Oasis Eye Care
Optical & Med Spa

Dr. Trent McKinney,
Board Certified Ophthalmologist
- Cataract Surgery
- Dry Eye Lab

Dr. Alex Brocato,
Board Certified Optometrist
- Comprehensive Eye Exams
- Contact Lens Fitting

NEW PATIENT DEMOGRAPHICS

Appointment date: _____

Patient Name: _____Nickname:_____

Date of Birth: ____/____/_____ Gender: ☐ Male ☐ Female Social Security #: _____ --____--_____

Address: _____

_____

Facility Name of which you live: *(if applicable)*_____

Home phone: (____) _____ -_____ Cell phone: (____) _____ -_____Work Phone: (____) _____ -_____

E-Mail address: _____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Spouses Name:_____

Employment Status: ☐ Employed ☐ Full-Time ☐ Part-Time ☐ Retired Occupation: _____

Emergency Contact: _____Phone number: (____) _____ -_____

Primary Physician: _____

How did you hear about our office? ☐ My doctor ☐ friend *name*?_____ ☐ your sign ☐ social media

Print ad *(specify publication)* _____other (specify) _____

What months are spent in Florida: _____ Northern phone number: (____) _____ -_____

Northern address (if applicable): _____

_____

Preferred pharmacy: _____

Location *(cross streets if address unknown)* _____

Note: A $50 fee will be assessed for appointments that are missed/cancelled without a 24-hour notice.

INSURANCE PLANS & FINANCIAL POLICIES

***No call/No show appointments*: A fee of $50 will be charged for missed appointments that you fail to cancel 24 hours in advance.**

Payment: is expected at the time services are rendered. This includes all deductible, copays and non-covered services. Note: refractions are a non-covered service with Medicare and most medical insurances. Payment will be expected at the time of service.

Delinquent accounts: will be sent to collections 120 days from the date of the first billing cycle. Patients having financial difficulties are encouraged to discuss payment options with the billing office before the account becomes delinquent.

Motor vehicle claims: are **not** filed.

Workman's Comp claims: are **not** filed

Insurance: is filed for all primary and secondary insurance carriers provided the physician is participating with the insurance plan. Non-par insurance claims will be filed at the discretion of the billing department.

Our office participates with the following *commercial* insurance plans:

AETNA COMMERCIAL PPO

AETNA COMMERCIAL HMO (referral from primary physician required)

FLORIDA BLUE COMMERCIAL PPO (excluding Blue Select)

UNITED HEALTHCARE COMMERCIAL PPO AND HMO

Our office participates with the following *Medicare* plans:

TRADITIONAL MEDICARE

FLORIDA BLUE MEDICARE ADVANTAGE PLAN PPO

UNITED HEALTHCARE MEDICARE ADVANTAGE PLAN PPO AND HMO

Please note that insurance companies are constantly adding/changing plans. While we will make every effort to verify your coverage, it is ultimately the patient's responsibility. We recommend that you check with your insurance company to verify your benefits and that Dr. McKinney/Dr. Brocato is listed as a participating provider with your plan, prior to your visit.

I have read the financial policy of Oasis Eye Care. I understand and agree to adhere to the policies as outlined.

_____ _____

Patient signature Date

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relies on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our policy notice.

Patient Name: _____

Signature: _____

Date: _____

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

1. TREATMENT AUTHORIZATION - I, the below named patient, do hereby give TRENT S. MCKINNEY M.D., and ALEX BROCATO, O.D. consent for medical treatment. 2. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician of this group examining and/or treating me to provide to any third party payer (i.e.: insurance company or government agency) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis. 3. PHYSICIAN INSURANCE ASSIGNMENT -I, the below named subscriber, hereby authorize payment directly to any physician of this group examining or treating me any surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for the services. 4. MEDICARE - Patients certification authorization to release information and payment requests. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act/Division of Family Services or its intermediaries or carriers of any information needed for this for a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
5. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This Assignment will remain in effect until revoked by me in writing.

Please remember that the insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. As a courtesy, our office will bill your insurance and resubmit only one time if necessary.

I UNDERSTAND IT'S MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, COINSURANCE, OR ANY OTHER BALANCE NOT PAID BY MY INSURANCE OR THIRD PARTY PAYER WITHIN 60 DAYS OF THE OFFICE VISIT.

I UNDERSTAND THE ABOVE AGREEMENT AND SIGN AS THE RESPOSIBLE FINANCIAL PARTY.

