Eyes of Athens and Cleveland

Clinic Policies and Patient Information

Patient Name: _____Date of Birth:_____
Mailing Address: _____ Marital Status: _____
City: _____ State_____ Zip_____ Sex: M / F
Primary Phone: _____
Social Security #:_____ E-mail: _____
Primary insured or legal guardian (if pt is a minor): _____
Primary insured or legal guardian date of birth: _____

Emergency Contact Name: _____Relationship:_____Phone:_____

Who may we thank for referring you to our office? Please provide their name. _____

Spectacle/Contact Lens Prescription Release Notice

Pursuant to the Federal Trade Commission's ruling 16 CFR Part 315:
I understand that Eyes of Athens and Cleveland will readily supply a copy of my **non-expired** glasses or contact lens prescription at my request. To abide by HIPAA guidelines, in the absence of a secure electronic submission portal, I understand that this prescription will be available to me by fax or postal mail, or that I may request to pick up the document at the office (allowing a reasonable time frame for office staff to obtain the doctor's signature).

Medicaid Notice

I acknowledge that Eyes of Athens and Cleveland is **not** a participating provider in **any** program funded by Medicaid/TennCare (except for Tennessee's state sanctioned QMB program) and does not have the ability to file any claims, whether primary or secondary to those coverages. I understand that any/all patients presenting with Medicaid coverage are responsible for any charges incurred at time of service, or copays/deductibles returned as "patient due" from primary insurance.

Medical Records Release Authorization

I authorize the staff of Eyes of Athens and Cleveland to act as my representative(s) in the signing and submission of any required documentation to release and/or obtain any medical records concerning myself to/from any physician, hospital or agency involved with my care.

Financial Policy: Payment for services is expected and due at the time of your visit

I understand that all copayments, exam fees, and contact lens fitting fees are due at the time services are rendered. Eyes of Athens and Cleveland will not dispense glasses or contact lens orders until the materials balance has been paid in full. I understand that I am financially responsible for all charges incurred, including any amounts not covered, reduced, or denied by my insurance carrier.
Credit balances of less than $100 will remain on my account and may be applied toward future services unless I specifically request a refund.

Authorization to Receive Insurance Payments

We request your signature on file, in the event the office files to your insurance at the completion of any office procedure. This clause applies to **all insurance carriers:**

I request that payment from my authorized insurance carrier be made on my behalf to Eyes of Athens and Cleveland for any services furnished to me by the doctors. I authorize Eyes of Athens to release to my insurance carrier/the Centers for Medicare and Medicaid Services and its agents any medical information needed to determine these benefits or the benefits payable for related services.

Notice of Privacy Practices Patient Acknowledgement

I understand that I may request to view/obtain the Notice of Privacy Practices for this office. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect.

Patient's Consent to Treat

I hereby give my consent for Eyes of Athens to evaluate and treat the above patient. I understand that my personal health information will be used for the purpose of treatment, payment and the coordination of health care needs. I authorize the following individuals for the ability to discuss and obtain my health information provided by Eyes of Athens:

1._____ 2. _____ 3._____

Medicare & Most Major Medical Plans Do Not Cover the Refraction or Eyewear

I acknowledge that Medicare and most major medical insurances **do not pay** for refractive services (the refraction determines eyeglass prescription)**.** These charges will be my responsibility.
*Speak with our opticians for more information.

Medical Insurance VS. Vision Benefit: Which will be used for my visit today?

Many of our patients have both a vision benefit and medical insurance, so we'd like to help explain the difference.
Vision benefits are for routine eye health exams with no medical findings.

- Vision plans/benefits do not cover any medical conditions or treatment plans
  - Contact lens fittings usually have a separate attached copay & will be outlined in your vision benefit

If you have any eye complaints or medical conditions below that may require testing & medical decision making, we will bill accordingly to your medical insurance.

- Floaters, flashes, sudden blurry vision, double vision, headaches, loss of vision, eye pain
- Infections, redness, dryness, itching, foreign body, eyelid bumps or swelling
- A systemic medical condition is present that can affect your eyes
  - Examples are diabetes, high blood pressure, vascular disorders, multiple sclerosis, thyroid eye disease, lupus, autoimmune diseases, taking high risk medications such as Plaquenil
- Ongoing previously diagnosed medical eye conditions
  - Examples are cataracts, glaucoma, macular degeneration, floaters, bleeds, eye surgeries, and ongoing medical treatments by ophthalmologists

*Copays & deductibles for your medical insurance will apply when your medical plan is utilized. In most cases, there is no way to know prior to your exam which type of insurance our office will be able to file for your visit.
*In the case of filing a medical exam, vision material benefits towards glasses and contact lenses can still be utilized.

