VISION FOR LIFE PATIENT INTAKE FORM

Last:_____First:_____MI_____
Address:_____
_____
Date of Birth:_____Age:_____Gender: (M / F / Other)
Primary phone #:(____)_____ (Home / Cell / Work)
Secondary phone #: (____)_____ (Home / Cell / Work)
Email:_____
I would like to receive correspondence and appointment confirmations via: (Voice / Text / Email)

VISION INSURANCE INFORMATION

Vision Insurance: (VSP / Eyemed/ Davis / March / Other / None)

MEDICAL INSURANCE INFORMATION

Medical Insurance:_____
Member ID:_____Group ID:_____
Policy Holder's Name(Last, First):_____
Policy Holder's DOB:____/_____/_____SSN:_____
Relationship to patient:_____
How did you hear about us?
_____

MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following? Circle yes, no, and f for family history.

Allergies _____y/n/f
Arthritis _____y/n/f
Blood/Lymph _____y/n/f
Cancer _____y/n/f
Cholesterol _____y/n/f
Diabetes _____y/n/f
Digestive/Gastric _____y/n/f
Ears/Nose/Throat _____y/n/f
Endocrine _____y/n/f
Fatigue _____y/n/f
Fevers _____y/n/f
Heart Disease _____y/n/f
High Blood Pressure _____y/n/f
Immune _____y/n/f
Integumentary (Skin disease) _____y/n/f
Kidney _____y/n/f
Muscle Bone _____y/n/f
Neurological/Headaches _____y/n/f
Psychological _____y/n/f
Respiratory _____y/n/f
Sinus _____y/n/f
Stroke/Seizures _____y/n/f
Throat Infections _____y/n/f
Thyroid _____y/n/f
Unusual Weight Loss/Gains _____y/n/f

Current Medications:_____
_____
_____
Allergies:_____
Do you currently smoke? (Yes / No)
List any prior surgeries and injuries:_____
_____
_____
Pharmacy name and address:_____
_____
Primary Care Doctor:_____

OCULAR HISTORY

Date of last eye exam:_____
Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision ❑ Burning ❑ Corneal Abrasions
- ❑ Cataracts ❑ Double Vision ❑ Eye Injury
- ❑ Crossed eye ❑ Floaters/Spots ❑ Grittiness
- ❑ Eye Infections ❑ Iritis/Uveitis ❑ Lazy Eye
- ❑ Flash of light ❑ Night vision ❑ Dryness
- ❑ Glaucoma ❑ Itchiness ❑ Tearing
- ❑ Headaches ❑ Sun Sensitivity ❑ Retinal Detachment
- ❑ Macular Degeneration ❑ Other Eye Disorders _____

FAMILY OCULAR HISTORY

Blindness _____y/n
Cataracts _____y/n
Corneal Problems _____y/n
Diabetes _____y/n
Glaucoma _____y/n
Heart Disease _____y/n
Lazy Eye _____y/n
Macular Degeneration _____y/n
Retinal Problems _____y/n

VISUAL NEEDS ASSESSMENT

Do you wear glasses?_____Do you wear contacts?_____
Interested in LASIK surgery?_____
Hours of computer usage:_____
Hours of outdoor activity:_____
Hobbies:_____
Eyestrain/neck strain/headaches:_____
Sports:_____
Hours before reading fatigue?_____

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations.
- ✓ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ✓ A description of uses and disclosures that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect, copy, or amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient: Name: _____ Date of Birth:_____

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

Payment Policy

I hereby assign all medical benefits, to include all major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Vision For Life. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Vision For Life within 60 days, I may be billed for any services or products that I have received. I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. ***I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs.***

Signature:_____Date:_____

DR. ALEKSANDRA WIANECKA O.D.
DR. CORINNE BLUM O.D. F.A.A.O.
66 DEER PARK AVE BABYLON, NY 11702
T: 631-789-6103 F: 631-789-6105

Refraction:

A refraction is a measurement taken by an eye doctor to determine whether a patient has nearsightedness (myopia), farsightedness (hyperopia), or astigmatism. Based on the results of the refraction, the doctor decides whether or not to prescribe glasses. A refraction can be accurately performed on a patient of any age, with or without his or her input. For the majority of patients, a refraction is a critical component of an eye examination.

Will my insurance pay for a refraction?

All patients using **medical insurance** for their routine exam are responsible for a **$40 refraction fee**. The refraction is considered a non-covered service by most medical insurances. The refraction **IS** covered by the following medical insurances: United Health Care Community Plan and Medicare with Medicaid as the secondary. The fee is applicable to all other medical plans.

All patients using a **vision plan** for their visit are covered for a refraction and will **NOT be responsible for the $40 fee.**

_____ I understand that by using my medical insurance for a routine exam I may be responsible for a $40 refraction fee

Optomap Retinal Photos (Optional):

Our doctors are concerned about retinal diseases such as macular degeneration, glaucoma, retinal detachments, and diabetic retinopathy; all which can lead to partial loss of vision or blindness. Additionally, systemic diseases such as diabetes and high blood pressure can be detected with retinal photos. Eye exams with retinal photos can help you safeguard both your eyesight and general health. The Optomap Digital Retinal Imaging allows us to thoroughly evaluate your internal eye health with dramatically improved precision that includes a depth in the retina not seen with regular dilation.

The Optomap is recommended annually. Since retinal photos are considered a non-covered service by medical and vision plans, with **medical** insurance there is a **$42 fee** for this service. With **vision** insurance this fee is **$39**. (Please advise staff if you have a history of epilepsy.)

_____ **YES**, I would like to have an Optomap Digital Retinal Scan. I understand that based on the doctor's examination **a dilation may still be recommended or necessary.**

_____ **I DECLINE** the Optomap Retinal Scan. I understand that after the doctor's examination, this service may be recommended for me or considered medically necessary. **A dilation may still be recommended or necessary.**

I understand I am responsible for any fees associated with medical services which may be noncovered benefits.

Print Name: _____Signature _____Date:_____

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Understanding Your Vision Benefits

Let's face it, insurance can be confusing. This is particularly true when an individual has both medical and vision coverage. Understanding your insurance PRIOR to any service can help you avoid confusion and frustration.

VISION INSURANCE is one of the most misunderstood benefits of all health-related coverage. Some insurance companies do a better job of educating their clients than others. At times insurance companies' "customer service" departments overstate benefits (and minimize or even ignore specific limits and restrictions) that can create an adversarial relationship between the patient and the doctor's office. We would like to avoid these misconceptions, and we hope that the following will help you better understand how vision coverage works.

Medical vs. Vision

Medical insurance DOES NOT cover vision related issues such as routine exams, glasses, and contact lenses. Many people with medical insurance have a separate rider policy to cover routine eye exams. Most vision plans do not cover ANY medical testing, diagnosis, consultation or treatment. Vision insurance covers ONLY routine eye exams for purchasing glasses or fitting and purchasing contact lenses. Regardless of your vision insurance, most plans do not cover 100% of expenses, and thus you should expect some out-of pocket costs. There may be co-pays, deductibles or a percentage of costs that you will pay out-of-pocket as required by your insurance policy. As with most doctors, at Vision for Life the patient's portion must be paid before materials (glasses or contacts lens) can be ordered.
And all co-pays are due at the time services are rendered.

MEDICAL concerns (Glaucoma, Dry Eyes, Macular Degeneration, Red-Eyes, Floaters, Allergic Conjunctivitis) take priority and as such will be treated first or concurrently with a vision problem. Sometimes a medical condition has to be treated and corrected before vision can be accurately evaluated. Medical insurance companies usually separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. (The refraction determines the prescription for eyeglasses and contacts.) Typically, VISION insurance policies usually cover both the ROUTINE EXAM and REFRACTION, while MEDICAL policies cover the EXAM only. You are responsible for the cost of the refraction if your insurance is medical only. If the presence of disease is detected that require additional testing, the doctor will provide you information regarding the condition and the testing required.

Although our staff members are very knowledgeable about insurance plans, remember that it is not the doctor's or staff's responsibility to know the details of your individual plan. It is to your benefit to be aware of possible deductibles and co-pays that are part of your plan. Your insurance plan may cover routine vision care, but if your deductible has not yet been met, you will still have to pay for the service until your deductible is met. Your insurance is a contract between you, your employer and the insurance company; not with the doctor. We encourage you to speak with your insurance company PRIOR to your appointment about your plans specific details. Then, as always, feel free to ask us questions about how they will apply to your upcoming visit. We will do everything we can to help you better understand your policy, but the more knowledge you have about how it works ahead of time, the less frustrating it will be for you at the time of the exam.