Graystone EYE • iLASIK Aesthetics

FOCUSED ON YOU

New Patient Paperwork

Dear Patient,
We are happy you have selected our practice for your eye care! Please download, print and fill out all pages and bring them with you to your scheduled appointment time. The first four pages are for your review and the remaining pages are consents to bring with you. If you have questions regarding your appointment, please call 888-626-2020 | Option 1.

Our Mission:
Preserving the Gift of Sight and Improving Lives
~ One Patient at a Time.

Welcome To Our Practice!

We are honored that you have chosen us as your eye care provider. Our mission as a practice is to Preserve the Gift of Sight and Improve Lives ~ One Patient at a Time. Our practice is committed to providing you the highest quality care and service, in a timely and respectful manner. You and your vision are our focus, and our goal is to keep your eyes as healthy as possible!

Just a couple things to keep in mind for your first visit:

Arrival Time: Please do not arrive any earlier than 15 minutes for your scheduled appointment. We will not check patients in earlier than that.

Guests joining you: We make every effort to allow your guests to accompany you during your visit, but due to space in our smaller waiting areas and exam rooms, only one person will be able to join you in our clinic. Any other guests will be asked to wait in our main lobby area.

Time in Office: Please plan to be at our office for two hours; time frames vary due to testing needed. Pediatric appointments may take a little longer, depending on eye conditions. We make every effort to keep your appointment as efficient as possible, but also want you to be prepared for the time needed to make that happen.

What to expect: Why does a visit with the eye doctor take so long? For starters, we are a specialty medical office, which means all our doctors are medical doctors (MDs). That means we do a health history review as well as an eye examination. Our staff and physicians work as a team getting patients through the workup process needed to ensure quality eye care, but there are a variety of tests and possible eye dilation that are included in that process.

Eye Refraction: This is a necessary test in which the visual potential of the eye is determined. This important test allows the physician to know if your decreased vision is from a disease process, or simply a need for updated glasses. If you are coming to see us for vision issues this test is necessary and will be performed. This test may not be covered by your insurance. If not covered, you will be responsible for the $45.00 charge at the time of your visit. This is not a copay, so that will also be due at the time of your visit.

> **Insurances that do not cover Eye Refractions*:** BCBS Federal, BCBS (State Health Plan), Champva, Humana Medicare, Medicare, Medicare Supplements (GEHA & Tri care for Life allow some benefit), Self-Pay, Railroad Medicare, United Healthcare Medicare.

**All other plans not listed above will be filed to the insurance company first and billed to the patient if there is a balance due.*

Routine vs. Medical (What does that mean?): You will need to sign a waiver at your visit indicating your choice of exam. A ROUTINE visit files through your VISION insurance. This visit includes an eye exam and a new prescription for glasses/contacts, if needed. A MEDICAL visit files through your MEDICAL insurance with the specialist copay. This exam is more thorough and examines the health of the eye. If you have any of the following conditions, your visit could be medical: Glaucoma, Cataracts, Headaches, Blurred Vision, Decrease in Vision, Eye Alignment Problems, Diabetes, Retinal Issues, Dry Eye, Floaters or Wavy Lines, Double Vision, or Developmental Delays.

If you are coming in for a treatment, have been referred by another medical doctor (MD), or for any of the following reasons, your visit WILL BE MEDICAL: Injury, Cysts, Sties, Irritation, Infections, Redness, or Drainage.

Amenities:

- We do offer guest WiFi in all our offices.
- Optical dispensary in each Graystone Eye Office
- Full service medical aesthetic center in Hickory

Just a couple things to keep in mind after your first visit:

For your convenience, we do have an online patient portal, appointment request inquiry, and an email communication option on our website at www.graystone-eye.com, should you ever want to utilize those options.

Our practice will never be perfect, but that's not to say we won't quit attempting it! We do send out 1 question surveys no more than one time a month, via text. We also email out full satisfaction surveys looking for your input to help us make our patient experience better. Please take just a few minutes to complete our surveys, so that we can use your feedback to better our future. What you think really does matter and can help us ensure superior care and service for all our patients.

