

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?
	Y	N				Y	N		
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

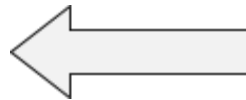
Please answer the following questions to assist our Opticians in determining your eyewear needs.

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

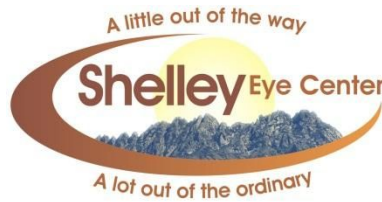
The above information is accurate to my knowledge. I personally guarantee payment for all services rendered. I authorize the release of any medical information to my insurance company in order to process claims related to my care.

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.

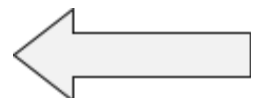
As per page 1.8 of the VSP Manual, VSP is considered SECONDARY to any and all medical insurances, including but not limited to Medicare, BCBS, Cigna, Aetna, Tricare, Presbyterian, etc. As such if you have diabetes, cataracts, macular degeneration, use medications that have potential ocular side effects, 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 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.

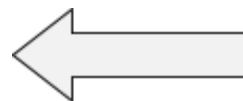
ALL MEDICAL SERVICE FEES, GLASSES FEES and CONTACT LENS EXAM FEES ARE DUE UPON COMPLETION OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

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