Shelley Eye Center
Welcome to Our Office
Invest in your vision. We do.

Shelley Eye Center is a medically oriented eye care practice.
We focus on your overall visual healthcare as well as your optical needs.

PLEASE FILL OUT COMPLETELY Date_____

PATIENT: _____ DOB ____/____/_____ AGE _____

MAILING ADDRESS _____CITY _____STATE_____ ZIP _____

Home #_____ Work # _____ Cell #_____ Email _____

SS# _____ Sex M☐ F ☐ Married _____ Single _____ Divorced _____ Other _____

RESPONSIBLE PARTY - Who is responsible for the account?

NAME _____DOB ____/____/_____ SS# _____

ADDRESS_____CITY _____STATE_____ ZIP _____

INSURANCE INFORMATION -- Please provide the insurance card(s) to receptionist

Insured's Name_____ DOB ____/____/_____ SS# _____

Insured's Address _____Phone # _____

Employer _____Phone #_____

Medical Ins. Co. _____ ID#:_____

Supplemental Insurance_____ ID#:_____

Vision Plan _____Relationship to Member ___ Self ___Spouse ___Child ___Other

REASON FOR VISITING OUR OFFICE TODAY (please check all that apply):

- ❑ Annual Ocular Health Exam
- ❑ Contact Lens Exam
- ❑ Blurred Near and/or Distance Vision
- ❑ Foreign Body (something in the eye)
- ❑ Trouble Seeing at Night
- ❑ Headaches
- ❑ Eyes ___burn/itch ___ feel tired ___ feel dry
- ❑ Flashes of Light
- ❑ Floaters (black specks & spots)
- ❑ Eye Injury
- ❑ Discharge from eyes

Do you wear contact lenses? Y N
How long have you worn contacts? _____
Type of Contacts

Soft Daily Disposable Gas Perm Other

Brand of Contacts _____
How long do you wear your contacts? _____hrs
Do you have a backup pair of glasses?: Y N
How often do you wear your glasses? _____hrs
Do you regularly wear sunglasses?: Y N
Date of Last Eye Exam _____

Referral source: Dr. _____ Internet Friend/Family:_____ Other:_____

MEDICATION (Including Vitamins)	**DOSAGE**	**FREQUENCY**
List medications are you allergic to:		

SURGERIES	**DATE OF SURGERY**

Circle "yes" or "not to indicate if you have any have any of the following conditions? Then list family members

	Self		Date of Onset	Family Member?		Self		Date of Onset	Family Member?
Diabetes***	Y	N			Blindness	Y	N		
Macular degeneration	Y	N			Cataracts	Y	N		
Glaucoma	Y	N			Digestive disease	Y	N		
Circulatory Problems	Y	N			Stroke	Y	N		
Respiratory Disease	Y	N			Tuberculosis	Y	N		
Heart Disease	Y	N			Blood Disease	Y	N		
Kidney Disease	Y	N			Thyroid Problems	Y	N		
Liver Disease	Y	N			Cancer	Y	N		
High Blood Pressure	Y	N			Arthritis, Rheumatism	Y	N		
Headaches	Y	N			Cortisone/Prednisone	Y	N		
Allergies	Y	N			Chemotherapy	Y	N		
Dementia/Alzheimer's	Y	N			Venereal Diseases	Y	N		
Back Problems	Y	N			HIV/Aids	Y	N		

******It is the standard of care in this office that if you are diabetic, you WILL BE dilated and your exam will be billed to your medical insurance -- no exceptions.***

LIFESTYLE QUESTIONNAIRE

Please answer the following questions to assist our Opticians in determining your eyewear needs.

1. Do you currently wear glasses? Y N Single Vision Progressive(no-line) Bi-Focal Other _____
2. What do you like most about your current eyewear (style, color, fit, brand, etc.)? _____
   _____
3. What don't you like about your current eyewear (weight, thickness, dryness, glare, etc. _____
   _____

How will you settle your account today? Check Cash Visa MasterCard CareCredit

The above information is accurate to my knowledge. I personally guarantee payment for all services rendered. I authorize the release of any medical information to my insurance company in order to process claims related to my care.

Patient/Guardian Signature _____Date _____

*******Ask about Care Credit*******

CareCredit is a payment option for your healthcare coverage and vision care needs

******IT IS IMPERATIVE THAT YOU READ OUR BILLING POLICIES IN FULL*******

I understand and agree that I am financially responsible for any and all charges for services rendered or not paid by my insurance(s). This includes any medical service or visit, preventative exam/physical, lab or diagnostic testing, and any other screening ordered by the doctor or doctor's staff.

