Greenman Eye Associates

Patient Demographics

First Name _____ Last Name _____

Date of Birth _____ Sex _____ Preferred Name / Alias _____

Mailing Address _____

City _____ State _____ ZIP _____

Home Ph _____ Work Ph _____ Cell Ph _____

Email Address _____

Preferred Contact Method [ ] Home [ ] Cell [ ] Work [ ] Email [ ] Text

Race _____ Ethnicity _____ Language _____

Marital Status _____ Spouse Name _____

Employer Name _____

Occupation _____ Employment Status _____

Emergency Contact Information

Emergency Contact Name _____

Emergency Contact Relationship to Patient _____

Emergency Contact Home Phone _____

Emergency Contact Cell Phone _____

Pharmacy Information

Preferred Pharmacy _____

Pharmacy Address _____

Pharmacy Phone _____

Primary Care Physician Name _____

Primary Care Physician Phone _____

Referral Information

Whom may we thank for referring you to our practice?

Referring doctor/source _____ Phone # _____

Address _____ City _____ State _____ ZIP _____

Any other eye doctor _____

Insurance Information

Primary Insurance Company _____

Policyholder Name _____

Date of Birth _____

Policy ID # _____

Group # _____

Policyholder Relationship to Patient _____

Secondary Insurance Company _____

Policyholder Name _____

Date of Birth _____

Policy ID # _____

Group # _____

Policyholder Relationship to Patient _____

GREENMAN EYE ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

PATIENT DOB: _____

REASON FOR VISIT: _____

DRUG ALLERGIES: YES OR NO If yes, list drug allergies and reaction: _____

List of current Medications: _____

PAST MEDICAL and SURGICAL HISTORY: (please check any medical problems, current or past)

_____Heart Disease

____Congestive Heart Failure

____High Blood Pressure/Hypertension (medication(s)) _____

____High Cholesterol (Medication(s)) _____

____Stroke or TIA

____Diabetes (Insulin, Medication)_____

____Gestational Diabetes

____Thyroid Disease

____Asthma

____COPD

____History of blood clots, DVT, pulmonary embolism

____Gastric Reflux Disease

____Arthritis

____Migraines, headaches

____Anemia

____Cancer

____Other

SURGERIES: (Please list any surgeries)

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

OCULAR HISTORY

Have you ever had any of the following eye problems? (Please check Yes or No for each)

	NO	YES		No	Yes
Cataracts			Retinal Detachment		
Glaucoma			Macular Degeneration		
Lazy/Crossed Eyes			Diabetic Eye Disease		
Color Blindness			Dry Eyes		
Iritis			Eye Trauma		

Comment(s): _____

FAMILY HISTORY

	NO	**YES**		**No**	**Yes**
Diabetes			**Macular Degeneration**		
Glaucoma			**Retinal Detachment**		
Cataracts			**Corneal Disease**		

MEDICATIONS (PRESCRIPTION and NON- PRESCRIPTION)

NAME **DOSE (mg)** **FREQUENCY (i.e. once daily, twice daily)**

_____

_____

_____

_____

SOCIAL HISTORY

Do you consume alcohol? How Much? _____

Do you smoke or use tobacco? How Much? _____

Greenman
EYE ASSOCIATES

2801 Randolph Road, Suite 200, Charlotte, NC 28211
704-375-2101 • Fax: 704-375-2107 • www.greenmaneyeassociates.com

Patient Agreement and Consent to Treatment

In order for Greenman Eye Associates to provide our patients with quality medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for the services rendered is our patient's responsibility. This document explains the obligations we require from our patients and how our patients meet these obligations. In exchange for services rendered, each patient agrees:

1. To authorize payment of surgical and medical benefits to Greenman Eye Associates, which would otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V, XVIII and/or XIX of the Social Security Act is Correct.

2. To pay for all non-covered charges, copays, Co-insurance, deductibles, out of network charges, and refractions (the measurement of the eye in order to obtain a prescription for Contacts or glasses) at the time of service or when otherwise advised. If this is not possible, you agree to contact our office at (704) 375.2101 BEFORE services are rendered.

3. To provide us with a copy of your most recent insurance card or other proof of insurance at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit and your insurance company subsequently denies our claim, you are personally responsible for any and all charges.

4. To obtain any authorization required by your insurance plan and/ or from your Primary Care Physician prior to each appointment. If you do not receive the required authorization, your insurance company may not pay us for our services. In these cases, you are personally responsible for any and all charges.

