(cornea) PATIENT DATA SHEET **NEW PATIENT: Y or N**

1. PATIENT DEMOGRAPHICS

First Name	Last Name	Middle Initial	☐ Male ☐ Female		
Address	City	State/Zip Code			
Social Security Number	Birth Date / /	Age	Race	Ethnicity	Language
Home Phone ( )	Work Phone ( )	Cell Phone ( )			
Email Address	Pharmacy Name	Pharmacy Phone#:			

2. EMERGENCY CONTACT

In case of emergency contact:		Relation to patient
Home Phone ( )	Work Phone ( )	Other Phone (specify)

3. I WAS REFERRED BY ☐ Doctor ☐ Family ☐ Friend ☐ Self ☐ Second Opinion ☐ Media / Other

Please provide name or media source::

4. MY CURRENT EYE DOCTOR IS:

Optometrist / Ophthalmologist	Address/ Phone

5. EMPLOYMENT INFORMATION

Occupation / Student	PHONE NUMBER
Employer / School	Address

6. INSURANCE INFORMATION .....CO-PAY IS COLLECTED ON ARRIVAL

PRIMARY Insurance	SECONDARY Insurance	Primary Doctor:
1-800 #	1-800 #	Primary Doctor PHONE#:

(you will be asked to update this information every year)

INSURANCE ACKNOWLEDGEMENT

I hereby assign payment of medical insurance benefits to the above named physician and Ultra Vision Center for all services rendered. I understand that I am responsible for all charges whether or not paid by said insurance. I further understand that I must keep the office updated with current insurance information and any changes that may occur. Should a filed claim be rejected due to inactive coverage, I understand that I will be responsible for all charges due. Should the account go unpaid it will be referred to a collections agency and an additional 33% collection fee will be added to the total balance.

I consent to the release of any medical information necessary to process any and all insurance claims. I give my consent for a personal photograph for office identification.

_____

Signature *Date*

Notice of Privacy Practices

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your health care.
We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are also required to follow the terms of the Notice currently in effect.

How We May Use and Disclose Health Information About You

We **WILL NOT** use or disclose your health information **WITHOUT** your authorization, except for treatment, payment or healthcare operations.

Notification &Communication of Family:

- You may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition.
- We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

_____YES _____NO

IF YES, THEN ONLY TO THE FOLLOWING PERSON(S):

_____ _____

_____ _____

To inspect or copy your health information. You must submit your request in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

My Medicine Record

Name : _____ Birth Date: _____

	What I'm Using RX – Brand & generic name OTC – Name & active ingredients	How much	How to Use / When to Use	Start / Stop Dates	Why I'm Using	Who Told Me to Use / How to Contact
Ex	XXXX/xxxxxxxxxxxx	40 mg; use two 20 mg pills	Take orally, 2 times a day	1-15-11	Lower blood pressure	Dr. X (210) 111-1111
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

Patient Medical History

(You will be required to update this information every year)

PATIENT IS RESPONSABLE FOR CONTACT LENS

DO NOT LEAVE ANYTHING BLANK. WRITE "NONE" IF ANYTHING DOES NOT APPLY

Name		**Known Drug Allergies:**	
Interested learning more about; LASIK, INTACS or Lens IMPLANTS?			**Yes No**
Do you have skin care problems that you want addressed?			
Last Eye Exam:			
Reason for today's visit: routine, second opinion, referred, other			
Past Eye History:			
Past Surgery:			

PLEASE WRITE ALL MEDICATIONS USED EVEN IF OCCASSIONAL USE

Eye Medications	**Other Medications (**including supplements)	

PATIENT'S MEDICAL HISTORY

- ☐ Diabetes Type I II x ____yrs
- ☐ Hypertension
- ☐ Heart Disease pacemaker? ____
- ☐ Heart Attack____/Surgery_____
- ☐ Kidney Disease dialysis? ___
- ☐ Arthritis (Rheumatoid or Osteo?)
- ☐ High Cholesterol
- ☐ Gastrointestinal Problems _____
- ☐ Acne (ever on Accutante?)
- ☐ Dry Mouth
- ☐ Pregnant or currently Nursing?
- ☐ Migraines ever on IMETREX? _____
- ☐ Asthma
- ☐ Thyroid Disease Hyper / Hypo?
- ☐ Hearing Problems hearing aid? _____
- ☐ Depression/Anxiety
- ☐ Cancer type? _____)
- ☐ Genetic Condition / Syndrome?
- ☐ Prostate Condition? _____)
- ☐ Smoke (How much? _____)
- ☐ Alcohol (How much? _____)
- ☐

Family History

- ☐ Genetic condition / syndrome
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Other _____
  _____

CONTACT LENS WEARERS

What Type and Brand do you wear?	
Do you sleep in contacts?	
What cleaning solution do you use?	
What is your Contact Lens Power? WEAR Torics?	

