyes. It is important to understand that if you decline, we may not be able to determine the cause of your decrease in vision.

Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the co-pay, co-insurance, and deductible are separate from, and not included in, the refraction fee.

Patient Signature_____Date_____

INFORMED CONSENT FOR DILATION OF EYES

In order to more fully examine your eye health, it is necessary to use drops to dilate your pupils. This allows us to obtain a stereoscopic view of the retinas of your eyes, while at the same time affording study of a greater area of the retina than normally available through a non-dilated pupil; Retinal tears or detachments may be missed if only a non-dilated exam is performed. Although you may experience some light sensitivity and blurred vision of the eyes, the benefit far outweighs the risks of performing the procedure. Temporary sunglasses will be provided for your convenience. Your eyes may remain dilated for up to three hours. Some patients may have difficulty reading after the procedure. If you have any questions or concerns, please talk to the doctor about it during your exam.

Patient Signature_____Date_____

Financial Policy and Agreement for Atlantis Vision Center

Release of Information: We ask for sensitive information. We understand people are concerned about the exposure of this information and we have policies and procedures in place to protect all your information. Atlantis Vision Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation which is or may be liable or under contract for reimbursement to Atlantis Vision Center for services rendered, and any health care provider for continued patient care.

Payment: I agree that in return for the services provided by Atlantis Vision Center, payment is due at the time the service is rendered. We accept cash, personal checks, MasterCard, Visa, Discover and American Express. Returned checks are subject to the following service charge starting at $25.00 but will not exceed 5% of the face value. In addition, you will lose your privilege to write a check to our office. Past due account will be subject to a service charge of 1.5% per month (18% APR).

Insurance: The doctor's service is provided directly to you and not to an insurance company. We cannot render services on the assumption that charges will be paid for you by the insurance company. As a courtesy to our patients, we submit medical claims to primary, secondary, and tertiary carriers with whom we are contracted. We do not bill carriers that we are not contracted or third-party carriers, this is the responsibility of the patient. You will be expected to pay any copay, deductible, co-insurance and non-covered amounts determined by your policy at the time of service. If your insurance company has failed to pay within a 60-day period, we will expect you to pay the balance of your bill in full. You must then collect from your insurance company. We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered. I understand my vision insurance cannot, and will not, be used for any services rendered in office.

Medicare/Managed Care: I request that payment of authorized Medicare benefits be made on my behalf to Atlantis Vision Center for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare, and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

PROTECTED HEALTH INFORMATION RELEASE FORM

It is the office policy of Atlantis Vision Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from your circumstances (for example, if you bring a family member or friend into the examination room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996, as amended in 2013. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the box marked none. By signing below, you authorize the following people to receive information regarding your treatment or care.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. Atlantis Vision Center is permitted to share with them test results and any other information contained in my health record. For copies of medical records, I understand that I will need to sign a separate authorization.

List below those individuals that you wish to receive your protected health information:

Patient Name:_____ **Relationship:** Self **Phone:**_____

Full Name:_____ **Relationship:**_____ **Phone:**_____

Full Name:_____ **Relationship:**_____ **Phone:**_____

Full Name:_____ **Relationship:**_____ **Phone:**_____

□ **NONE**

In addition to those individuals listed above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

Leaving messages on the following numbers:

1) **Home Phone:**_____ **3) Work Phone:**_____

2) **Cell Phone:**_____

I understand that it is my responsibility to update Atlantis Vision Center with any changes in the above listed contact numbers. I understand that this authorization will remain in effect until it is revoked by me in writing.

□ I am the patient

□ If the patient is under 18 years of age, I am the patients legal guardian.

□ I am the legal guardian or power of attorney holder for the patient.

Name:_____ **Date:**_____

Signature:_____ **Witness:**_____

I acknowledge that I have been made aware of Atlantis Vision Center's HIPAA Policy and Notice of Privacy Practices clearly on display in the reception area of said practice.