PATIENT'S SIGNATURE: _____DATE:_____

MEDIGAP OR SECONDARY INSURANCE SIGNATURE

I request that payment of Medigap benefits be made on my behalf to Trent McKinney, M.D. and Alex Brocato, O.D. for any services furnished to me by (physician/supplier). I authorize any holder of medical information about me to release to my insurance any information needed to determine benefits or the benefits payable for related services.

PATIENT'S SIGNATURE: _____ DATE: _____

SUBSCRIBER (if different from patient) _____Birthdate __/___/____

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MEDICAL INFORMATION RELEASE AUTHORITY

I authorize the physician/staff of Oasis Eye Care to release/leave information pertaining to the following:

___ My medical condition and treatment ___ My finances and insurance obligations

The above information may be discussed with the following:

_____

Name phone number relationship

_____

Name phone number relationship

_____

Name phone number relationship

_____

Name phone number relationship

The above information may be left on my answering machine/voicemail. Y N

I understand that no information will be provided to family members, including spouses, unless their name(s) appear above. I also understand that this release of information will remain in effect until I provide written notification of any change.

Patient signature:_____Date:_____

CANCELLATION/NO SHOW POLICY

At Oasis Eye Care, Optical and Med Spa we ask that if you need to cancel or reschedule your appointment you give the office 24-hour notice. Cancellation without notice will result in a $50 fee. We understand that emergencies or unexpected situations may arise and we will do our best to accommodate each circumstance. If you should exceed more than three cancellations your return to the practice must be approved by the physician.

Patient signature:_____Date:_____

Witness:_____Date:_____

Optical Coherence Tomography (OCT)

Optical coherence tomography (**OCT**) is a non-invasive tool that takes pictures of the back of your eye. It functions like an ultrasound, but uses light waves instead of sound to map the shape of your retina and optic nerve. The **OCT** aids the physician in diagnosing and managing various eye problems including: ***Macular degeneration, glaucoma, diabetes and other pathologies of the eye.***

This screening is **NOT** covered by your insurance and the cost is $**60**. Please indicate whether or not you would like to have this performed. If during the exam, your physician finds one or more of the above mention eye conditions, it may be covered by your insurance and the cost would be subject to your individual health care agreement.

- ☐ Yes, I wish to have the OCT Screening performed during my exam
- ☐ No, I do not wish to have the OCT Screening performed during my exam

_____ _____

Signature Date

Refraction Policy

A **REFRACTION** is an important part of a comprehensive eye exam and a glasses prescription cannot be dispensed without it. This test is performed by a skilled technician (or physician) using a phoropter. This test allows us to determine if a glasses prescription could be issued to achieve your best functional vision. Without a consistent refraction, it becomes increasingly difficult for a doctor to follow you for visual changes. However, the most important reason we require a yearly refraction is to protect your vision. Most silent diseases (***Glaucoma, Cataracts and Macular degeneration***) can be diagnosed and treated earlier if an annual refraction has been performed.

MEDICARE AND MOST MEDICAL INSURANCES DO NOT COVER THE COST OF A REFRACTION. THE OFFICE FEE FOR THIS IS $50 AND PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

I have read the above explanation about the purpose and need for a refraction and understand that I will be responsible for payment.

□ I wish to proceed with a Manifest Refraction as described above

□ I refuse the Manifest Refraction and accept the risk of missing a possible silent eye disease

_____ _____

Signature Date

Name:_____ Date of Birth:__/__/____ Age:_____ Date:_____

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Who referred you here:_____ Primary Doctor:_____

Endocrinologist:_____ Cardiologist:_____

Reason for your visit:_____

Please list any allergies & reaction(s):_____
_____

Ocular History: *Please check all that apply* ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Amblyopia/Lazy Eye ☐ Dry Eyes ☐ Other_____

Have you ever had **EYE SURGERY** or an **EYE INJURY**? ☐ No ☐ Yes—list below

Year	Which Eye	Type of Surgery/Injury

Eye Medications or Drops:

Med/Drop	Which Eye	Frequency
	☐ right ☐left ☐ both	
	☐ right ☐left ☐ both	

Have you ever used **steroid eye drops or pills**? ☐ Y ☐N If yes, what Medication? _____
When? _____

Medical History: *Please check all that apply and **place year** diagnosed beside*

☐ Allergies (seasonal) _____
☐ Anemia _____
☐ Arthritis _____
☐ Asthma _____
☐ Cancer _____
☐ Cataracts _____
☐ Chronic Bronchitis _____
☐ Diabetes Type ☐ 1 or ☐ 2_____
☐ Emphysema (COPD) _____
☐ Gastric Reflux _____
☐ Heart Attack _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Kidney Disease _____
☐ Lupus _____
☐ Macular Degeneration _____
☐ Migraines _____
☐ Parkinson's _____
☐ Prostate Problems _____
☐ Shingles/Zoster _____
☐ Sinusitis _____
☐ Sjogren's _____
☐ Sleep apnea _____
use CPAP? ☐ Yes or ☐ No
☐ Stroke_____
☐ Thyroid Disease _____
☐ TIA's _____
☐ other: _____
_____
_____

