Atlantic Eye Institute
Live Your Vision℠ • TheEyeGuys.com

Doctors

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Locations

Southside Office:
6207 Bennett Rd.
Jacksonville, FL 32216
F: (904) 731-7504

Beaches Office:
3316 Third Street S. Suite 103
Jacksonville Beach, FL 32250
F: (904) 249-2352

Atlantic Retina:
2710 Third Street S.
Jacksonville Beach, FL 32250
F: (904) 372-9217

St. Johns Office:
Coming Soon

Phone

(904) 241-7865

Website

atlanticeyeinstitute.com

Welcome! We are glad you have chosen Atlantic Eye Institute for your eye care needs. We look forward to seeing you at your upcoming appointment.

Name: _____ Date/Time: _____

Location: _____ Doctor: _____

Before Your Appointment

- Please ***complete both sides*** of the enclosed Registration Form and Medical History Questionnaire.
- Please ***review and sign*** the Patient Agreement.
- Please contact your insurance company to ***verify your well vision and medical coverage.*** An appointment may be billed as a well vision or medical visit depending on the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. If you have questions, please contact a patient account representative at (904) 241-7865.
- If your primary care doctor is listed on your insurance card, you may be required to receive a referral. Please contact your doctor's referral department for more information. If you have questions, please contact a patient account representative at (904) 241-7865.

Day of Your Appointment

- Please bring completed forms, insurance card(s), and a photo ID.
- ***Co-pays, co-insurance, and deductibles are due at the time of your appointment.***
- For services not covered by your insurance, payment is due at the time of your appointment. Discounts may be available for certain services. Please ask front desk staff for more information.
- If you wear contact lenses, please bring a back-up pair of glasses in a protective case.
- Routine visits may take up to 2 hours, while medical and surgical evaluations may take between 2-3 hours. Please plan accordingly.

As part of your appointment, ***your pupils may be dilated.*** For some, dilation may cause light sensitivity and blurry vision. These effects may last for several hours and protective eyewear is recommended.

If you should have any questions or concerns before your appointment, please contact us at (904) 241-7865 or visit us online at www.atlanticeyeinstitute.com.

REGISTRATION FORM

Last Name: _____ **First Name**: _____ **MI**: _____

Nickname: _____ **SSN:** _____

Birth Date: _____ **Sex**: ☐ Male ☐ Female **Employer:** _____

Address: _____
STREET CITY / STATE / ZIP

Home Phone: _____ **Work Phone**: _____

Cell Phone: _____ **Preferred Phone:** ☐ Home ☐ Cell ☐ Work

E-Mail: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Spouse's Name:** _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Doctor: _____ **Primary Care Doctor**: _____

How did you hear about Atlantic Eye Institute (check all that apply)?

☐ Referring Doctor: _____ ☐ Word of Mouth: _____

☐ Television / Radio: _____ ☐ Internet: _____

☐ Mailing: _____ ☐ Magazine / Newspaper: _____

☐ Event / Exhibit: _____ ☐ Insurance: _____

☐ Other: _____

Cultural Background Information
Federal healthcare programs require that we collect and report patient race and ethnicity data in an effort to identify and improve healthcare disparities among various racial / ethnic groups. This information is confidential, and will not impact your care at Atlantic Eye Institute. Your response is voluntary, and you may select "Decline to Specify".

Race (select as many that apply) Ethnicity (select one)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ White
☐ Decline to Specify

Preferred Language: _____ **Interpreter Required**? ☐ Yes ☐ No

Patient Portal
The patient portal is a convenient and secure way to access your health information. If you are not yet enrolled, we will complete your enrollment at the time of your appointment. You will receive instructions to complete registration to participate in the patient portal when enrollment has been completed. Participation is encouraged but not required.

Pharmacy Name: _____ Phone Number: _____

Location / Address: _____

Do we have your permission to obtain a list of your prescriptions directly from your pharmacy? ☐ Yes ☐ No

Primary Medical Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____

Secondary Medical Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____

Routine Vision Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____ ID# _____

Subscriber Information (if different from patient):

Address: _____ Phone: _____

Guardianship / Medical Power of Attorney
Do you have a legal representative, or does someone make medical decisions for you? ☐ Yes ☐ No
If you answered "Yes", please provide a copy of legal guardianship / power of attorney paperwork.

