EYE ASSOCIATES OF WEST JEFFERSON

PATIENT INFORMATION

Please print

Patient Name: _____ □ Male □ Female Date of Birth: _____

Patient email address _____

Race : □ African American □ American Indian □ Asian □ Hispanic □ White Caucasian □ Native Hawaiian

Ethnicity: □ Hispanic/ Latino □ Non Hispanic Preferred Language: _____

Address:_____City_____State_____Zip_____

S.S.#: _____ Home Phone: ( ) _____

Preferred Communication: □ Home □ Cell □ Work

Cell Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

Address:_____City_____State_____Zip_____

PARENT/SPOUSE INFORMATION

Name: _____ □ Male □ Female Date of Birth: _____

Address:_____City_____State_____Zip_____

S.S.#: _____ Home Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

Cell Phone: ( ) _____

EMERGENCY CONTACT PERSON

Name: _____ Phone: ( ) _____

Cell Phone: ( ) _____

WORKERS' COMPENSATION INFORMATION

Employer: _____ Phone: ( ) _____

Address:_____City_____State_____Zip_____

Date of Accident: _____ Person verifying W/C: _____

INSURANCE INFORMATION

Please present your current Insurance Cards, with a valid ID to the front desk to be scanned.

I authorize the release of information to my insurance carrier/managed care company/workers' compensation company for quality assurance of utilization review purposes and payment directly to my physician for all services**. I understand that I am financially responsible for NON-COVERED charges by this assignment.**

Signature: _____ Date: _____

Relationship to patient: _____ (Over)

Please list all persons you wish to accompany and authorize examination/treatment of minor children in the absence of a parent or legal guardian.

AND/OR

List any persons with which the patient's medical findings/recommendations may be discussed with. (If none are authorized please state so.)

_____ _____

_____ _____

Parent/Legal guardian/Patient signature: **Date**

PAYMENT POLICY

***ALL PAYMNTS ARE DUE AT THE TIME OF SERVICE INCLUDING COPAYS AND/OR DEDUCTIBLES.**
***THERE WILL BE A $25.00 CHARGE FOR ALL NSF CHECKS.**
***YOU MUST CANCEL/RESCHEDULE YOUR APPOINTMENT 24 HOURS PRIOR TO APPOINTMENT TIME TO AVOID $20.00 MISSED APPOINTMENT FEE.**
***YOUR ACCOUNT IS ELIGIBLE FOR THIRD PARTY COLLECTIONS AFTER 60 DAYS.**
***MISSED APPOINTMENT FEES MUST BE PAID PRIOR TO ANY RETURN VISIT.**
***IF YOUR ACCOUNT IS PLACED IN COLLECTIONS, ALL FEES MUST BE PAID PRIOR TO ANY RETURN VISIT.**

I HAVE READ AND UNDERSTAND THE ABOVE PAYMENT POLICY

Parent/Legal guardian/Patient signature: **Date**

HIPPA NOTICE Version #1
Effective Date: 04/14/2003

EYE ASSOCIATES OF WEST JEFFERSON

RECEIPT OF NOTICE OF PRIVACY PRACTICES

The HIPAA Privacy Rule concerning use and disclosure of protected health information.
(This agreement is in compliance with US law effective 4/2003.)

By signing this consent form, I am giving Eye Associates of West Jefferson consent to use information concerning my treatment, payments, and all other health care operations, as outlined in the Notice of Privacy Practices. I have the right to revoke this consent, in writing, at any given time.

I, _____(patient name), have reviewed and fully understand the nature of this consent.

Signed: _____ **Date:** _____

Relationship to patient: _____

I may be contacted at the numbers listed below to be reminded or notified of current appointments, missed appointments, or overdue treatment. If you are unable to contact me, you may call the other person or number listed below.

Alternate Name: _____ Alternate phone number: _____

Eye Associates of West Jefferson
Payment Policy

Patient Name: _____ Patient DOB: _____

Thank you for choosing **Eye Associates of West Jefferson**. We are committed to providing you with quality and affordable health care. We have updated our payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. **If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.** Knowing your insurance benefits is your responsibility. *Please contact your insurance company with any questions you may have regarding your coverage.*

2. **Co-payments, Co-Insurance and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. **Failure on our part to collect co-payments and deductibles from patients can be considered fraud.** Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that refractions – and perhaps other services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. **You must pay for these services in full at the time of visit.**

4. **Proof of insurance.** We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the *correct insurance information* in a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Should your insurance company need you to supply certain information directly, it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility.

6. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

7. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient/Parent/Guardian: _____ Date: _____

Routine Eye Exams, Medical Eye Exams, and Refractions

Please Read Before Your Eye Examination

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit, so you will know how billing will be handled. Ultimately, it is <u>YOUR RESPONSIBILITY</u> to know what your own medical or vision plan covers. We hope this information will help you understand how your visit is submitted to your insurance for today's visit and future visits with Eye Associates of West Jefferson.

Benefits may vary based upon the reason for your visit. Your symptoms, description or the findings of your exam will determine where your claim is filed. Any medical condition or finding must be billed to your medical insurance.

<u>Routine Eye Examinations</u>: A routine eye exam takes place when you come for an eye examination without any medical eye problem and there are no symptoms except for visual changes that can be corrected by eyeglasses or contact lenses; the doctor screens the eyes for disease and **finds no medical problems**. Glasses and contact lens prescriptions may be updated.