To learn more about us and our practice, visit our website (www.graystone-eye.com) and check out the story of Graystone Eye, as well as some of our patients' stories!

See you at your next visit!

The **Eye Refraction** is a necessary test in which the visual potential of the eye is determined. This important test allows the physician to know if your decreased vision is from a disease process, or simply a need for updated glasses.

If you are being seen for vision complaints, or your vision measures less than 20/20, this test is **necessary** and will be performed.

The Eye Refraction MAY NOT BE covered by your health insurance.

This $45.00 charge is the responsibility of the patient **at the time service is rendered.**
If the Eye Fraction is covered by the patient's insurance the Eye Refraction fee will be filed.

This is not a co-pay. After your insurance responds, you may be billed for other charges that were not collected at the time of service.

Insurances that do NOT cover Eye Refractions:
Blue Cross and Blue Shield Federal, Cigna (Commercial Plans), Humana and Humana Medicare Plans, Medicare, Medicare and Supplement (ex: Bankers, AARP, etc), Private Pay/Self Pay and Railroad Medicare.
(For all other plans not listed above, we will file insurance first and bill the patient if there is a balance due.)

(Updated 9-2020)

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Routine Or Medical?

A **MEDICAL** visit files through your **MEDICAL** insurance with the specialist copay. This exam is more thorough and examines the health of the eye. If you have any of the following conditions, your visit should be medical.

- Glaucoma
- Cataracts
- Headaches
- Blurred vision
- Decrease in vision
- Eye alignment problems
- Diabetes
- Retinal issues
- Dry eyes
- Floaters, flashes or wavy lines
- Double vision
- Developmental delays

- If you are **65 OR OLDER**, national guidelines recommend a dilated medical exam.
- If you were referred to us by another physician, your visit will be **MEDICAL**.
- If you are here for a **TREATMENT** or for any of the following reasons, your visit will be **MEDICAL:**

- Injury
- Cyst
- Stye
- Irritation
- Infection
- Redness
- Drainage
- Other Symptoms

You may file for a **ROUTINE** visit under your **VISION** plan, if none of the above apply. A **ROUTINE** visit files through your **VISION** insurance. This visit includes a basic eye exam and a new prescription for glasses, if needed. If a medical condition is identified on your **ROUTINE** exam, you will need to return for a separate visit.

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Routine Or Medical?

Date of Service: _____

Patient Name: _____

Date of Birth: _____

I want to use my **Medical Insurance** for today's visit.

Insurance Plan:

Copay/Coinsurance Estimate:_____(additional Cost for ctl exam)

Patient Signature:

I want to use my **Vision Insurance** for today's visit.

** Any medical assessment will require a follow up exam for treatment of condition**

Insurance Plan:_____

Copay/Coinsurance Estimate:_____(additional Cost for ctl exam)

Patient Signature:_____

I do not have Vision Insurance but I want a routine exam.

** Any medical assessment will require a follow up exam for treatment of condition**

Payment Estimate Due:_____(additional Cost for ctl exam)

Patient Signature:_____

Once your insurance is filed, it cannot be changed.

Patient Privacy Consent Form

PATIENT: _____ DOB: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Graystone Eye has a Notice of Privacy Practices and the patient has the opportunity to review this policy.
- Graystone Eye reserves the right to change the notice of Privacy Policies.
- The patient has the right to restrict the uses of their information by Graystone Eye does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Graystone Eye may refuse treatment without the execution of this Consent.

Signature: _____

Relationship to Patient (if other than patient): _____

Witness Signature: _____ Date: _____

(Practice Representative)

Consent To Release Protected Health Information

PATIENT: _____ DOB: _____

Due to HIPAA regulations, we no longer are allowed to release any medical information regarding your medical condition, diagnosis, treatment, or prognosis to any person without your consent.

You may designate a person or persons who are allowed to obtain this information, in your absence, by phone or in person.

If you have a Legal Guardian or Power of Attorney, we require that a copy of the legal document by on file with your records at Graystone Eye.

It is important for our office to have on record your designated person/persons to whom we can release medical information. Please list below the appointed person/persons that you will allow to obtain this information.