Name: _____ Phone: _____

Hospice Care
Are you currently under inpatient or outpatient hospice care? ☐ Yes ☐ No

Hospice Care Service: _____ Phone: _____

_____ _____
Signature Date

PATIENT AGREEMENT

Consent for Treatment

_____ I authorize Atlantic Eye Institute to assess and treat me, complete tests, and administer medications considered necessary or advisable. I understand that my healthcare provider is available to explain the purpose of any procedure and that I have the right to refuse, even if against medical advice.

I understand that my pupils may be dilated as part of the appointment. For some, dilation and other drops used during the visit may cause light sensitivity and blurry vision for a period of time.

Minors

_____ A minor child needs an Agreement signed by a parent or guardian. By signing the Agreement, the parent or guardian assumes responsibility for information on behalf of the patient. It is strongly recommended that a parent or guardian accompany a minor to all appointments. Atlantic Eye Institute reserves the right to request identification of any adult accompanying a minor. In the event that a parent or guardian is unable to accompany a minor to an appointment, please contact us at (904) 241-7865, in addition to signing this form.

Release of Protected Health Information to Health Care Providers

_____ I authorize the release or retrieval of my health information, including prescription medication history and other information related to health care services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my care and the continuation of my care for up to one year. A release may be revoked by me in writing at any time.

Communication

_____ By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving of multiple messages per day from my healthcare provider, when necessary. I consent to be contacted by email, text and phone, as well as, allowing detailed messages being left on my voicemail or answering machine if I am unavailable at the number provided by me.

Disclosure of Protected Health Information (PHI) to Specific Individuals

_____ I authorize disclosure of my health information, including appointment and billing information, to the following
individual(s) involved in my care and the coordination of my care.

☐ Spouse / Significant Other: _____ ☐ Parent / Guardian: _____

☐ Child / Children: _____ ☐ Other: _____

If I would like a copy of my health information released to me or any individual(s), I will request and submit an Authorization for Release of Medical Information. A release may be revoked by me in writing at any time.

For medical records questions, please contact a medical records assistant at (904) 241-7865.

Cancellation Policy

_____ Atlantic Eye Institute is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice it may prevent another patient from being seen. Kindly provide 24 hour notice to cancel an appointment. If prior notice is not given, you will be charged $35 for the missed appointment.

Notice of Privacy Practices

_____ I acknowledge that I have been made aware of Atlantic Eye Institute's privacy practices, which are posted in the waiting room. I understand that a copy of the Notice of Privacy Practices is available at my request, and if I would like a copy, I will ask for one.

Insurance Authorization & Assignment of Benefits

_____ I authorize Atlantic Eye Institute, on behalf of myself and/or my dependents, to furnish medical records and other information related to health care services provided by Atlantic Eye Institute to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which Atlantic Eye Institute participate, and the contractors and third party administrators of any of these parties, as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf, to Atlantic Eye Institute for any services furnished by Atlantic Eye Institute.

I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organization, including accountable care organizations, and their contractors and third party administrators, to share my medical records and information obtained from Atlantic Eye Institute, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which Atlantic Eye Institute participates, and the contractors and third party administrators of these parties, as needed for payment and health care operations.

For insurance and billing questions, please contact a patient account representative at (904) 241-7865.

Routine vs. Medical Coverage

_____ Office visits may be categorized as either "routine" or "medical". A comprehensive "routine" vision exam may contain the same elements as a comprehensive "medical" eye exam. The type of eye exam you have is determined by the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. Routine vision exams typically produce diagnoses such as nearsightedness or astigmatism, while medical eye exams may produce diagnoses such as glaucoma or conjunctivitis. Please verify your routine and medical coverage with your insurance company.

Refraction Fee

_____ A ***refraction*** is a test that is used to determine any optical defect present in the eye. A refraction is necessary for a prescription for best corrective lenses, a determination of the progression or diagnosis of certain ocular conditions, and/or a determination for the basis of your visual complaints. Refractions are not always covered by insurance and you may be responsible for the $40 fee at the time of service.

