b&b shelle OPTICAL

Patient Information:

Name: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Mobile Phone: _____

Birth Date: _____ Last 4 of SS#: _____ Last Eye Exam: _____ Email: _____

Employer: _____ Occupation: _____

Previous Patient: Yes/No Student: Yes/No _____ Referred by: _____

What is the purpose of your visit today?

Annual Exam: _____ Glasses: _____ Contacts: _____ Both: _____ Other: _____

Parent's or Guardian's name if patient under 18 years of age, and in case of emergency, who we should contact:

Name: _____ Relationship: _____ Phone: _____

Insurance:

Vision/Medical Insurance: _____ No Insurance: _____

Vision/Medical Insurance: _____ Member's Birth Date: _____

Member's Name: _____ Member's Employer: _____

Member's SSN/ID#: _____ Relationship: _____

Medical/Ocular History (Please check all that apply)

Self (Ocular)	**Self (Medical)**	**Family**
___ Healthy, No complaints	**___ High blood pressure**	**___ Healthy, no diseases**
___ Blurred vision without correction	**___ Heart Disease**	**___ Heart Disease**
___ Lazy Eye	**___ Diabetes**	**___ High blood pressure**
___ Headaches/Eye strain	**___ Glaucoma**	**___ Diabetes**
___ Double vision	**___ Asthma**	**___ Glaucoma**
___ Eye Injury	**___ Thyroid**	**___ Cataracts**
___ Eye Surgery	**___ Others, please list**	**___ Others, please list**
___ Flashes of light	_____	_____
___ Eye Irritation	_____	_____
___ Floaters	_____	_____

___ Others, Please Explain_____

List all drug allergies: _____

List all medications taken: _____

Are you pregnant? Yes/No Are you nursing? Yes/No Tobacco Use? Yes/No Alcohol Use? Yes/No

How did you hear about us?

___ Friend ___ Vision Center ___ Banner ___ Web ___ Other

ADDITIONAL TESTS – PLEASE READ CAREFULLY

Dilation:

Dilation is the opening of the pupils by using medicated eye drops. This allows a better view of the retina and helps the doctor to detect many eye conditions that may be missed during a routine eye exam. Dilation is strongly recommended for patients with a history of cataracts, high blood pressure, high prescriptions, and patients older than 40. However, dilation is mandatory for all diabetic patients, patients with a history of glaucoma, and children 12 and under. After being dilated, you may experience blurred near vision and light sensitivity. These side effects can last from 3-6 hours. **There is no additional charge for this procedure***

___ Yes, I would like to be dilated today

___ Yes, but I would need to reschedule for another day

___ No, I do not want dilation (*By signing below, I understand and release B&B Shelle Optical and their doctors from all liability to treat or diagnose any eye condition due to lack of diagnostic information that could have been obtained from dilation.)*

Please sign here if you do not want dilation: _____
Date:_____

Retinal Imaging

A highly sophisticated computerized instrument now allows us to provide our patients with more thorough medical analysis of the eye. The digital retinal imaging system takes photographs of the retina (the back of the eye). This procedure assists the doctor in the early detection of many eye diseases, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. The process is quick, painless, and a useful tool to educate the patient and to monitor progression*. During the exam our doctor will review the results with you.

It is especially important for people who have:

- Personal or family history of:
    - Diabetes
    - Glaucoma
    - Macular degeneration
    - High blood pressure
    - High cholesterol

- High prescription
- Headaches
- New Patients
- Certain systemic medications (e.g. Plaquenil, Tamoxifen, Oral contraception, etc.)

The Doctors at B&B Shelle Optical highly recommend that all our patients have this procedure done.

Insurance may cover the cost, depending on your coverage. The normal fee for this procedure is $95.00. However, we have chosen to keep the additional fee at $45.00 to make it available to more of our patients.

*Please indicate your preference by checking the appropriate response.

___ Yes, I do want the retinal photo

___ No, *I decline to have the retinal photo at this time. By signing below, I understand and release B&B Shelle Optical and their doctors from all liability to treat or diagnose any eye condition due to lack of diagnostic information that could have been obtained from retinal imaging.*

Signature: _____
Date:_____

This test is not a replacement to dilation

Signature on file, Assignment of Benefits, Financial Agreement, HIPAA Notice

Patient Name: _____

1. **HIPAA Notice of Privacy Practices:** I acknowledge that I have received the Notice of Privacy Practices issued by B&B Shelle Optical that was effective April 1, 2005.