5. To monitor your insurance company's payment of your account and if unpaid following 30 days from the date of service to contact them regarding their non-payment. You also agree to cooperate with Greenman Eye Associates to resolve the unpaid status of your account. As a courtesy to our self-pay patients seeking routine eye care, Greenman Eye Associates will provide a reduced charge for payment at the time of service. The entire balance must be paid in full to receive the discount. Once you accept the discount, Greenman Eye Associates will not be responsible to file claims to any insurance company nor will Greenman Eye Associates accept payment on a discounted rate from the insurance company. In the event we received a payment from an insurance company under this circumstance, we will refund the money back to the insurance company. It is your responsibility to inform us at the point of service if you have insurance coverage for "routine" eye services. The undersigned, whether as the patient or guarantor of a patient, agrees that in consideration all the services rendered by Greenman Eye Associates, that you are individually obligated to pay for such services in accordance with the

[Type here]

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regular rates, terms, and conditions of Greenman Eye Associates. In the event we must refer the patient's account to an attorney or collection agency for collection of an amount 90 days or older, the undersigned agreed to pay all actual attorney's fees and collection expenses, including any accrued interest and any bank fees incurred from a returned check.

I voluntarily consent to health care treatment from the physicians and staff at Greenman Eye Associates. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and operations. I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understood and agree to be bound by the above provisions.

Name (Patient or Guardian)

_____

Signature _____ Date _____

MAXWELL GREENMAN, M.D. *Adult & Pediatric Ophthalmology • Laser Vision Correction • Cataract & Glaucoma Surgery • Eye Lid & Muscle Surgery*
DAVID GREENMAN, M.D. *Vitreo-Retinal Diseases • Macular Degeneration • Diabetic Retinopathy & Uveitis • Consultative Ophthalmology*
HERB GREENMAN, M.D. *Laser Vision Correction • Cataract & Glaucoma Surgery • Diabetic & Macular Degeneration • Plastic Surgery & Strabismus*

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AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

Home Phone: _____
Cell Phone: _____

May we contact you at your place of employment?
If so, may we leave a message?

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____

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I hereby authorize GREENMAN EYE ASSOCIATES to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed GREENMAN EYE ASSOCIATES Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

REFRACTION SERVICES AND FEES

A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses.
A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

Our office fee for a refraction is $45 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

We cannot file insurance on both the medical and routine vision plan for the same visit.

Patient's Name (printed) _____ **Date** _____

Patient Signature (Legally responsible applicable) _____ **Relationship to patient** _____ **Staff Witness** _____

Routine vs Medical Eye Exams

Your reason for visiting the eye doctor and the results of your examination determine whether your insurance company will classify the exam as "routine" or "medical."

What is a routine eye exam? A routine eye exam is defined by insurance companies as an office visit for the purpose of checking **vision, screening for eye disease, and/or updating eyeglass prescriptions**. Routine eye exams produce a diagnosis **like nearsightedness, farsightedness, or astigmatism**.

Vision insurance plans provide coverage (or discounts) for routine exams, glasses and contact lenses. Most vision insurance plans do not cover contact lens evaluations. This fee is collected to evaluate the health of your eye for contact lens wear and to update your contact lens prescription.

In many cases, your medical insurance will not pay for a routine eye exam. By law, Medicare does not pay for routine vision exams.

Refraction fees: A refraction is the part of an office visit that determines your eyeglass prescription. It typically involves questions like, "which is clearer -one or two". Medical insurance will not cover the cost of refraction.

What is a medical eye exam? A medical eye exam produces a diagnosis like conjunctivitis, **dry eye, allergies, or cataracts**, to mention a few. A medical eye exam is also indicated if you have a medical condition that could affect the health of **your eyes**. Examinations to assess an eye complaint or a medical condition are billed to your medical insurance plan. These visits can be subject to copays, coinsurance, and deductibles.

Your eye doctor is legally bound by your insurance carrier to follow certain healthcare guidelines regarding billing your insurance. A medical eye exam should be billed to your medical insurance, while a routine vision exam should be billed to either your vision insurance or to you if you are self-pay. A routine eye exam and a medical eye exam may not be combined or billed on the same date.

Because of this, our protocol is to take actionable steps to ensure you have the best experience possible with us. If your exam has the potential to be billed medically, our staff will take time to explain that to you. We will do everything we can to help you understand any medical procedures performed or charges you receive.

Keep this in mind: Insurance coverage does not mean payment. Many medical plans have copayments and deductibles that must be met before your insurance will pay any amount towards your bill.

Patient Signature _____

Date _____