Surgical History: *list all major surgeries other than eye surgery:*

Year	Surgery/Procedure	Site

Medication List: *please list all medications and supplements **or** attach list*

Drug	Dosage *(ie: mg)*	Frequency *(ie: once or twice a day)*

Family History:

Description	Relation *(immediate family only)*	Status	Age
Arthritis □ Y □N		□Living □Deceased	
Blindness □ Y □N		□Living □Deceased	
Cancer □ Y □N		□Living □Deceased	
Cataracts □ Y □N		□Living □Deceased	
Diabetes □ Y □N		□Living □Deceased	
Glaucoma □ Y □N		□Living □Deceased	
Heart Disease □ Y □N		□Living □Deceased	
High Blood Pressure □ Y □N		□Living □Deceased	
Kidney Disease □ Y □N		□Living □Deceased	
Lazy Eye □ Y □N		□Living □Deceased	
Macular Degeneration □ Y □N		□Living □Deceased	
Retinal Disease □ Y □N		□Living □Deceased	
Stroke □ Y □N		□Living □Deceased	
Tuberculosis □ Y □N		□Living □Deceased	

Social History:

Smoking Status: (*check one)* □ former smoker □ never smoked □ smoker, status unknown
□ heavy tobacco use □ light tobacco use □ unknown if ever smoked

Alcohol use: *check one* □ on occasion □ socially □ ½ pack/day □ 1pack/day □ 2 packs/day
□ 1 glass wine □ 2 glasses of wine □ > or =3 glasses of wine

Recreational Drug Use: □ No □ Yes Drugs used_____

Support system: □ Married □ Widow □ Single □ Assisted Living □ Nursing Home
Do you currently work? □ Y □N Occupation_____

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EYES		**RESPIRATORY**		**BLOOD/LYMPHNODES**	
Previous Surgery	Y or N	Cough	Y or N	Easy Bruising	Y or N
Contact Lenses—Do you		Congestion	Y or N	Gums Bleed Easily	Y or N
wear?	Y or N	Wheezing	Y or N	Prolonged Bleeding	Y or N
Pain	Y or N	Asthma	Y or N	Heavy Aspirin Use	Y or N
Double Vision	Y or N				
Glaucoma	Y or N	**GASTROINTESTIONAL**		**MUSCULOSKELETAL**	
Cataracts	Y or N	Heartburn	Y or N	Stiffness	Y or N
Macular Degeneration	Y or N	Nausea/Vomiting	Y or N	Arthritis	Y or N
Dry Eyes	Y or N	Jaundice/Hepatitis	Y or N	Joint Pain/Swelling	Y or N
Flashes	Y or N				
Floaters	Y or N	**GENITO-URINARY**		**SKIN**	
		Pain/Difficulty	Y or N	Rash/Sores	Y or N
EAR, NOSE, & THROAT		Blood in Urine	Y or N	Lesions	Y or N
Hard of Hearing	Y or N	History of Kidney		Hives/Eczema	Y or N
Ringing in Ear	Y or N	Stones	Y or N		
Vertigo	Y or N	History of		**NEUROLOGICAL**	
		STD's	Y or N	Seizures	Y or N
CARDIOVASCULAR		Pregnant or Nursing	Y or N	Weakness/Paralysis	Y or N
Chest Pain	Y or N	**PSYCHIATRIC**		Numbness	Y or N
Dizziness	Y or N	Anxiety/Depression	Y or N	Tremors	Y or N
Fainting	Y or N	Mood Swings	Y or N		
Shortness of Breath	Y or N	Difficulty Sleeping	Y or N	**IMMUNOLOGIC**	
Irregular Heartbeat	Y or N			Hives	Y or N
Difficulty Lying Flat	Y or N	**ENDOCRINE**		Itching	Y or N
		Increased Thirst	Y or N	Runny Nose	Y or N
CONSTITUTIONAL		Increased Hunger	Y or N	Sinus Pressure	Y or N
Fatigue/Weakness	Y or N	Increased Urination	Y or N		
Fever	Y or N	Increased Sweating	Y or N		
Weight Gain/Loss	Y or N	Fingernail Changes	Y or N		

Additional Medical History:

_____

_____