6450 Poplar Avenue Suite 117 Memphis, TN 38119

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI: ________

Date of Birth: ______ / ______ / __________ SSN: XXX—XX— _____ _____ _____ _____

Occupation/Grade: ______________________ Employer/School: ______________________

Responsible for Account (if minor): Name:______________________DOB:__________

Address: ______________________ City: __________ State: ________ Zip: ________

Telephone Primary: ______________________ Alternate: ______________________

Email: ______________________ May we text you? YES NO E-mail? YES NO

VISION PLAN

Vision Plan: ______________________ Policyholder's Name: ______________________

ID # : ______________________ Policyholder's SSN: XXX—XX— _____ _____ _____ _____

MEDICAL INSURANCE

Medical Insurance: ______________________ ID # : ______________________

Primary Policyholder's Name: ______________________ Policyholder's DOB: _____/______/______

Secondary Insurance: ______________________ID # : ______________________

Secondary Policyholder's Name: ______________________ Policyholder's DOB: _____/______/______

OCULAR HISTORY — Circle all that apply and note relation (i.e. self, mother, father, grandmother etc.)

Blindness ______________________

Cataracts ______________________

Corneal Problems ______________________

Diabetic Retinopathy ______________________

Dry Eye ______________________

Eye Injury ______________________

Floaters ______________________

Flashes ______________________

Frequent Eye Infections ______________________

Styes ______________________

Glaucoma ______________________

Glaucoma Suspect ______________________

Iritis / Uveitis ______________________

Lazy/Crossed Eye ______________________

Macular Degeneration

____

Retinal Detachment ______________________

Other ______________________

PATIENT OCULAR SURGICAL HISTORY — Circle all that apply to your eye history.

Cataract

Corneal Transplant

Eye Muscle Surgery

Glaucoma Laser

Glaucoma Surgery

Lasik / PRK

Retinal Laser

Retinal Surgery

Retinal Injections

RK Incisions

Yag (Laser after Cataract)

Other:

____

____

____

SOCIAL HISTORY

Tobacco (please mark one):

◯ Never ◯ Former Smoker ◯ Current Someday Smoker ◯ Current Everyday Smoker ◯ Light Tobacco ◯ Heavy Tobacco

Alcohol (please mark one): ◯ NO ◯ YES (if yes, how much?) ______________________

Recreational Drug Use: ◯ NO ◯ YES (if yes, please circle all that apply) Cocaine Heroin Marijuana Other: ______________________

Mark any that you have been infected with: ◯ Gonorrhea ◯ Hepatitis ◯ HIV ◯ Syphilis

Patient Medical History—Circle all that apply to your personal medical history.

Asthma	Cholesterol Problems	Emphysema	Osteoporosis	Surgery
High Blood Pressure	Depression	Heart Problems	Seizures	Other:
Cancer (if circled, type:)	Type 1 Diabetes	Kidney Disease	Strokes	____________________
____________________	Type 2 Diabetes	Liver Disease	Thyroid Problems	____________________

Do you have any allergies? (If yes, please list) :

____

____

Are you taking any Medications? (If yes, please list) :

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Patient Lifestyle—Circle any activities you perform regularly.

Arts/Crafts	Cooking	Gardening	Knitting/Sewing	Spectator Sports	Watching TV
Sports	Fishing	Hunting/Shooting	Musical Instruments	Video Games	Water Sports
Boating/Sailing	Flying	Internet	Snow Skiing	Walking	Power Tools

Authorization for Release of Information

Please list authorized persons with whom we may discuss your protected health information, including but not limited to financial questions, eyeglass orders, contact lens orders, and appointment history. Please notify us if you desire to remove a name from this list in the future.

1. ____ Relationship: ________________________
2. ____ Relationship: ________________________
3. ____ Relationship: ________________________
4. ____ Relationship: ________________________

Signature: ____Date: ________________________

Authorization

By signing, I attest that I am either the patient being seen or the parent/legal guardian of this minor being seen. I certify that I have read and understand the above information to the best of my knowledge and that I have provided the information as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I give permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate. I authorize the doctor to release any information including the diagnosis and a summary of any treatment or examination rendered to me or my child to appropriate third party payers or other health care providers. I authorize and request my insurance company to pay all appropriate benefits directly to the doctor. I acknowledge that I have been given the opportunity to read a copy of the privacy practices of East Memphis Eye Associates DBA Eye Society.

____ ________________________

Signature of Patient or Legal Guardian Date

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FINANCIAL POLICY

We appreciate your trust in us and we appreciate the opportunity to serve you. We are committed to providing the highest level of eye care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

PATIENT PAYMENTS

Payment is due at the time of service. You may use cash, check, credit card, or debit card to pay your account. Without exception, it is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB). All patients without insurance must pay in full at the time services are rendered.