I understand that Shelley Eye Center does **not** accept Medicaid, whether it is my primary or my secondary insurance, and that I am solely and wholly responsible for any and all fees.

I understand that it is my responsibility and not the responsibility of the doctor or staff, to know if my insurance will pay for such medical services, preventative exam/physical, lab or diagnostic testing, and any other screening ordered by the doctor or doctor's staff.

I understand that while my insurance may confirm benefits, confirmation of benefits does not mean that the insurance company will pay the doctor, and that I am responsible for **any** unpaid balance.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the service I receive and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may result in claims being denied or higher out of pocket expenses to me.

I understand that the office will file my insurance but if for any reason the insurance has not made payment within 45 days, the balance becomes my responsibility. Any money received from the insurance company after the 45 days will then be reimbursed to me. It is my responsibility to let the office staff know of any insurance changes so that claims can be filed correctly. If insurance is not active at time of service, I will be charged the balance in full.

Most Medicare Secondary plans receive the secondary claim directly from Medicare therefore; it is your responsibility to inform the front desk and to provide them with your secondary insurance card. The only secondary plan we directly submit to is VSP. If for any reason you have two commercial insurances, we will only bill the primary. If we do not obtain the proper secondary insurance information from you, this office will not bill the secondary. It will then be your responsibility to file the claim and request payment.

As per page 1.8 of the VSP Manual, VSP is considered SECONDARY to any and all medical insurances, including but not limited to Medicare, BCBS, Cigna, Aetna, Tricare, Presbyterian,etc. As such if you have diabetes, cataracts, macular degeneration, use medications that have potential ocular side effects, glaucoma, or any other medically related eye condition, your medical insurance is PRIMARY, while your vision plan is SECONDARY. Under no circumstances does VSP cover any form of exam requiring medical treatment of the eye or a prescription for medication.

If you are a Medicare recipient and provide us your with a standard Medicare card, and your insurance is declined because you opted into a Medicare HMO or PPO plan, you will be financially responsible for the entire bill. We will not re-file a claim on your behalf. It is your responsibility to provide us with the proper insurance card at the time of service.

Ultimately, it is your responsibility to know what your insurance and vision plans cover. The doctors and staff of Shelley Eye Center sincerely appreciate your compliance with these policies

_____ _____

Patient's Signature (Parent and/or Guardian) Date

By signing below, I affirm that I, and/or my dependent(s), have medical insurance coverage and/or vision coverage as stated above. I assign directly to Southwest Vision Specialists PA, all insurance benefits, if any, for all services rendered. I authorize the use of my signature on all claims submitted to the insurance company(ies) I have listed above. Southwest Vision Specialists PA may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits and as allowed by the federal HIPPA law.

- I may request a copy of the Shelley Eye Center Notice of Privacy Practices although it is displayed in the office and available online at www.shelleyeyecenter.com,
- I am financially responsible for ***all*** charges incurred today,
- I am financially responsible for any charges that my insurance or vision plan ***does not*** pay, including, but not limited to, any deductibles, co-pays, and/or services not covered by my insurance or vision plan,
- If I have any questions regarding payment or non-payment, I MUST contact the insurance company directly,
- It is my responsibility to know what my medical insurance and vision plan coverage is,
- Professional fees (exam, testing and contact lens fitting fees) and optical materials are ***NOT*** REFUNDABLE (absolutely NO exceptions),
- The information I have provided is accurate to the best of my knowledge.

ALL MEDICAL SERVICE FEES, GLASSES FEES and CONTACT LENS EXAM FEES ARE DUE UPON COMPLETION OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

We gladly offer interest free financing through WWW.CARECREDIT.COM
By signing below I affirm that I have read, received, and understand the billing policies of Shelley Eye Center.

Printed Name (**and** guardian name if applicable)

Signature and Date (or guardian signature)

OUR OFFICE DOES NOT MAKE THE RULES
THEY ARE DETERMINED BY YOUR SPECIFIC MEDICAL INSURANCE OR VISION PLAN

Refraction Policy (Medicare Advanced Beneficiary Notice)

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but it is ***not*** a covered service by Medicare or most insurance plans. Our office fee for refraction is $40.00 and this fee is collected in addition to the patient's co-pay.

Acknowledgment

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.

Patient Signature (Parent for minor)

Date