Uninsured / Self Pay

_____ If you don't have insurance, payment is required at time of service.

Financial Responsibility

_____ Atlantic Eye Institute contracts with most major insurance plans; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. I understand that I am financially responsible and agree to pay any charges for care rendered to me not covered by my insurance plan or if I do not have active insurance coverage. I agree that for services rendered to me by Atlantic Eye Institute, I will pay my account at the time of service or upon insurance claim processing.

If payment plan consideration is necessary, I understand that it is my responsibility to call and make financial agreements satisfactory to Atlantic Eye Institute for payment.

Any benefits of any type under any policy of insurance or any other party liable to the patient, is hereby assigned to Atlantic Eye Institute. If copayments and/or deductibles are assigned by my insurance company or health plan, I agree to pay them to Atlantic Eye Institute. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

By signing below, you acknowledge that you have read and understand the above Patient Agreement.

_____ _____

(Signature of Patient/Authorized Representative) (Date)

_____ _____

(Patient Name) (Date of Birth)

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Birth Date**: _____

Vision Correction – Do you wear glasses? ☐ No ☐ Yes Do you wear contact lenses? ☐ No ☐ Yes

Reason(s) for Visit – In your own words, please describe the reason for your visit today:

_____

_____

Allergies – Please list all known medication (including intravenous contrast dye and anesthetics) and environmental (including seasonal, food and latex) allergies or indicate ☐ NO KNOWN ALLERGIES.

Allergy	Reaction	Allergy	Reaction

Current Medications – Please list all current prescribed medications (including eye drops and medical cannabis), over-the-counter medications, vitamins and supplements or indicate ☐ **NO MEDICATIONS.**
****If not enough space is provided, please supply on a separate sheet of paper.

Name	Dosage	Frequency	Name	Dosage	Frequency

Review of Symptoms – Please check if you are experiencing any of the following:

Symptom	Y	N	Symptom	Y	N
Difficulty reading small print			Constipation		
Difficulty seeing street signs			Vomiting / nausea		
Eye pain			Heartburn		
Tearing, redness, itching			Joint Pain / stiffness		
Sudden loss of vision			Painful Urination		
Flashes / floaters			Frequent Urination		
Double Vision			Blood in urine		
Glare / Halos			Depression		
Fever / chills			Anxiety		
Fatigue			Insomnia		
Weight Change			Rash / Hives		
Sinus Problems			Skin Growth / Warts		
Ear Ache			Uncontrolled blood sugar		
Hard of Hearing			Headaches / Migraines		
Dry Mouth			Memory Loss		
Uncontrolled Blood Pressure			Numbness / weakness		
Irregular Heartbeat			Slurred Speech		
Shortness of Breath			Dizziness		
Diarrhea			Abnormal Bruising / Bleeding		

Past Surgical History – Please list any surgeries you have had: (tonsillectomy, appendectomy, cataract, etc.)

Procedure	Year	Doctor	Procedure	Year	Doctor

Personal and Family Medical History – Please check if you or a family member have / have had any of the following or indicate ☐ NO RELEVANT PERSONAL HISTORY ☐ NO RELEVANT FAMILY HISTORY.

Condition	Self	Mother	Father	Sibling	Grandparent
Congestive Heart Failure					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Atrial Fibrillation					
COPD					
Asthma					
Emphysema					
Cancer (Please specify: _____)					
Diabetes					
HIV / AIDS					
Hepatitis					
MRSA					
Thyroid Disease					
Psychiatric Disorder					
Lupus					
Anemia					
Stroke					
Rheumatoid Arthritis					
Sjogren's Disease					
Macular Degeneration					
Glaucoma					
Fever Blisters / Cold Sores					
Other:					
Other:					
Other:					

Females: Are you currently pregnant? ☐ No ☐ Yes Are you currently breastfeeding? ☐ No ☐ Yes

