LA EYE
& VISION CENTER

Patient Responsibility Statement

Please initial/sign where indicated

_____ Patients with Insurance:

INTL It is our pleasure to help you file insurance claim forms or take assignment on your insurance benefits as designated by the plan of which you have indicated you are a member. A refraction fee (test that determines your vision correction) is not covered by medical insurance. This fee is the responsibility of the patient at checkout. All insurances for which the patient is a member must be presented or stated at the time of visit and will not be accepted after services are rendered.

_____ Notice for contact lens wearers:

INTL To determine the correct contact lens prescription, a contact lens evaluation is required after the comprehensive examination is completed. This procedure is an additional fee that is not included in the basic eye exam for glasses. The fee for this service ranges in price based on difficulty.

_____ Financial Responsibility:

INTL In the event that your insurance carrier determines that you are not eligible for a reduced level of coverage, you do hereby agree to be financially responsible for any and all charges incurred, including but not limited to deductibles. In the event, the patient does not pay in a timely manner, all charges including finance fees, collection fees and attorney fees, will be the responsibility of the patient and will be turned over to collections. All fees for services rendered will be collected on day of service.

_____ Dilation:

INTL The doctor uses dilation eye drops to dilate or "open up" the pupil of the eye. This allows for better observation of the internal structures of the eye-to more easily detect eye diseases such as, but not limited to glaucoma, macular degeneration, holes, tears, tumors. If the doctor feels that it is necessary to dilate your eyes at this or subsequent visits:

Please Circle: YES – I agree to have my eyes dilated **NO**- I have read the above, and I do NOT want my eyes dilated.

_____ NOTICE OF HIPAA COMPLIANCE PRIVACY PRACTICES

INTL This notice describes how your medical information may be used and disclosed and how you can get access to this information. Our office will use your protected health information to provide appointment referrals, reminders, describe or recommend treatments and provide health related benefits and services. The **HIPAA Privacy Act** requires us to keep your medical information private, provide this notice to you, abide by the terms of this notice and reserve the right to revise the privacy practices of this office at any time. A full version of this notice can be retrieved at the front desk per request.

****BY SIGNING BELOW, I ACKNOWLEDGE ALL INFORMATION DISCUSSED IN THE ABOVE PARAGRAPHS****

Individual responsible for payment: _____Relationship to patient:_____

_____

Patient or Authorized Person's Signature **Date**

FOR OFFICE USE ONLY

Insurance Name_____Reference#_____

Vision Co-pay $_____ Medical Co-pay $_____ Material Co-pay $_____

Ded. Amt. $_____ Amt. Remaining $_____ Co-Ins $_____

Frame Allow. $_____ Contact Lens Allow. $_____ CL Fitting Allow. $_____

Patient Name: _____Pt DOB: _____/_____/_____

Insured Name: _____ Ins. DOB _____/_____/_____

ID#_____ Group #_____

NOTE:

Appt. Date and Time:_____@_____AM/PM

LA EYE & VISION CENTER

WELCOME TO OUR OFFICE

DATE:____/_____/_____

(PLEASE PRINT)

First Name _____ Last_____Middle initial_____ Nickname_____

Mailing Address_____City_____State_____Zip_____

Date of Birth_____/_____/_____Age_____Email Address_____

***STAR your preferential phone number**

Home Phone___ (_____)_____Work Phone___ (_____)_____Cell Phone___ (_____)_____

Employer (or School)_____ Occupation (or grade)_____

Social Security # _____-_____-_____ Medical Insurance (1st)_____(2nd)_____

(Circle one) Married Single Other Vision Insurance (1st)_____(2nd)_____

Can we release medical information to the following person you list below: Yes No

Spouse's or Parent's Name_____ Phone_(_____)_____

Date of Last Eye Exam_____ Outcome_____

Date of Last Physical Exam_____Date of Last Blood Work_____ Facility Collected_____

Family Doctor or Specialist_____Pharmacy_____City_____

How did you learn about our office?_____

MEDICAL/OCULAR HISTORY

Allergies	No	Yes
Asthma	No	Yes
Skin Disorder	No	Yes
Macular Degeneration	No	Yes
Eye Injury	No	Yes
Eye Surgery	No	Yes
Lazy Eye/Eye Turn	No	Yes
Cataracts	No	Yes
Glaucoma	No	Yes
Arthritis	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
Kidney Disease	No	Yes
Nerves/Anxiety	No	Yes
Stroke	No	Yes
Other_____	No	Yes

