

****PLEASE PRESENT ALL INSURANCE CARDS TO RECEPTIONIST****

***Verification of benefits IS NOT a guarantee of payment by your insurance company. You are responsible for any charges ultimately not covered by insurance.**

Financial Policy

The financial side of medical care has become increasingly complex over the past few years with the advent of managed care, vision care plans, and the many types of health insurance plans that are now available. At Carolina Eye Care, we try our best to be familiar with the regulations and restrictions of each company, though you, the patient, are ultimately responsible for understanding the details of your own health care coverage. Therefore, the following policies apply:

1. All co-pays and non-covered services are due the day of service.
2. If a medical condition is your primary complaint/diagnosis, your medical insurance will be filed for the visit, rather than your routine vision insurance.
3. Balances due after your insurance has processed your claim are due within 30 days of receipt of your bill.
4. Charges for services rendered to children whose parents are divorced will be the responsibility of the parent who seeks treatment for the child and are due at the time of service.
5. There will be a \$35.00 charge for any returned checks, and such checks will not be re-deposited. Personal checks will no longer be accepted from any patient who has previously presented a check which was returned.
6. We do all the work of filing your insurance for you. However, keep in mind that you are responsible for any co-pays and non-covered charges on the day services are rendered. If no payment is made by your insurance company after 90 days, you will be billed for the insurance portion of your visit. You may file with insurance on your own and be reimbursed directly.

Vision Insurance

1. **No vision insurance plan pays 100% of all fees.** All insurance plans have limitations, such as maximum allowances for the year and co-payments on services or materials.
2. Vision Plans will tell you that they cover your vision care. However, what is covered is determined by what your insurance company defines as routine. These minimums are established by the insurance companies and are usually well below what is accepted as appropriate standard of care for some patients' ocular conditions.

Medical Insurance

1. If you do not have a medical issue related to your eyes your medical insurance will not cover your eye exam.
2. Medical insurance **does not pay** for a **refraction**. A refraction is the portion of the exam where we test your eyes to determine your current prescription. You are responsible for this service because health insurance companies classify it as non-medical even if the rest of the visit is medical in nature. At the time of your visit you will need to pay any applicable insurance co-pays plus the refraction fee.
4. If your visit is medical in nature we are more than happy to file the visit with the health insurance you present us on the day of your appointment. Please be aware that you will be responsible for any deductibles or coinsurance your policy dictates after the claim is filed on your behalf.

Please present your most current vision and health insurance cards at the time of service. We can only file the insurance you present at the time of your visit, as the claims are processed and submitted daily.

I have read and understand the financial policies as set forth in the above notice.

Patient/Guardian Signature: _____ Date: _____
Please Print Name _____

How did you hear about us: _____

Patient Information (As it appears on the insurance card)

Patients First Name _____ Middle _____ Last _____

Nickname _____ M / F _____ DOB ____/____/____ Marital Status S / M / W / D

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

SSN _____

Reason for today's visit _____

Contact Information **May we leave a detailed message on your phone? Y / N** Cell Work Home

Phone: Cell () _____ Work () _____ Home () _____

Text? Y N

Email address _____

Digital Retinal Screening

The health of your eyes is the most important component of your eye exam. At Carolina Eye Care on Merrimon, we recommend **Digital Retinal Screening** in which a high-resolution digital photograph is taken of the back/interior portion of your eye called the **retina**. This is a screening and will not be covered by insurance.

The cost for this service is \$25 **Perform this service?** **Yes** **No**

With my signature, I authorize treatment by Carolina Eye Care on Merrimon, OD PA and staff. I understand I am financially responsible for all charges and any services rendered including, if applicable, the balance remaining after possible insurance benefits. I authorize Carolina Eye Care on Merrimon, OD PA to act on my behalf regarding services received. I authorize the release of any medical information necessary to process my insurance claim. I assign and request that insurance payments be made directly to Carolina Eye Care on Merrimon, OD PA. It is your responsibility to read and understand your own insurance policy. Certain services and procedures may or may not be covered by your insurance. It is your responsibility to contact your insurance company to find out whether Dr. Lesley N. Brooks is a participating provider. Insurance information must be presented at the time of service.

In the event the account becomes delinquent, requiring collections assistance and/or an attorney, I understand that I am responsible for these fees. Our returned check fee is \$35.