Social History

Have you ever smoked? ☐ Current ☐ Former ☐ Never

Do you drink alcohol? ☐ No ☐ less than 1 a day ☐ 1-2 a day ☐ 3 or more a day ☐ 5 or more a day

Occupation: _____ Status: ☐ Full Time ☐ Part Time ☐ Retired / Other

Have you had the pneumonia vaccination? ☐ No ☐ Yes

Do you have a living will? ☐ No ☐ Yes

Do you have a health care proxy? ☐ No ☐ Yes If yes, please list their name and phone number below:

Name: _____ Phone: _____

Insurance and Billing Information

As a courtesy, Atlantic Eye Institute has compiled commonly requested insurance and billing information for your reference. If you have questions, contact a Patient Account Representative at (904) 241-7865.

Co-pays and payment for any non-covered services are due at the time of service.

Medicare

If you have Medicare, our office will bill Medicare and any secondary insurance. You are responsible for the following:

- Any deductibles and co-pays
- Up to 20% of allowed charges
- Routine eye examinations and refraction charges
- Payment of any service that does not meet Medicare guidelines for medical necessity
- Payment of any other non-covered service

Managed Care HMO & PPO Plans

If you have HMO or PPO coverage, you may be required to obtain an insurance referral for many of our services. It is your responsibility to obtain all insurance referrals before services are provided. You may obtain an insurance referral by calling the referral department of the clinic listed on your insurance card. If you fail to obtain an insurance referral and service coverage is denied, you are responsible for payment of the balance in full.

Commercial Plans

If you have a commercial plan, our office will bill your insurance. If payment from your insurance has not been received within 30 days, you are responsible for payment of the balance in full. You are also responsible for any deductibles and co-pays, and payment of any non-covered services.

Routine Vision Plans

Some employers offer separate vision benefit plans that cover routine eye examinations, often called "Carve Out" plans, which are different from your medical coverage. Atlantic Eye Institute participates with the following plans:

- VSP (Vision Service Plan)
- VCP (Vision Care Plan)
- EyeMed
- Davis Vision
- Superior Vision

Routine versus Medical Coverage

Coverage of routine eye examinations and refraction vary by insurance plan, and coverage may change from year to year. Please verify coverage before your appointment. An appointment may be billed as a routine or medical visit depending on the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. Generally, an examination may be billed as "routine" when a patient has no specific illness or injury, symptom or complaint that requires diagnosis and treatment.

A ***refraction*** is a test that is used to determine any optical defect present in the eye. A refraction is necessary for the following:

- A prescription for best corrective lenses
- A determination of the progression or diagnosis of certain ocular conditions
- A determination for the basis of your visual complaints

Refractions are not always covered by insurance and you may be responsible for the $40 fee at the time of service.

Billing Cycle

If your insurance information has been verified at the time of your appointment, you will not receive a billing statement until:

- Your insurance company has denied a claim
- Your insurance company has paid a claim, leaving co-insurance before deductible or a noncovered service
- Your insurance company has not responded to a claim

Contact Lens Removal Policy

LASIK or Cataract Surgery Evaluations ONLY
The physicians and staff at Atlantic Eye Institute want to make every effort to ensure you have the best visual outcome following any refractive or cataract procedure. Therefore, we ask that you adhere to the recommended clinical protocols for the removal of contact lenses in advance of your evaluation.

Wearing contact lenses, especially over a long period of time, may temporarily alter the shape of the front surface of the eye (the cornea). This alteration of shape may influence critical measurements taken in preparation for your procedure.

It is essential that contact lenses are removed, and your eyes allowed to "rest," for a period of time in advance of your appointment. *If contact lenses are worn during the recommended removal period, there is a strong possibility that the measurements and procedure will need to be rescheduled for a later date.*

Please Adhere to the Following Guidelines for Contact Lens Removal

- Hard contact lenses, including gas permeable, must be removed for a minimum of 1 week before a *LASIK or cataract evaluation.*

- Soft contact lenses must be removed for a minimum of 3 days before a *refractive or cataract evaluation.*

If you have questions or concerns related to the contact lens removal guidelines, please contact a Patient Care Coordinator at (904) 241-7865.