Thank you for returning to our practice for your eye care needs!

Patient Name/Nombre: _____ **Date** Fecha de hoy: _____

Address/DIRECCIÓN:_____

DOB / fecha de Nacimiento:_____

Cell Phone Number TELÉFONO/: _____**(Required)**

Email Address/ Dirección de correo electrónico : _____

Eye-Health - Patient (check all that apply)

- ◯ Blurry vision at distance/ Visión borrosa a distancia
- ◯ Blurry vision at near/ Visión borrosa de cerca
- ◯ Foreign body Sensation/ Sensación de cuerpo extraño
- ◯ Diabetic eye disease / Enfermedad ocular diabética
- ◯ Glare/Light Sensitivity / Resplandor/Sensibilidad a la luz
- ◯ Eye surgery /Cirugía Ocular
- ◯ Itching/ Pico
- ◯ Infection of EYE/ Infección del OJO
- ◯ Macular Degeneration /Degeneración Macular
- ◯ Tearing/Watery eyes/ Ojos llorosos/llorosos
- ◯ Fluctuation Vision/Visión de fluctuación
- ◯ Cataracts
- ◯ Burning Eyes/ ojos ardientes
- ◯ Headaces/ dolores de cabeza
- ◯ Double vision/Distorted Vision
- ◯ Drooping Eyelid/ Párpado caído
- ◯ Dry Eyes/ Ojos secos
- ◯ Lazy eye/ ojo vago
- ◯ Floaters/Spot/ Flotadores/Punto
- ◯ Glaucoma

Contact lens exam Yes_____ NO_____

Any Medical Changes? YES_____ NO_____
¿Algún cambio médico? SÍ_____ NO_____
If any please list:/ Si alguno, por favor enumere:_____

Have you had any major illness or injuries since your last visit?
¿Ha tenido alguna enfermedad o lesión importante desde su última visita?

_____

DILATION: In order to fully examine your eye health, it is necessary to use eye drops to dilate your pupils. This allows for the best direct view of the retina-inside lining of the eye. Early signs of high blood pressure, diabetes, cataract, glaucoma, macular degeneration and torn retina can be detected from this procedure. The temporary side effects include blurry vision and light sensitivity lasting about several hours. Dilation is not necessary to get glasses/contact lens prescription.
DILATACIÓN: Para poder examinar completamente su salud ocular, es necesario utilizar gotas para los ojos para dilatar las pupilas. Esto permite la mejor visión directa del revestimiento interno de la retina del ojo. Con este procedimiento se pueden detectar signos tempranos de presión arterial alta, diabetes, cataratas, glaucoma, degeneración macular y desgarro de retina. Los efectos secundarios temporales incluyen visión borrosa y sensibilidad a la luz que duran aproximadamente varias horas. La dilatación no es necesaria para obtener gafas/lentes de contacto.

Do you authorize the doctor to dilate your eyes today? YES, _____ NO _____
¿Autoriza al médico a dilatarle los ojos hoy? SÍ, _____ NO _____

(If no, you may return to do so within 30days, at no extra charge, if you make an appointment.)
Your eye doctor cannot tell you how blurry your vision will be and for how long. That depends on the type of dilating eye drops used and how your eyes react. It may not be safe to drive yourself after having your eyes dilated. You should make arrangements to have someone drive you after your appointment.

Su oftalmólogo no puede decirle qué tan borrosa será su visión y por cuánto tiempo. Eso depende del tipo de colirio dilatador utilizado y de cómo reaccionan sus ojos. Puede que no sea seguro conducir usted mismo después de tener los ojos dilatados. Debe hacer arreglos para que alguien lo lleve después de su cita.

Please answer all questions/Por favor responda todas las preguntas

If the answer is NONE, please state NONE/ Si la respuesta es ninguna, por favor indíquelo

Please list all your medications/Lista de todos medicamentos

Allergies/Alergicas: No Known Allergies/ No se conocen Alergicas

List/Lista:_____

_____

Have you ever smoked/ Alguna vez has fumado? YES NO

Years/Anos_____ **When did you Quit/Cuando lo dejeste?**_____

Do you drink/Tu bebes? No Socially/socialmente____

Height/Altura _____ **Weight/Peso**_____

Diabetic/Diabético? Yes/SI No No

For how many years have you had diabetes? Por cuantos años?_____

What was your blood sugar today/Cual fue tu azúcar hoy?_____

What was your lowest and highest blood sugar within the past 2 weeks? _____

Cual fue tu azúcar mas bajo y mas alto en las ultimas 2 semanas?_____

What was your A1C/ cual fue tu glucosa?_____ **and when/cuando?**_____ **Do you have HIV/Tienes VIH? Yes/si NO**
CD4 Count/CD4 contar _____