Please address all concerns with our front desk staff prior to the start of your exam. We do our best to confirm all medical insurances & require updated copies when checking in to help file claims for you.

By my signature below, I acknowledge all above notices and policies.

Printed Name: _____ Signature _____

Relationship to pt if pt is a minor _____ **Date**_____

Patient Name _____ DOB ____/____/_____

Patient Information

Primary Care Physician: _____

Occupation: _____ Hobbies: _____

When was your last eye exam? _____

Do you wear glasses? Y / N

If yes, how old is your present Rx/pair of lenses? _____

Do you wear contact lenses? Y / N

If yes, what brand and Rx do you currently wear? _____

Current Medications

Including eye drops (if you have a list, we are happy to make a copy):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies

Including latex, medications and environmental

_____ _____ _____

_____ _____ _____

Family History

Please list any immediate family members with any of the following:

Macular Degeneration: _____ Cancer: _____

Glaucoma: _____ Heart Disease: _____

Cataracts: _____ Diabetes: _____

Hypertension: _____

Social History (confidential):

Tobacco Use: Y / N Frequency: _____

Alcohol Use: Y / N Frequency: _____

Have you been diagnosed or treated for any of the following (please circle all that apply):

Vision Related:

Cataract(s) Eye turn/Lazy eye (Right Eye / Left Eye) Macular Degeneration

Retinal Detachment Dry Eye Syndrome Glaucoma Headaches/Migraines

List all other eye disorders/trauma:

_____

Medical:

Hypertension Diabetes Elevated Cholesterol Cancer Thyroid Disorder

Heart Disease Kidney Disease Asthma/COPD Auto-Immune Disease

List all other medical diagnoses:

_____

Surgical History

Cataract(s) Post-Cataract Laser Procedure LASIK/RK Injections

Glaucoma Sx Eye turn/Lazy eye Sx Eyelid(s) Retinal Detachment Repair

List all other ocular surgeries/procedures:

_____

List any other medical surgeries/procedures (non-eye related):

_____

_____

_____

Please Read and Sign if Interested in Contact Lenses

Contact Lens Prescriptions Expire Yearly

Professional Standards of Care require that all people who wear contact lenses have a full comprehensive exam and contact lens evaluation every year. We will not dispense contact lenses or write a contact lens prescription without a yearly comprehensive eye exam and contact lens evaluation, including all necessary follow-up visits.

Additional Professional Fees Apply Towards Contact Lens Evaluations

The fee is dependent on the level of complexity of the fitting process which is determined by the doctor evaluating your vision requirements, the type of contact lenses needed, and the health of your eyes.

Follow-up Visits for Contact Lenses

A ninety (90) day care window following contact lens services is provided by this clinic. It is the patient's responsibility to communicate with our office if any changes are desired within the fitting time frame. *If you require adjustment or additional contact lens services beyond that care window, a new fitting or evaluation must be scheduled, performed and charged before any changes can be made to your contact lens prescription.* This care window also applies to requesting trials of your specific lens. No trials will be dispensed to any patient outside of the ninety-day care window without completing a new fitting or evaluation.

The evaluation fees do not include the price of your contact lens supply, but do include your trials, and are as follows:

1. Contact Lens prescription with minimal to no prescription change: **$60**
2. Experienced Contact Lens wearer that requires soft, spherical, single vision contact lenses: **$75**
3. Experienced Contact Lens wearer that requires soft, toric (astigmatism), multifocal, or monovision contact lenses or RGP contact lenses: **$120**
4. New Contact Lens wearer that requires soft, spherical, single vision contact lenses: **$150**
5. New Contact Lens wearer that requires soft, toric (astigmatism), multifocal, or monovision contact lenses or RGP contact lenses: **$175**

If you are unsure which level evaluation your eyes require, please address this concern with the doctor prior to proceeding with contact lenses.

I have read and by signing, I understand that if I choose to be fit with contact lenses, I am financially responsible for all fees not covered by my vision benefits.

_____ _____

Patient Signature Date