<u>Medical Eye Examinations</u>: Your visit will be coded as a medical eye examination whenever you are being evaluated or treated for a medical condition or symptoms, eye problems you tell our staff about, or a condition that the doctor finds during the examination. Examples that will necessitate your visit being submitted to your medical insurance include headache, diabetes mellitus, eye irritation, dry eyes, allergies, floaters, contact lens intolerance, glaucoma, cataract, eye muscle imbalance, lazy eye, macular degeneration, and others. Please note that if you have diabetes mellitus, it will be coded as a medical examination, and a letter will be sent to you to your primary care physician.

<u>All Vision Plans</u>: If you have a vision plan we need to be aware of this coverage 48 hours prior to your exam to obtain an authorization. Vision Plans cover only routine eye examinations. If you report symptoms during your visit related to an eye problem, disease, or injury, or your doctor determines that your problem falls under the category of a medical eye examination, your visit will be billed to your medical insurance instead of your vision insurance, which will be subject to co-pays and deductibles according to your plan. In summary, how your eye exam will be submitted to your insurance carrier will depend not only upon what you tell the doctor, but also what the doctor finds upon examination. Remember, there are vision plans that do not cover medical exams and medical plans that do not cover routine eye care. If you have any questions, please ask a member of our staff.

<u>What is a Refraction</u>? *A refraction is a vision test that determines your best-corrected visual acuity with eyeglasses. This is a measurement that the doctor or technician takes with an instrument called a phoropter that holds corrective lenses in front of your eyes. While you look at the eye chart through the phoropter, the lenses are adjusted until the clearest vision is achieved. This test is performed on your first visit with us, your annual visit, and anytime there is a vision change. The refraction is a vital test to the care of your eyes because it allows for assessment of your current eye health and the detection of eye diseases. With it we may provide you with a prescription for updated glasses, or it may be required by Medicare, Tricare, or other insurance plans to determine if you qualify for particular eye procedures such as cataract or laser eye surgeries.*

<u>Will your insurance pay for a refraction?</u> *Even though this is a vital test to the care of your eyes, the refraction is a non-covered service through Medicare and most insurance plans. Unfortunately, they do not differentiate between medical refractions and refractions performed solely for the purpose of providing glasses. We are required to charge for the service regardless of whether insurance will pay.*

<u>As a courtesy, we reduce the refraction fee to $20.00 when paid at time of visit. Any refractions not paid at the time of visit, and not covered by insurance will be billed to patient at the full price of $35.53. PLEASE NOTE * This is not the same as a contact lens prescription, which has an $80 fitting fee, in addition to the refraction.</u> If your insurance plan should reimburse our office for this test, we will refund you the difference. This is a routine charge at all medical and surgical Ophthalmologists' offices. ***To receive a copy of your eyeglass prescription, THIS FEE MUST BE PAID.***

I understand the difference between routine and medical eye examinations and the potential implications of these differences on which type of insurance is billed and the potential for fees that may include co-pays, deductibles, and/or co-insurance fees. I understand that I am responsible for any of these fees that my insurance does not cover. I further understand that a refraction is an important test that I may need, and if so, that I will be responsible to pay for this test.

_____ _____

Signature of patient, responsible party, or beneficiary *Date*

EYE ASSOCIATES OF WEST JEFFERSON - MEDICAL QUESTIONNAIRE

ARE YOU PREGNANT? YES NO N/A
ARE YOU NURSING? YES NO N/A

IS IT POSSIBLE YOU ARE PREGNANT?
YES NO

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO IF YES, PLEASE LIST BELOW:

_____ _____

PATIENT INFORMATION

NAME: _____

SEX: M / F DOB: ____/____/____

ARE YOU HERE FOR A ROUTINE EYE EXAM? Y / N

WILL YOU BE USING YOUR VISION PLAN TODAY? Y / N

INSURANCE INFORMATION

VISION INS: _____

SUBSCRIBER NAME: _____

SUBSCRIBER ID: _____

SUBSCRIBER DOB: ____/____/____

Patient Medical History

Have you been diagnosed/treated for the following?

☐ Allergies ☐ Asthma
☐ Arthritis ☐ Cancer
☐ Diabetes ☐ Cholestrol
☐ Heart Disease ☐ High Blood Pressure

Other: _____

If female, are you Pregnant or Nursing? Y / N

Date of last medical exam: ____/____/____

Current Medications (prescription or over the counter)

_____
_____
_____
_____

Allergies to Medications? Y / N
If yes, please explain: _____

_____

Privacy Agreement *

I consent to the use and disclosure of my health information for the purpose of treatment, payment, and health care operations. I understand that if my insurance does not cover the charges for services and/or materials, I am responsible for the amount due.

Signature: _____
Relationship to pt _____
Today's Date: ____/____/____

***Notice of Privacy Practices furnished upon request**

Patient Eye History

Do you experience any of the following

☐ Blurry Vision ☐ Tearing ☐ Floaters
☐ Flashes of light ☐ Dryness ☐ Discharge
☐ Burning ☐ Eye Turn ☐ Headaches
☐ Itching ☐ Redness ☐ Double Vision

Date of Last Eye Exam: ____/____/____

Are you planning to get new glasses today? Y / N

Do you currently wear contact lenses? Y / N

What kind? _____

Are you satisfied with your current contacts? Y / N

Have you been diagnosed/treated for the following:

☐ Cataracts ☐ Glaucoma ☐ Eye Infection
☐ Iritis/Uvietis ☐ Lazy Eye ☐ Eye Trauma
☐ Retinal Detachment ☐ Macular Degeneration

Other: _____

Family Medical /Eye History

☐ Glaucoma _____
☐ Diabetes _____
☐ Retinal Detachment _____
☐ Macular Degeneration _____