You may release the following information:

☐ Medical ☐ Financial ☐ Do not release to anyone other than me

Release to:

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____
(Practice Representative)

This document will remain effective indefinitely unless otherwise rescinded by written noted.

Minor Consent Form

PATIENT: _____ DOB: _____

If patient is a minor, please complete the following consent form and provide parent or guardian information.

I / We _____, being the parent(s)/guardian(s) of _____, do hereby request and authorize the physicians of Graystone Eye or person designated by them to perform necessary services for my child. This is including but not limited to dilation of pupils, whether or not I am present at the actual appointment when the treatment is rendered. It is understood that this consent will be effective for one year from the date of the most recent dated signature, as indicated below.

_____

Signature of Parent or Guardian Date

_____

Signature of Parent or Guardian Date

_____

Signature of Parent or Guardian Date

If parent is not available for signature, verbal authorization may be obtained by phone. The following information must be obtained from the parent/guardian giving permission for treatment.

Patient Full Name: _____ Date of Birth: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

Patient Full Name: _____ Date of Birth: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

Patient Financial Policy

PATIENT: _____ DOB: _____

Thank you for choosing Graystone Eye for your eye care needs. Below is our financial policy, which we ask that you read and sign prior to receiving services.

PATIENT CO-PAY IS DUE AT THE TIME OF SERVICE.

Patient Responsibility

As a patient of Graystone Eye, you are financially responsible for any services not covered by your health insurance (which includes co-pays, co-insurance, and deductibles).
These amounts will be collected the day of your appointment. We accept Cash, Check, Visa, MasterCard, Discover, American Express, Care Credit and all Health Savings Account debit cards.

- *Some insurance plans, including Medicare, do not cover eye refractions (measurement taken to determine the need for glasses or change in prescription).*
- *If you currently wear or wish to start wearing contacts, there is a separate charge for the contact lens fitting fee which must be paid at time of service.*

In order to bill your insurance company, we must have your current insurance card and billing information. We will verify this information at each visit.

If you have a scheduled appointment and have an outstanding balance, you will be expected to pay your balance or establish payment arrangements with our billing department before being seen. Non-payment of outstanding balances could result in being discharged from our practice.

Many insurance plans require a referral/authorization for services provided. You will need to obtain this referral/authorization prior to being seen in our office.

Minor Patients

For all services provided to minor patients, the guarantor of the patient is responsible for payment.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize insurance benefits to be made on my behalf to Graystone Eye for any services provided. I authorize any holder of medical information about me to be released to my insurance carrier and it's agents to determine benefits payable for related services.

I also authorize Graystone Eye to access my medication history.

Patient Signature Date

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Missed Appointment Acknowledgment

We are committed to accommodating our patients, within reasonable limits, by providing appointment times that can meet individual needs and schedules. Our appointments are limited, as our physician's schedules are arranged to provide maximum availability for the best possible care to our patients.

We ask that you make every attempt to keep your scheduled appointment. We do understand that conflicts do arise, at which we ask that you contact our office to cancel and/or reschedule your appointment within 24 hours of your appointment. Doing so will allow our team to provide this appointment time to another patient in need of care by our physicians.

If you are unable to make your appointment and do not cancel/reschedule prior to the appointment date and time; this missed appointment will be documented in your chart and tracked throughout the year. We do understand there are unforeseen circumstances that occur, therefore please contact us at your earliest convenience when this happens so that we may document accordingly.

Below is our missed appointment policy:

- 1st Missed Appointment: Review of Missed Appointment Policy.
- 2nd Missed Appointment: Appointment availability restricted. to 24-48 hours from the most recent request.
- 3rd Missed Appointment: Dismissal from practice.

This policy is the same for our new patients as it is our established patients. We respect your time and expect the same in return. Missed appointments are disregarded after a consistent 6-month time reflects arrival for all scheduled appointments.

By signing below, you acknowledge that you have read and fully understand the expectations we have regarding appointments made with our providers.

