EYES OF ATHENS & CLEVELAND
Clinic Policies and Patient Information

Patient Demographics

PATIENT NAME: _____BIRTHDATE: _____

MAILING ADDRESS: _____MARITAL STATUS: _____

CITY: _____STATE_____ZIP_____SEX: M_____F_____

HOME PHONE: _____CELL PHONE: _____

SOCIAL SECURITY #: _____E-MAIL: _____

PRIMARY INSURED OR LEGAL GUARDIAN (IF MINOR): _____

BIRTHDATE: _____

EMERGENCY CONTACT NAME: _____PHONE: _____

We love it when our friends tell others about us! Who may we thank for referring you to our office?

_____

Financial Policy

As a courtesy to our patients, we file most medical insurance claims.

I understand that I am financially responsible for all charges incurred if my insurance denies payment. I also understand that eye refractions and **routine** eye examinations are not covered by Medicare and other insurers and that I am responsible for payment of this service.
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM.
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICES RENDERED.

Signature _____ **Date** _____

Medicaid Notice

By my signature below, I acknowledge that Eyes of Athens & Cleveland is **not** a participating provider in **any** program funded by Medicaid/TennCare (except for Tennessee's state-sanctioned QMB program) and cannot 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 the time of service or copays/deductibles returned as patient due from primary insurance.

Signature _____ **Date** _____

Patient's Consent to Treat

1. I hereby give my consent for Eyes of Athens & Cleveland to evaluate and treat the above patient.
2. I understand that my personal health information will be used for treatment, payment, and the coordination of health care needs of the patient.

_____ _____ _____

Signature Relationship Date

Patient Name _____ **DOB** ____/____/_____

Please initial each blank to acknowledge acceptance of the following statements:

_____ **Payment for services is expected and due at the time of your visit.**

All copays, exam charges, and fitting charges must be paid after your exam. We will not dispense contact lens or glasses orders without the materials balance being paid in full.

_____ **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/Medicare benefit carrier be made on my behalf to Eyes of Athens & Cleveland for any services furnished to me by this/these doctors. I authorize this holder of my medical information 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 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. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

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

Medicare and most major medical insurances **do not pay** for routine eye exams or refractive services. The refraction is the vision evaluation part of the examination that determines your eyeglass prescription**.** These charges will be your responsibility.

If you have a lens implant as the result of cataract surgery, Medicare and some major medical insurances may cover conventional lenses and a portion of your frames one time after surgery. They do not cover deluxe frames that are more than the allowance. They also do not cover lens treatments such as scratch and anti-reflective coatings. These charges will be your responsibility.

Spectacle/Contact Lens Prescription Release Notice

Pursuant to the Federal Trade Commission's ruling 16 CFR Part 315:

I understand that Eyes of Athens & Cleveland will readily supply a copy of my **non-expired** spectacle 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).

A ninety (90) day care window following standard contact lens fitting or evaluation services is provided by this clinic. 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. Barring doctor's approval in an extreme unusual circumstance, no trials will be dispensed to any patient outside of the ninety day care window without completing a new fitting or evaluation.

Signature _____ **Date** _____

Medical Records Release Authorization

By my signature below, I authorize the staff of Eyes of Athens & 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.

Signature _____ **Date** _____

Patient Name _____ **DOB** ____/____/_____

Patient Information

Primary Care Physician: _____

How do you use your eyes on a daily basis?

Employer: _____ Occupation: _____

Hobbies: _____

Medical History

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

Vision Related:

Cataract(s) Eye turn/Lazy eye Macular Degeneration Headaches/Migraines

Retinal Detachment Dry Eye Syndrome Glaucoma

List all other eye disorders/trauma:

_____ _____ _____

Medical:

Hypertension Diabetes Elevated Cholesterol Cancer Thyroid

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):

_____ _____ _____

_____ _____ _____

Current Medications

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

Plaquenil Elmiron

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies

Penicillin Sulfa

Other(s): _____ _____ _____

_____ _____ _____

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: YES NO Frequency: _____

Alcohol Use: YES NO Frequency: _____