INSURANCE COVERAGE

We make a good faith attempt to verify your insurance coverage. **We are not able to guarantee that the information given to us by your insurance is correct.** It is your responsibility to know the name of your insurance plan, supply us with the correct information at the time of your visit and know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some and perhaps all of the services provided may be not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

INSURANCE PAYMENTS

Regarding insurance, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. Be assured our office works diligently to obtain payment from your insurance company. However, if we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception. In the event that your insurance pays us after that time, you will be reimbursed.

ESTABLISHED PATIENTS / MISSED / LATE CANCELLED APPOINTMENTS

Please give us at least 24 working hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise.

RETURNED CHECKS

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a $35.00 handling fee. All future visits will need to be paid with either cash or a credit card. We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak with our office manager if you have any questions, comments, or concerns. We sincerely regret having to maintain such a policy and hope you understand our reasoning.

-Patient Authorization-

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to East Memphis Eye Associates, PLLC DBA Eye Society. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original.

Patient Name ____ Date of Birth ___________________

➡ Patient/Guardian Signature ____ Date_____________________

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CONTACT LENS EXAM AND FITTING POLICY

Eye Society provides exceptional professional contact lens services. If you are interested in contact lenses or currently wear contact lenses, our doctors or staff can discuss your options with you for contact lenses. Our recommendations are individually tailored to each patient and are based on many factors including, available modalities, your visual needs, and your overall eye health. ***<u>Contact lens exams and fitting charges are not typically covered by vision plans and therefore result in additional charges in addition to your routine examination copayment.</u>*** *The contact lens exam and fitting charges are dependent on the complexity of the type of contact lens that you currently wear or are being fitted, and the complexity of the insertion and removal instruction if needed.*

<u>CONTACT LENS EXAM</u>

A contact lens exam is a separate part of a comprehensive eye examination and requires additional testing that non-contact lens wears do not need. Patients wearing contact lenses requires more of the doctor's time and expertise. In order to prescribe contact lenses, the doctor must complete several additional tests including:

1. Evaluation of the health of the eye, with special observation of the cornea, eyelid, and conjunctiva. This evaluation will determine if the contact lens is affecting the eye health or has the potential to affect the eye health in the future.
2. Determination of the proper contact lens prescription is based on the individual patient's glasses prescription, visual needs, quality of the tear film, and corneal health and curvature.
3. Examination of the contact lens on the eye to ensure proper alignment on the cornea.
4. Measurement of the vision with the contact lenses and determination if adjustments needed to be made in the contact lens prescription.

CONTACT LENS EXAMAINATIONS AND FITTINGS HAVE DIFFERENT LEVELS OF DIFFICULTY. THIS DEPENDS ON THE TYPE OF CONTACT LENSES NEEDED AND THE VISUAL REQUIREMENTS OF THE PATIENT'S EYES, THEREFORE THE DIFFERENT LEVELS OF CONTACT LENS EXAMS AND FITTINGS RESULT IN DIFFERENT LEVELS OF FEES FOR THOSE SERVICES.

<u>YOUR VISION PLAN AND CONTACT LENS MANAGEMENT AND FITTING FEES</u>

Most, if not all, vision plans require doctors to separate routine comprehensive eye examination fees from the services provided for contact lenses. More time and testing is required for the patient who wears contact lenses in addition to the management of ocular health risks associated with wearing contact lenses. **Most, if not all, vision plans treat contact lens services as an additional and separate exam from the routine eye examination.**

<u>WHAT IS A CONTACT LENS PRESCRIPTION?</u>

Contact lenses are medical devices that can only be dispensed by a prescription. Contact lens prescriptions expire after one year (or sooner if the doctor determines there is a medical reason for a shorter expiration). They must be regarded with the same caution as you would for prescription drugs, which includes expiration dates and follow-up visits with the eye doctor. Your eyes go through gradual changes in size, shape, and physiological requirements (such as oxygen) while you wear contact lenses. These changes can affect the health of the cornea and need to be monitored at least every year. The federal government requires contact lens prescriptions to expire after one year for these reasons.

-Patient Authorization-

I have read, understand, and agree to abide by the terms stipulated above. (Please ask the receptionist if you have any questions about CL fees prior to your exam.) <u>I understand that CL management, fitting and exam fees are not covered by insurance and agree to pay East Memphis Eye Associates, PLLC DBA Eye Society on the day that services are rendered.</u> I understand that, without the exam, management, and fitting procedures, I will not receive diagnostic contact lenses and/or a contact lens prescription.

Patient Name ____ Date of Birth ______________________________

➡ Patient/Guardian Signature ____ Date_____________________