2. **Release of information:** B&B Shelle Optical may disclose all or part of any medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to B&B Shelle Optical for reimbursement for services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of original.

3. **Non-Covered Services:** I understand that B&B Shelle Optical contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by health care service plans. **Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered, including refraction fee (which is not covered by Medicare)**. I agree to cooperate with B&B Shelle Optical to obtain necessary health care service plan authorizations.

4. **Financial Agreement:** I agree that in return for the services provided to me by B&B Shelle Optical, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to B&B Shelle Optical for payment. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal

rate. Any benefits of any type under any policy of insurance are hereby assigned to B&B Shelle Optical. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to B&B Shelle Optical. However, I understand that I am primarily responsible for the payment of my bill.

5. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to B&B Shelle Optical, for services furnished to me by B&B Shelle Optical. I authorize any holder of medical information about me to release the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorized releasing the information to the insurer or agency shown. B&B Shelle Optical accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

6. **Other Insurance:** I authorize payment of my medical and surgical insurance benefits to B&B Shelle Optical. I understand that I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to B&B Shelle Optical.

Patient or Authorized party Signature: _____
Date: _____

Vision Care Fees v. Medical Care Fees

To avoid misunderstanding and confusion about our professional fees for Vision Care vs. Medical Care, please read and sign the following:

No Insurance Coverage

If you are healthy and have healthy eyes, wellness eye exam fees will be charged for your eye exam and/or contact lens exam to correct your nearsightedness or farsightedness, astigmatism and/or presbyopia.

If you have a general health problem or an eye disease then medical eye exam fees will be charged for your medical eye care. (Further explanation under Medical Insurance below)

Vision Plan and/or Medical Insurance

Many patients have vision plans and many have medical insurance coverage for their eye care, some have both. Your eye care problem will determine which insurance carrier we will file with for your eye care visit. Often, there is no way to know before your examination which type of insurance we file. If you have questions about your insurance coverage and/or your eye care fees, please feel free to discuss them with our staff or doctors.

Vision Plan

A vision plan will pay for your wellness eye exam if you are healthy and have healthy eyes. The results of your wellness eye exam are used to correct vision problems such as; myopia, hyperopia, astigmatism and/or presbyopia. A vision plan usually (but not always) requires a co-pay if you are examined for contact lenses. A vision plan **does not** pay for your examination if the examination requires medical decision-making and/or the treatment of a medical eye problem.

Medical Insurance

Medical Insurance will pay for your eye care if your examination requires testing and medical decision-making because you have:

- Systematic health problems (diabetes, high blood pressure, thyroid, etc.)
- An eye disease (cataracts, glaucoma, diabetic retinopathy, allergic conjunctivitis, ocular surface disease, etc.)
- A medical condition that requires taking a high-risk medication (plaquenil, etc.)

If you have a medical problem or we discover a medical eye problem during the exam, we are required to furnish a Medical-level eye examination that is determined by your Medical Insurance Carrier. The complexity of your medical condition and the level of the medical decision-making required to treat the problem are factors used to determine the exam fee level and co-pay amount. We did not set these fees your Insurance carrier did.

Also, depending on your medical problem, certain Supplemental Tests may be necessary. The fees for these Tests are usually paid by your Insurance Carrier but often they will also require you to pay an additional co-pay amount. Medical Insurance Carriers have very specific guidelines regarding every aspect of your medical eye care testing and documentation which they require us as a provider by signed contract to follow.

Our office did not make the Insurance policies, they were made by the Insurance Carriers.

In the event we do not take your major medical or vision plan, we will provide you with an itemized statement that you can file with your carrier.

Please sign one of the applicable lines below:

I DO have insurance and I authorize B&B Shelle Optical to file my vision plan and/or Medical insurance claims.

Patient's Signature (or Guardian if minor): _____
Date: _____

I DO NOT have insurance

Patient's Signature (or Guardian if minor): _____
Date: _____