FAMILY MEDICAL/OCULAR HISTORY **Relationship to you**

Macular Degeneration	No	Yes	_____
Blindness	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Other _____	No	Yes	_____

MEDICATIONS (Rx or Over the Counter) **Name of Medication/Strength(mg)**

_____

_____

_____

_____

_____

_____

Medication Allergies (list) _____

Were you recently hospitalized? Yes No **Which hospital?_____**

Height _____ Weight_____ Are you currently pregnant or breast feeding? No Yes Both

Smoke Cigarettes? No Yes (amt.)_____ **Drink Alcohol?** No Yes (amt.)_____ **Use other Substance(s)?** No Yes (amt) ____

Do you suffer from any of the following?:

Burning	Tearing/Mucous	Redness	Blurred Vision	Poor Night Vision
Itchy Eyes/Lids	Floaters	Double Vision	Dryness	Headaches

Other_____

Are you interested in contact lenses? No Yes **Do you currently wear contact lenses?** No Yes **Brand _____**

Do you wear? Daily/ 2week/ Monthly Disposable Gas Permeable (Rigid) Colors Multifocal (Bifocal)

Please bring a full list of all medications taken on a daily basis

Include: NAME, strength, directions for use.

Please also bring all currently used eye glasses and contact lens boxes if available.

Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery Appointments

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies, or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable toschedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep all patients and doctors on time.
If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

****All paperwork MUST be filled out prior to appointment time. If paperwork is not filled out prior to appointment time, the appointment will be rescheduled. If you did not receive your paperwork in the mail, the patient MUST arrive 20 minutes PRIOR to appointment time to fill out paperwork.**

3.*Cancellation/ No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses to the office.
If a surgery is not cancelled at least 5 days in advance you will be charged a fifty dollar ($50) fee; this is not be covered by your insurance company.

4. Account balances

We will require that patients with balances on their accounts or accounts of immediate family members pay their account balances to zero ($0.00) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and speak to a business office representative with whom they can review their account and concerns.

Patients with balances over ($100) must make payment arrangements prior to future appointments being made.

_____ _____

Patient Name **Patient/Guardian Signature**

Today's Date: ____/____/____

LA EYE
& VISION CENTER

There are two types of insurances that will help pay for your eye care services and materials. You may have both and our practice accepts both:

1. Vision care plans (such as Superior, Eyemed, VSP, UHC Vision, etc.)

2. Medical Insurance (such as Blue Cross/ Blue Shield, Aetna, Medicare, Cigna, etc.)

- Vision care plans only cover routine vision exams along with discounts towards eyeglasses and contact lenses. Vision plans only cover a basic screening for eye diseases. They do not cover diagnosis, management or treatment of eye diseases.

- Medical insurance **must** be used if you have any eye health problem or systemic health problem that has ocular complications. Your diagnosis and/or exam findings will determine if these conditions apply to you during the process of the exam, but some are determined by your case history.

- If you have both types of insurance plans it may be necessary for us to bill some services/materials to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

- We will bill your insurance plan for services or materials purchased in our office. We will try to obtain advanced authorization of your insurance benefits, so we can tell you what is covered or what you may receive reimbursement from your insurance company for. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with the above policies.

_____

Patient Name (parent if child)

Date: _____

Please provide ALL insurance cards (medical and vision) and license to the front desk staff member.

315 N. Broadway
Church Point, LA 70525
Ph. 337.684.0018 Fax. 337.684.0715

200 Fairway Drive, Ste. A
Crowley, LA 70526
Ph. 337.250.4474 Fax. 337.514.2280

Records Release

The patient _____ gives permission to _____ to release his/her records, scans, testing to the office of LA Eye & Vision Center for the purpose of further analysis, treatment and testing.

Patient &/or Guardian's Signature:_____

Patient's DOB: _____

Patient's Address: _____

If you have any questions or concerns, please call my office.

Sincerely,

Dr. C. Smith Boudreaux
Dr. Eric Boudreaux