HIPAA PRIVACY: By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that Eye Deal Optical and Florida Optical may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye Exam information and/or type of products provided) to another party to permit Eye Deal Optical and Florida Optical to perform its administrative duties, provide me with eye care services and products, process my vision benefits claims, and communicate with me regarding vision care services provided by Eye Deal Optical and Florida Optical (for example, mailings of exam reminders or information about services/products provided by Eye Deal Optical and Florida Optical. I can be assured that Eye Deal Optical and Florida Optical does not sell my personal health information of any kind to a third party for such party's own use. I authorize Eye Deal Optical and Florida Optical to submit by vision benefits claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from Eye Deal Optical and Florida Optical.

Al firmar este acuse de recibo de Aviso de prácticas de privacidad (el "Aviso"); Reconozco y acepto que he recibido una copia del Aviso de prácticas de privacidad para revisarla y conservarla en mis registros en la fecha identificada a continuación. Entiendo que Eye Deal Optical and Florida Optical puede usar y divulgar información de salud personal necesaria (por ejemplo, mi nombre, dirección, número de identificación de suscriptor, información del examen de la vista y/o tipo de productos proporcionados) a otra parte para permitir que Eye Deal Optical and Florida Optical realice sus tareas administrativas. brindarme servicios y productos para el cuidado de la vista, procesar mis reclamos de beneficios de la vista y comunicarse conmigo con respecto a los servicios de cuidado de la vista proporcionados por Eye Deal Optical and Florida Optical (por ejemplo, envíos por correo de recordatorios de exámenes o información sobre servicios/productos proporcionados por Eye Deal Optical and Florida Optical. Puedo estar seguro eso Eye Deal Optical and Florida Optical no vende mi información de salud personal de ningún tipo a un tercero para el uso propio de dicho tercero. Autorizo a Eye Deal Optical and Florida Optical a presentar reclamaciones de beneficios de la vista al patrocinador de mi plan

o plan de salud para recibir un reembolso directamente por los servicios y productos de la vista que. He recibido de Eye Deal Optical and Florida Optical.

_____ _____

Patient/Legal guardian Signature: **Date:**

Retinal Image

The digital retinal imaging camera captures photos of the retinal (back of the eye). Images captured are important in the early detection of glaucoma, diabetic retinopathy, hypertensive retinopathy, macular degeneration, and other sight threatening diseases, these images assist the doctor in diagnosing and managing these conditions. They also serve as documentation that the doctor can use for future comparison (since photos never change). By having a photo, the doctor can see the year-to-year changes in the retina and optic nerve and can therefore observe the smallest changes that can occur. It is highly recommended that all patients have this procedure, especially if they have the following conditions:

La cámara digital de imágenes de retina captura fotos de la retina (parte posterior del ojo). Las imágenes capturadas son importantes en la detección precoz de glaucoma, retinopatía diabética, hipertensiva, degeneración macular y otras enfermedades que amenazan la vista, estas imágenes ayudan al médico a diagnosticar y manejar estas condiciones. También sirven como documentación que el médico puede utilizar para la comparación futura (ya que las fotos nunca cambian). Al tener una foto, el médico puede ver los cambios año a año en la retina y el nervio óptico y, por lo tanto, puede observar los cambios más pequeños que pueden ocurrir. Se recomienda altamente que todos los pacientes tengan este procedimiento especialmente si tienen las siguientes condiciones:

- Diabetes
- Glaucoma or family history of glaucoma
- High blood pressure
- Headaches/migraines
- Age 18 and older
- New Patient

- Diabetes
- Glaucoma O antecedents Familiares de glaucoma
- Alta Presion sanguinea
- Dolores De Cabeza/migrañas
- Edad 18 y mayores
- Nuevo paciente

There is an additional charge of $20 for these images that most insurance do NOT cover. You are fully responsible for the charge. Hay un cargo adicional de $20 por estas imágenes que la mayoría de los seguros NO cubren. Usted es totalmente responsable de la carga.

I would like to have photos taken _____

Me gustaría tener fotos tomadas _____

I DO NOT want to have photos taken _____

NO ME gustaría Tomar fotos _____

Signature:_____ Date:_____

1. I am interested in purchasing my eye wear (circle): Online In person Somewhere else (if so where)_____

   Estoy interesado en comprar mis gafas (círculo): En línea En persona En otro lugar (si es así, dónde)_____

2. I am most interested in/Lo que más me interesa es:

☐ Budget Frames $ (in house no name frames)/Marcos económicos $ (marcos internos sin nombre)

☐ Luxury Frames $$ (Tommy Hilfiger, Guess, Oakley, Guess, RayBan + more)/Marcos de lujo $$ (Tommy Hilfiger, Guess, Oakley, Guess, RayBan y más)

☐ Ultra Luxury $$$ (Gucci, D&G, Tom Ford, Versace, Tiffany, + more)/Ultra Lujo $$$ (Gucci, D&G, Tom Ford, Versace, Tiffany y más)

3. Referral Source(circle)/Fuente de referencia (círculo): Facebook, Instagram, Online, Physician Referral Friend/Family Insurance Referral Name: _____
4. I have a current budget of $_____ for my eye wear today

   Tengo un presupuesto actual de $_____ para mis anteojos hoy

Written Financial Policy/ Política financiera escrita:

Thank you for choosing Eyedeal Optical and Florida Optical. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options you can choose from:
- Cash, Visa®, MasterCard®, American Express®, Discover Card®, Care Credit, Sunbit, Afterpay , Acima.
- CareCredit healthcare credit card, Sun bit and After pay and Acima is the preferred healthcare credit, providing special financing and payment options* for out-of-pocket medical expenses. Ask about how the payment plan can help you.

1. I Understand of Charges: I understand that I am receiving optical services which may include, but are not limited to, eye examinations, vision tests, and the provision of eyewear. I acknowledge that there will be charges associated with these services rendered to me.
2. Responsibility for Payment: I agree to be fully responsible for all charges incurred for the services provided. I understand that it is my responsibility to verify my insurance coverage and to pay any portion of the costs not covered by my insurance.
3. No Chargebacks: I promise not to initiate a chargeback with my bank or credit card company for any services rendered by Eyedeal Optical or Florida Optical. I understand that by doing so, I would be disputing legitimate charges for services that I have received and accepted.
4. Payment Arrangements: I understand that if I am unable to pay the full amount due at the time of service, I must make prior arrangements with the billing department of EyeDeal Optical AND Florida Optical
It is customary to pay for professional services when rendered. However, if you have a medical problem then we will bill your insurance on your behalf. Refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams (when no medical eye problem is known or suspected). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company.
We are a Medicare participating practice. If you are a Medicare Beneficiary, we will file a claim for you. You will be responsible for the 20% co-payment.
MINORS ACCOMPANIED BY AN ADULT: The adult accompanying a minor and his/her parents (or guardian) are responsible for payment prior to the beginning of your exam or consultation.
In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments at the time of service.
If you have a separate plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. We will bill your vision plan as above.
We require payment prior to the product is received.
I promise not to process a charge back on credit card for no show fees.
We require a 50% deposit collected prior to delivery of your optical purchase.
5. Returns/Exchange: Eyeglass lens orders are highly customized and cannot be cancelled once they have been placed with laboratory.
NO Refunds allowed:

No refund on open box contacts lenses.
"Due to the time involved and custom nature of eyewear, all sales are final. We are unable to offer refunds or Exchanges We will gladly restyle within 30 Days from date of purchase due to allergies.
Prescription changes at (No Charge) within 30 days from date of purchase. Any issue not able to see please come in within the 30 days from your date of purchase or Exam.
6. Signature: By signing below, I confirm that I have read and understood this financial responsibility form and agree to comply with its terms.
Si tiene un plan separado que cubre exámenes oculares y/o anteojos de rutina o anuales, infórmenos. Su plan de visión puede ayudarlo con sus necesidades de atención oftalmológica que no están cubiertas por su plan médico. Facturaremos su plan de visión como se indica arriba.
Requerimos el pago antes de recibir el producto.
Prometo no procesar un cargo de devolución en la tarjeta de crédito por cargos por no presentarse.
Requerimos un depósito del 50% cobrado antes de la entrega de su compra óptica.
POLÍTICA DE DEVOLUCIÓN / CAMBIO
Los pedidos de lentes para anteojos son altamente personalizados y no se pueden cancelar una vez que se hayan realizado en el laboratorio.
NO se permiten reembolsos:
No hay reembolso por lentes de contacto de caja abierta.
"Debido al tiempo que implica y la naturaleza personalizada de las gafas, todas las ventas son definitivas. No podemos ofrecer reembolsos o cambios.
Con mucho gusto cambiaremos el estilo dentro de los 30 días a partir de la fecha de compra debido a alergias.
La receta cambia en (Sin cargo) dentro de los 30 días posteriores a la fecha de compra. Cualquier problema que no pueda solucionarse debe presentarse dentro de los 30 días posteriores a la fecha de compra o examen.
5. **Firma: ** Al firmar a continuación, confirmo que he leído y comprendido este formulario de responsabilidad financiera y acepto cumplir con sus términos.

Patient Signature: _____ Date:_____