*****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?

◯ Fatigue Syndrome ◯ Ulcer

◯ Cancer ◯ Acid Reflux

◯ Developmental Disorder ◯ Prostate Disease

◯ Laryngitis ◯ Kidney Disease

◯ Sinusitis ◯ Muscular Dystrophy

◯ Hearing Loss ◯ Arthritis

◯ Multiple Sclerosis ◯ Fibromyalgia

◯ Stroke ◯ Eczema

◯ Epilepsy ◯ Thyroid

◯ Depression ◯ Diabetes ◯ Type 1 ◯ Type 2

◯ High Blood Pressure ◯ Bronchitis

◯ Vascular Disease ◯ Anemia

◯ Congestive Heart Failure ◯ Asthma

◯ Rheumatoid Arthritis ◯ Emphysema

◯ ADHD ◯ Other___________________

____

Are You having any of the following Vision Concerns?

◯ Blurred Vision ◯ Eye Strain

◯ Eye Pain ◯ Severe Light Sensitivity

◯ Headache ◯ Poor Night Vision

◯ Bothersome Night Glare ◯ Double Vision

◯ Total Loss of Vision

◯ 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….)**
◯ Cancer	___________________
◯ Diabetes Type 1	___________________
◯ Diabetes Type 2	___________________
◯ High Blood Pressure	___________________
◯ Thyroid	___________________
◯ Cataracts	___________________
◯ Macular Degeneration	___________________
◯ Glaucoma	___________________

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

◯ Cataracts ◯ Surgery Yes No

Sx Dates Right__________ Left__________

◯ LASIK Sx Date_________________

◯ Macular Degeneration ◯ Glaucoma

◯ Dry Eye ◯ Diabetic Retinopathy

◯ Eye Infection ◯ Inflammation

◯ Floaters/Spots ◯ Flashes of Light

◯ Iritis ◯ Retina Defects

◯ Other____

____

____

◯ Latex Sensitivity

Medications ◯ None ◯ See List

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____

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__________________________________