LA EYE

315 N. Broadway
Church Point, LA 70525
337.684.0018

Patient Responsibility Statement

Please initial/sign where indicated.

_____ Intl.

To our patients with insurance:
It is our pleasure to help you file your 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 of $25 is not covered by medical/vision 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.

_____ Intl.

Notice for contact lens wearers:
To determine the correct contact lens prescription for you requires a contact lens fitting. 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 from $55 to $150. The cost of your fitting fee is determined by your doctor when your full eye exam is complete. The price will depend on the difficulty of your prescription.

_____ Intl.

Financial Responsibility:
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 by you including deductibles. In the event, the patient does not pay in a timely manner, all charges including finance fees, collection fees, attorney fees, will be the responsibility of the patient.

Individual responsible for payment: _____

Relationship to patient: _____

_____

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

FOR OFFICE USE ONLY

Insurance Name_____ **Reference#**_____

Vision Copay_____ **Medical Copay**_____ **Material Copay**_____

Ded. Amt_____ **Amt. Remaining**_____ **CO/IN**_____

Frame Allow_____ **Contact Lens Allow**_____ **CL Fitting Allow**_____

Patient Name_____ **Pt. DOB**___/___/___

Insured Name_____ **Ins. DOB**___/___/___

ID #_____ **Group #**_____

Note:

Appt. Date and Time:_____@_____

LA EYE & VISION CENTER

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WELCOME TO OUR OFFICE

Dr./Mr./Miss/Ms._____ Sex: M/F Today's Date___/___/___
(PLEASE PRINT)
Mailing Address_____ City_____ State_____ Zip_____

Date of Birth_____ Age_____ Email Address_____

Home Phone___(_____)_____ Work Phone__(_____)_____ Cell Phone__(_____)_____

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

Social Security # _____-_____-_____ Insurance (1st)_____

(Circle one) Married Single Other Insurance (2nd)_____

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

Date of Last Eye Exam_____ Drs. Name_____

Main Hobbies_____

Family Doctor or Personal Physician_____ Phone___(_____)_____

Whom can we thank for referring you to our office?_____

Or how did you learn about our office?_____

Any problems with current contact lenses or glasses?_____

PERSONAL MEDICAL HISTORY

Allergies	No	Yes
Asthma	No	Yes
Skin Disorder	No	Yes
Eye Disease	No	Yes
Eye Injury	No	Yes
Eye Surgery	No	Yes
Lazy Eye	No	Yes
Cataracts	No	Yes
Glaucoma	No	Yes
Arthritis	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
High Blood Pressure	No	Yes
Kidney Disease	No	Yes
Nerves/Anxiety	No	Yes
Stroke	No	Yes
Other_____	No	Yes

FAMILY MEDICAL HISTORY **Relationship**

Macular Degeneration	No	Yes	_____
Blindness	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
Stroke	No	Yes	_____
Cancer	No	Yes	_____
High Blood Pressure	No	Yes	_____
Other _____	No	Yes	_____

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

Antihistamines	No	Yes	_____
Diuretics ("water pill")	No	Yes	_____
High Blood Pressure Pills	No	Yes	_____
Contraceptives	No	Yes	_____
Eye Drops (Rx or OTC)	No	Yes	_____

Other Meds not listed above (list) _____

Medication Allergies (list) _____

Do you use smoke? No Yes (amt.)_____ **Alcohol?** No Yes (amt.)_____ **Other Substance(s)?** No Yes (List) (amt.)

Do you have or see the following?

Burning	Gritty Sensation	Spots	Tearing/Mucous	Redness
Itchy Eyes/Lids	Floaters	Double Vision	Dryness	Headaches
Sensitivity to Light	Blurred Vision	Dizziness	Flashes of Light	Night Blindness

Other_____

Are you interested in contact lenses? No Yes
Which kind? Daily Wear Soft Gas Permeable (Rigid) Extended Wear Colored Disposable Bifocal
Have you or do you currently wearing contact lenses? No Yes What Kind?_____ **Solution?**_____

LA EYE
& VISION CENTER

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

1. Vision care plans (such as EyeMed and Superior Vision)

2. Medical insurance (such as Blue Cross/Blue Shield, Aetna and Medicare).

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. 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 doctor 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 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 if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. 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 these policies.

_____

Patient signature (parent if child)

Date _____

Please provide your insurance cards and licensee to the front desk staff member.

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WELCOME TO OUR OFFICE

NOTICE OF HIPAA COMPLIANT PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. We will use your Protected Health Information to provide appointment referrals, reminders, describe or recommend treatment alternatives and provide information about health related benefits and services that may be of interest to you. We will maintain the privacy of your health records, provide this Notice to you, abide by the terms of this Notice and reserve the right to revise the privacy practices of this office. A full version of this notice can be retrieved at the front desk.

I HAVE RECEIVED AND READ THE PRIVACY NOTICE FOR THIS OFFICE

SIGNATURE **DATE**

A. Notifier: LA Eye & Vision Center
315 N. Broadway
Church Point, LA 70525

B. Patient Name:
C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** listed below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** listed below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
92015 GA	Medicare does not cover Refraction test	$25.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

PLEASE BRING A FULL LIST OF ALL MEDICATIONS TAKEN ON A DAILY BASIS

INCLUDE: NAME, STRENGTH, AND DAILY DOSAGE