Patient Signature: _____

Patient Name: _____

Private Pay Discount Waiver

PATIENT: _____ DOB: _____

Our Policy for Private Pay Discount extends a discount to patients that do not have insurance benefits. The guidelines of this policy are as follows:

Physician charges billed and adjusted for the Private Pay Discount for any procedures performed in the office setting are required to be paid in full on the day of service; otherwise a discount will not be extended to the patient. If payment in full is not received, the discount adjustment will be removed from the patient account and the original charge will be the patient's responsibility.

Physician charges billed and adjusted for the Private Pay Discount for any procedures performed in the Hospital or Surgery Center are required to be paid in full on or before the day of service, otherwise a discount will not be extended to the patient. If payment in full is not received, the procedure may be rescheduled or cancelled.

Private Pay Discount Policy does not include Optical services or products.

Graystone Eye reserves the right to change the notice of this policy at any time.

By signing this waiver, the patient understands the Private Pay Discount policy extended by Graystone Ophthalmology Associates.

Signature: _____

Relationship to Patient (if other than patient): _____

Witness Signature: _____ Date: _____

(Practice Representative)

Waiver Of Liability For Non-Covered Services Or medically Unnecessary Provider Notice

PATIENT: _____ DOB: _____

Non-Covered Services

There are services that Medicare and other insurance companies do not cover. It does not mean that these are not important for you to have. It only means your insurance policy does not include them in your coverage.

The following are examples of some of the services provided by Graystone Eye that are, or many be considered non-covered services by your insurance carrier. You will be expected to pay for these services:

- Contact Lens
- Refraction
- Routine Eye Exams
- Cosmetic Surgery
- Refractive Surgery
- Managed Care Patient did not obtain authorization from primary care doctor
- Other: _____

I agree that I am personally responsible for payment for these and any other non-covered services I receive at Graystone Eye.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(Practice Representative)

Medically Unnecessary Provider Notice

Medicare will only pay for services that are determined to be “reasonable and necessary” under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare Program standards, Medicare will deny payment for that service. We believe that, in your case, Medicare is likely to deny payment for _____ for the following reason(s): _____

Employee Signature: _____ Date: _____

Beneficiary Agreement

I have been notified by my physician that he/she believe that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature of Medicare Beneficiary: _____ Date: _____

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Patient Questionnaire

Name: _____ **Date of Birth:** _____
Family Physician: _____ **Referred by:** _____
Email Address: _____
Reason for your visit today _____

Are you experiencing?	Yes	No
Blurred distance vision		
Trouble seeing to drive		
Blurred Near Vision		
Double Vision		
Headaches		
Eye Pain		
Red Eyes		
Floaters		
Dry Eyes		
Flashes		
Tearing		
Itching		
Any other problems		

3. Current Eye medications:

_____

_____

_____

4. Current Medications (list over the counter and prescriptions)

_____

_____

_____

_____

_____

5. Do you or have you had any of the following disorders?

	Yes	No	**Date/ Type/ Treatment**
Thyroid Disease			
Arthritis			
Diabetes			
Asthma			
Stroke			
Heart Disease			
Cancer			
Trauma			
Previous Surgery			

Eye Conditions:

Cataract	_____	_____	_____
Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Crossed Eyes	_____	_____	_____

6. Have you experienced any of the following in the 5-7 days?

	Yes	No		Yes	No
Fever	_____	_____	Painful Urination	_____	_____
Chest Pain	_____	_____	Insomnia	_____	_____
Excessive Thirst	_____	_____	Bruising	_____	_____
Skin Rash	_____	_____	Environmental Allergies	_____	_____
Sore Throat	_____	_____	Joint Pain	_____	_____
Difficulty Swallowing	_____	_____	Dizziness	_____	_____

7. Do any of your blood relatives have? **If so, who in the family?**

	Yes	No	
Glaucoma	_____	_____	_____
Crossed or Lazy eye	_____	_____	_____
Macular Degeneration	_____	_____	_____
Diabetes	_____	_____	_____

8. Do you use:	Yes	No	**How much/how long?**
Tobacco products	_____	_____	_____
Alcohol Products	_____	_____	_____

9. List any medical allergies and type of reaction to each:

_____

_____

_____

10. Occupation:

Have you ever been seen by a Graystone physician in any of our locations? Yes ____ No _____

If yes, approximately how long ago? _____