A BETTER VUE
EYE PHYSICIANS, LLC

DAVID D. TRAN, MD ~ LANI P. VU, MD
1333 3rd AVE. S., STE 301
NAPLES, FL 34102
TELEPHONE (239) 262-2020
FAX (239) 435-1084

Patient Registration

Name:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ D ☐ W Age:_____

Social Security #_____ Date of Birth:_____

Local Address_____

_____

Home Phone:_____ Email:_____

Cell Phone:_____ Occupation:_____

Employer (Name and Address):_____

_____

Emergency Contact: (Name)_____ (Relationship)_____
(Address/Phone) _____

_____

Northern Address:_____

_____

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____
Policy Holder (Name/DOB/Relationship if not self)_____

_____

Policy ID_____ Secondary Policy ID_____

Pharmacy Information

Name_____ Cross Streets_____ Phone_____

Referred By

Name_____

Race: [ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American
[ ] Native Hawaiian/Pacific Islander [ ] White [ ] Other

Ethnicity: [ ] Non-Hispanic or Latino [ ] Hispanic or Latino

Name: Weight:_____Height_____
Date of Birth:

Medical History Form

Yes	No	Medical History: Do you have a history of any of the following?
		High blood pressure
		Diabetes
		Thyroid disease
		Heart disease
		Heart Attack
		Lung disease
		Asthma
		Neurologic disease
		Stroke
		Arthritis
		Cancer type?
		Hearing loss
		Kidney problems
		Bladder problems
		Anemia
		Seizures / Convulsions
		Weakness
		Weight Loss
		Liver disease
		Stomach ulcer

Yes	No	Eye History
		Cataracts
		Glaucoma
		Retinal Detachment
		Macular Degeneration
		Other Retinal Disease
		Laser Treatment
		Eye surgery type?

Yes	No	Have you experienced any of the following?
		Decreased vision
		Blind spots in vision
		Poor side visions
		Poor color vision
		Poor depth perception
		Abnormal sensitivity to light
		Halos around lights
		Problems with glare
		Red eye
		Eye discomfort
		Eye dryness
		Eye itching
		Pressure in or behind eye
		Crusting or red eyelids
		Tearing of eyes
		Double vision
		Flashing lights
		Jagged lines in vision
		Episodes of vision loss
		Lazy eye
		Spasm of the lids
		Serious eye infection
		Abnormal pupil

Yes	No	Family History
		Diabetes
		Heart Disease
		Retinal Disease
		Glaucoma

Have you ever smoked? ☐YES ☐NO packs per day_____ ☐QUIT? How long ago_____

Do you drink alcohol? ☐YES ☐NO frequency_____

Drug Allergies:_____

Medications:_____

Do you wear contacts / glasses / both? (please circle one)

Primary Care Physician:_____

A BETTER VUE
EYE PHYSICIANS, LLC

1333 3rd AVE. S., STE 301
NAPLES, FL 34102

TELEPHONE (239) 262-2020 FAX (239) 435-1084

Dear Client:

Physicians, like all providers of personal / professional services, are now required by law to inform their clients of their policies regarding privacy of client information. Physicians have been and continue to be bound by professional standards of confidentiality.

We collect non public personal information about you that is provided to us by you or obtained by us with your authorization.

For current and former clients, we do not disclose any nonpublic personal information obtained in the course of our practice except as required or permitted by law. Permitted disclosures include, for instance, providing information to our employees necessary for your care, to your individual insurance companies and medicare as required for payment for claims for you, and to other physicians for the continuance of your care. In all situations, we stress the confidential nature of information being shared.

We retain records relating to professional services that we provide so that we are better able to assist you with your medical needs and to comply information, we maintain physical, electronic and procedural safeguards that comply with our professional standards.

If you have questions, feel free to ask, because your privacy, our professional ethics, and the ability to provide you with quality care are very important to us.

Sincerely,

A Better Vue Eye Physicians, LLC and Naples Premier Surgery Center LLC

Patient Consent for Use and DISCLOSURE OF Protected Health information

With my consent, the office of Drs. David Tran and Lani Vu (herein known as "The Practice") may use and disclose my protected health information to carry out treatment, billing, and healthcare operations.

The Practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained physically in the office or by written request forwarded to the Practice office.

With my consent the Practice may leave messages:

	On my home answering machine		With my spouse
	With my children or anyone residing at my home		On my cell phone voicemail
	On my work voicemail		
	On my e-mail address. **leave address here:**		

I, _____ give permission to all my health care and medical providers and payors to disclose and release my protected health information described below to:

Name(s)	**Relationship**
_____	_____
_____	_____
_____	_____

I have the right to request that the Practice restrict how it uses or discloses my protected health information to carry out treatment, billing, and healthcare operations. However the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I have the right to refuse to sign this authorization. If I do not sign this consent, the Practice may decline to provide treatment. I also have the right to inspect or copy the information to be used or disclosed.

PRINTED NAME:_____

SIGNATURE:_____

DATE:_____ Relationship to patient if other than self:_____

A BETTER VUE
EYE PHYSICIANS, LLC

1333 3rd AVE. S. STE 301
NAPLES, FL 34102

TELEPHONE (239) 262-2020 FAX (239) 435-1084

Statement of Financial Responsibility

A Better Vue Eye Physicians appreciates the confidence you have shown in choosing us to provide for your health care needs.

A Better Vue Eye Physicians will act in good faith and contact your primary insurance carrier to verify your coverage and benefits. We will not, however, be held responsible for any financial miscalculation that derives as a result of misinformation conveyed by your insurance carrier. We will bill your insurance carrier/s on your behalf. As a patient, it is in your best interest to know and understand your responsibility for any co-payment, deductible and/or coinsurance as determined by your contract with your insurance carrier prior to your visit and any scheduled procedure. You can gather such information by calling your insurance carrier or/and reading your insurance coverage package. Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know their coverage and benefits and payment of service rendered.

You will be responsible for payment of the following:

- Coinsurance or copay amounts
- Yearly deductible amounts
- Non-covered services
- Out of Network charges
- Terminated coverage
- Denied workers compensation claim
- No insurance coverage
- No referral obtained from Primary Care Physician
- Failure to respond to coordination of benefits inquiry
- Failure to respond to insurance carrier correspondence
- If your insurance carrier denies any part of your claim
- If you elect to continue services past your coverage/policy period, you will be responsible for your balance in full
- Cosmetic Surgery, deemed not medically necessary by insurance company

If your insurance carrier requires a referral or authorization before you can be seen by a specialist, it is your responsibility to obtain such referral or authorizations before being seen at A Better Vue Eye Physicians. If payment is denied for lack of referral/authorization, you understand that you will be responsible for payment in full.

Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you will be liable for full payment of the bill.

Statement of Patient Financial Responsibility

For patients with health insurance, you are responsible for payment of any deductible and copayment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Please understand the amount we ask you to pay prior to your procedure/surgery is only a **"guess-timation"**. Your exact patient's portion will be determined when your insurance carrier processes your claim. All necessary adjustment of your financial obligation will be made at that time.

Payments are due upon receipt of your statement. Accounts over 90 days past due may be turned over to collections. You will then be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of the balance due. A fee, as much as **30% or more,** will be added to your total account balance in accordance with this facility's contract with its collection agency. For patients who do not have health insurance (Self Pay) and those for whom we do not participate in their insurance health plan, entire payment is expected at the time of the visit. You are responsible for notifying us if your insurance, benefits, address or phone number(s) changes.

Refraction Notification

Refraction is the optical determination of the best possible eye vision. It is the test done to determine and therefore provide a prescription for glasses. It is also needed to determine if any medical, optical or surgical treatment may be indicated. It is a necessary part of an ophthalmic examination, but it is NOT a covered service by Medicare and most insurance companies and will NOT be submitted in attempt to collect. Our office fee for the refraction is **$50.00** and this fee is collected in addition to any co-payment, co-insurance, or deductible.

Acknowledgement

I have read the information and understand that the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service if uncovered by my insurance carrier. The co-payment, co-insurance, and deductible are separate from and not included in the refraction fee.

I have read the above and understand the statement of Patient Financial Responsibility.

Patient's Signature (Or Guardian): _____ Date: _____