Signature _____ Date _____

DATE _____ NAME _____ Birth Date _____

Family Physician _____
Address _____
Phone _____
Pharmacy _____
Location _____

Phone _____

Have you ever been diagnosed or treated for the following health problems?

- | | |
|--|--|
| <input type="radio"/> Fatigue Syndrome | <input type="radio"/> Ulcer |
| <input type="radio"/> Cancer | <input type="radio"/> Acid Reflux |
| <input type="radio"/> Developmental Disorder | <input type="radio"/> Prostate Disease |
| <input type="radio"/> Laryngitis | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Sinusitis | <input type="radio"/> Muscular Dystrophy |
| <input type="radio"/> Hearing Loss | <input type="radio"/> Arthritis |
| <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Fibromyalgia |
| <input type="radio"/> Stroke | <input type="radio"/> Eczema |
| <input type="radio"/> Epilepsy | <input type="radio"/> Thyroid |
| <input type="radio"/> Depression | <input type="radio"/> Diabetes <input type="radio"/> Type 1 <input type="radio"/> Type 2 |
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Bronchitis |
| <input type="radio"/> Vascular Disease | <input type="radio"/> Anemia |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Asthma |
| <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Emphysema |
| <input type="radio"/> ADHD | <input type="radio"/> Other _____ |

Are You having any of the following Vision Concerns?

- | | |
|--|--|
| <input type="radio"/> Blurred Vision | <input type="radio"/> Eye Strain |
| <input type="radio"/> Eye Pain | <input type="radio"/> Severe Light Sensitivity |
| <input type="radio"/> Headache | <input type="radio"/> Poor Night Vision |
| <input type="radio"/> Bothersome Night Glare | <input type="radio"/> Double Vision |
| <input type="radio"/> Total Loss of Vision | |
| <input type="radio"/> Other _____ | |

Allergies None Environmental _____

Date of Last Eye Exam _____

By Whom _____

Do you wear: Eyeglasses Contacts Neither

If contacts, which lenses are you currently wearing?

What solution are you using?

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Is there a family medical history of any of the following?

Check all that apply **Please list relationship (Mother, Father....)**

- | | |
|--|-------|
| <input type="radio"/> Cancer | _____ |
| <input type="radio"/> Diabetes Type 1 | _____ |
| <input type="radio"/> Diabetes Type 2 | _____ |
| <input type="radio"/> High Blood Pressure | _____ |
| <input type="radio"/> Thyroid | _____ |
| <input type="radio"/> Cataracts | _____ |
| <input type="radio"/> Macular Degeneration | _____ |
| <input type="radio"/> Glaucoma | _____ |

Have you ever been diagnosed or treated for the following Eye Conditions?

- | | |
|--|--|
| <input type="radio"/> Cataracts | <input type="radio"/> Surgery Yes No |
| Sx Dates Right _____ | Left _____ |
| <input type="radio"/> LASIK | Sx Date _____ |
| <input type="radio"/> Macular Degeneration | <input type="radio"/> Glaucoma |
| <input type="radio"/> Dry Eye | <input type="radio"/> Diabetic Retinopathy |
| <input type="radio"/> Eye Infection | <input type="radio"/> Inflammation |
| <input type="radio"/> Floaters/Spots | <input type="radio"/> Flashes of Light |
| <input type="radio"/> Iritis | <input type="radio"/> Retina Defects |
| <input type="radio"/> Other _____ | |

Latex Sensitivity

Medications None See List

**HIPAA PRIVACY
REQUEST ON USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

Carolina Eye Care on Merrimon OD PA

NOTICE TO PATIENT: Your request is applicable only to the information maintained by the Practice. If you would like restrictions to be maintained by any other health care provider or health plan, you must submit a separate request to the other health provider or plan.

Patient Name _____ Date of Birth _____

Use and Disclosure of My Protected Health Information

I request the Practice named above to allow disclosure of my protected health information relating to treatment, payment and health care operations, and/or disclosures to family members or others involved in my care as follows:

_____.

Check one: The time period for the restrictions is: From _____ to _____;
or Until I notify the Practice in writing of termination.

Signature of Patient or Legal Guardian or
Personal Representative

Date

Print Name of Guardian or Representative

Relationship to Patient _____