FITTING FEE: Int:_____

Patient Name: _____ Date: _____

NOTICE OF EXCLUSION

NOTE: Y*our insurance may DENY any of the service(s) that are described below.*

Some insurance does not pay for ALL health care costs. Your insurance only pays for covered items and services **when rules set by your insurance are met**. A Claim will be submitted for all services rendered, however, you should be informed of the possibility that these items may be denied.
Should your doctor see it necessary to request any of the following items, you will be previously informed.

$80.00……..Corneal Topography/ *Corneal Mapping*
$20.00……..Pachymetry *(determines corneal thickness)*
$50.00 *per eye*……OCT Scan *(Optical Coherence Tomography for diagnosing glaucoma, early retinal and / or corneal changes)*
$300.00……Specular Microscopy *(endothelial cell count)*
$100.00……Complete Visual Fields *(glaucoma, droopy lids, patients on plaquenil)*
$150.00……..…"Routine" eye exam
$120.00……Bandage Contact Lens – single
$50.00……..After hours office visit
$29.00…….. Refraction
$400.00……Amniotic membrane *(possibly used in surgery for patients with symblepharon, pterygiums),*

PLEASE CHECK **ONE** OPTION. **SIGN AND DATE** YOUR CHOICE.

☐ **Yes,** I want to receive services **IF** the doctor deems it necessary for diagnoses and treatment.
I have been informed my insurance may not cover these services. In the event that the doctor requests any of the above services please submit my claim regardless. I understand I am financially responsible for services rendered medically necessary until my insurance reaches a decision cover or not. If my insurance pays, I will expect a refund of any payments made to you that are due to me. If my insurance denies payment, I agree to be fully responsible for payment in full. I understand I can personally appeal my insurance's decision in case of denial.

☐ **No,** I am not financially prepared to receive the above services, **EVEN IF necessary.**
I DO NOT want to receive these services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay. Furthermore, I understand that the above services could be necessary in my diagnostic evaluation and treatment and the doctor may not be able to perform adequate or complete patient care to meet my needs. By refusing said services I may be hindering future medical care with this facility and I do not hold Ultravision liable.

_____ _____
Print Name date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. Your health information which your insurance sees will be kept confidential by your insurance.

Ultravision

INFORMATION ABOUT REFRACTIONS & WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, but they typically do not cover the eye service called "refractions".

What is Refraction?

Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

When Does Insurance NOT Pay for a Refraction?

Most health insurances were not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs and most private policies will not pay for refraction. Almost all insurance payors consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

When DOES Private Insurance Pay for Refraction?

Most health insurances will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, refraction will be performed as part of your eye evaluation. Refraction in this instance is necessary to learn your eye's best vision capability at the time of the examination. That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated. *It is a necessary part of the exam for both medical and legal purposes.* In this care, it is possible that the refraction may be covered by your insurance. However, Medicare typically will not cover refraction under any circumstance.

Who Has Made This Distinction for Insurance Coverage?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore if you any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

What Is Our Policy?

At Ultravision, we are dedicated to providing our patients with the very best medical and surgical eyecare in the region. Therefore, a refraction will be performed when medically necessary (typically *this includes all new patients, those presenting with decreased vision, and on a yearly basis thereafter*). Additionally, we are happy to perform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.

Our fee for the refraction is **$29.00**, and is collected at the time of your visit in addition of any co-payments or deductible due for the medical portion of your exam.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment and deductible are separate from and not included in the refraction fee.

_____ _____

Patient Signature or Signature of person acting on patient's behalf Date

A. Notifier: **B. Patient Name :** **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ **below.**

D. Diagnostic Test	E. Reason Medicare May Not Pay:	F. Estimated Cost
Pachymetry	Medicare does not cover items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to IMPROVE the function of a malformed body member. The basis for denying payment for these types of care/services is according to Social Security Act section 1862(a)(1): • Not generally accepted in the medical community as safe& effective in the setting/condition for which used. • Not proven safe or effective… • Experimental • Not medically necessary in particular case • Duration/frequency not appropriate • Not furnished in accordance with accepted standards of medical practice • Not furnished in appropriate setting	$20.00
OCT Tomography)Scan (Optical Coherence		$50.00 (Per eye)
After hours visit		$50.00
Corneal Topography		$80.00
Complete visual field		$100.00
Bandage contact lens x 1		$120.00
Routine Eye exam		$150.00
Refraction		$29.00
Specular Microscopy		$300.00
Amniotic Membrane		$400.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: