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:_____Patient ID#:_____

Patient Name:_____ Patient DOB:_____/_____/_____

Copay: $_____ Deductible Amnt: $_____ Ded Remaining: $_____

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)_____

Race/Ethnicity: Black/African American White Hispanic Asian Other:_____

RESPONSIBLE PARTY INFORMATION (Parent/Guardian)

Name: _____ Address:_____

DOB: _____/_____/_____ SSN: _____ Phone #: (_____) _____

Emergency Contact Name: _____ Phone (_____)_____ Relationship: _____

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
Hypertension	No	Yes
Sleep Apnea	No	Yes
High Cholesterol	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	_____

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

_____

_____

_____

_____

_____

_____

Medication Allergies(list) _____

Were you recently hospitalized? No Yes 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)

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OFFICE POLICIES

1. Appointment Confirmations

Appointments must be confirmed with our office prior to scheduled date. If we have not received confirmation your appointment will be removed from our schedule. Upon rescheduling you will be booked next available.

2. Cancellation/ No Show Policy

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 to schedule you for a visit, due to a seemingly "full" appointment schedule.

If a <u>Dr. appointment</u> is not cancelled at least <u>24 hours</u> in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses to the office.

If a <u>Surgery</u> is not cancelled at least <u>3 days</u> in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company

3. 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.

4. Account balances

We will require that patients with balances on their accounts pay their account balances to zero ($0.00) prior to receiving further services by our practice.

5. Patient Purchases

Upon submitting payments you are agreeing to purchases. **All sales are final.**

_____ _____

Patient Name **Patient/Guardian Signature**

Today's Date: ____/____/____

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& 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.

LA EYE
& VISION CENTER

Authorization to Release or Obtain Health Information

315 N. Broadway St.,
Church Point, LA 70525
Ph# : 337-684-0018
Fax #: 337-684-0715

200 Fairway Dr., Suite A
Crowley, LA 70535
Ph#: 337-250-4474
Fax #: 337-514-2280

Name:_____ Date of Birth: _____ SSN:_____

Address:_____ City:_____ State:_____ Zip Code:_____

I authorize LA Eye & Vision Center to (circle one): Release Information To OR Obtain information From

Clinic Name:_____ Physician Name:_____

Address:_____ City: _____ State:_____ Zip code:_____

Phone Number: _____ Fax #:_____

The **Purpose of this Authorization** is indicated below: (Please place a check in the box that applies)
_____Changing Physicians. _____ Other Medical Care _____Other:_____

Preferred Provider: _____ Dr. Eric Boudreaux _____ Dr. Claudette Smith-Boudreaux

Records to include:
This authorization pertains to the disclosure of the record types indicated below between the allowing dates of service:
From:_____to_____ OR select once of the following options:

_____All records retained by facility/office	_____Hospital records	_____OCT(Macula/Nerve)
_____ Progress notes	_____ Laboratory results	_____HVF
_____Operative reports	_____Imaging results	_____Other:_____

Terms and conditions:
-I have the right to revoke this Authorization, in writing, at any time by notifying the staff at LA Eye & Vision Center and the health care provider being requested to disclose health information (if applicable). Such renovation will not apply to information already had been disclosed in reliance on this Authorization.

- I have the right to not sign this Authorization. LA Eye & Vision Center will not condition treatments, payment for services or enrollment or eligibility for benefits on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and not longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- Please note, this Authorization expires one(1) year after the date of signature unless otherwise specified.

I understand that the information to be released is considered confidential and is to be utilized by the recipient only for the purpose of medical treatment.

Signature:_____Date:_____Phone Number:_____

Printed Name:_____ Relationship:_____

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.