KERNERSVILLE EYE SURGEONS

Patient Registration Information

Last Name: _____ First Name:_____ Date of Birth:___/___/___ Gender: Male or Female Preferred Name:_____ Social Security #: _____ Address: _____ Apt#:_____ City: _____ State: _____ Zip Code:_____ Home Phone:_____ Cell: _____ Marital Status:_____ Email (if applicable):_____
Emergency Contact:_____ Phone:_____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Workers Compensation (if applicable):_____

Primary Care Physician: _____ **Referred By:** _____

Optometrist: _____

Primary Insurance:

Name of Insurance Company: _____

Name of Insured party: _____ Relationship: _____ Date of Birth __/__/___

Name of Patient: _____

Additional Insurance:

Name of Insurance Company: _____

Name of insured party: _____ Relationship: _____ Date of Birth __/__/___

Name of patient: _____

Check all that apply:

- If you have insurance that we are **IN NETWORK** with, we bill these companies and will follow up on outstanding balances. You are responsible for your designated Co-Pay at Each office visit which is due **BEFORE** seeing the doctor.
- If you have insurance that is **OUTSIDE OF NETWORK** and provide us with a copy of your card, we will submit the claim directly to your insurance company for reimbursement as a courtesy. You as the patient should

follow up with your insurance and also be aware that the entire balance is your responsibility.

- **If you have <u>NO INSURANCE:</u>** You are responsible for payment of your bill. A payment of **$175.00** is due before visit. This may not cover the entire cost of the visit. At which point you will be required to set up a payment plan.
- If your bill exceeds $200.00, payment plans can be arranged. We accept personal checks, credit cards and cash.
- **<u>If patient is minor:</u>** You as the parent or guardian will take responsibility of the patient medical bills and will provide the office any information and changes. We are unable to hold a person responsible as the guardian when he/she is not present to authorize signature.

Signature: _____ Date: _____

KERNERSVILLE EYE SURGEONS

Refraction Fee and Service

Refraction is the process of determining the eye need for corrective lens or the refractive error. It is a necessary part of the medical eye examination. This does not always mean an eyeglass prescription will be required.

Please be advised that we are unable to utilize this information from another doctor's office. A refraction may be necessary to be performed at any office visit if deemed medically necessary by our medical staff.

Most medical insurance plans and ALL Medicare/Medicare Advantage Plans DO NOT cover the routine refraction.

We are required to notify you that this is **NOT** a Covered benefit. The cost of the refraction is the patient's responsibility.

Our office fee for the refraction is **$30.00**.

If you have a vision plan, it may cover the refraction however, we are not a participating provider with any vision plan. Our office is happy to provide a detailed receipt for the refraction that may be submitted by the patient to the vision plan for possible reimbursement.

If you have any questions regarding insurance policies and procedures, please do not hesitate to

ask. We will do our best to assist you.

Co-payment/Payment policy

We are participating provider with most medical insurance plans. Please be advised that we collect the co-payment at the time of the office visit. You will be billed for any remaining balance on a covered service at the contracted rate including co-insurance and deductible amounts.

"I have read the above information and understand that the refraction is a **NON-COVERED** service. I also understand that the copay will be taken at each office visit. I accept full financial responsibility for the cost of services rendered due at the time of service. I understand that any Co-payment, co-insurance, or deductible I may have is separate from and not included in the refraction fee."

Signature:_____ Date:_____

KERNERSVILLE EYE SURGEONS

APPOINTMENTS AND CANCELLATION POLICY

At Kernersville Eye Surgeons, our goal is to provide the most comprehensive care for your eyes in as timely manner as possible. We have implemented an appointment and cancellation policy which enables us to better utilize available appointments for our patients in need of urgent eye care.

Cancellations of Appointments

We appreciate your courteous call to our office as soon as you know you are unable to keep your scheduled appointment. Cancellations and rescheduled appointments open availability for others waiting to be seen for urgent eye care evaluation and treatment. If it is necessary to cancel your scheduled office appointment, we request that you give at least 24 hours' notice. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely eye care. Any cancellation made without 24 hour notice will be subject to a fee of $50.00. This fee **will not be billed to insurance** but will be sent to your address on file.

We do understand that emergencies arise. Under these circumstances where the 24 hour notice can not be given for a cancelled appointment, consideration may be given by the Practice Administrator and Physician to waive the cancellation fee.

Please understand that the implementation of this cancellation policy is to allow us to utilize our available appointments more effectively and to ensure you receive quality, compassionate eye care in a timely manner. Thank you for allowing us to care for you and your eyes. We look forward to seeing you at your next appointment and please contact us for any questions or concerns.

Please be advised that we are happy to send medical records to the DMV, disability, and other physicians' offices for transfer of care. However, if you have an outstanding unpaid balance on your account, these records will not be sent until your account is paid in full.

Signature: _____ Date: _____

KERNERSVILLE EYE SURGEONS

Notice of Health Information Practices Summary

Your Medical Record: Each time you visit a hospital or a physician, a record is made of your visit. This information, commonly known as a medical record, contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. The confidentiality of your medical record is protected under the state-specific and federal law.

Your health information rights: Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

Our Responsibilities: Kernersville Eye Surgeons is required by the federal privacy rule to maintain the privacy of your medical record and to provide you with a notice of our legal duties and privacy practices.

Uses and Disclosures for treatment, payment, and health care operations: Kernersville Eye Surgeons will use your health information to treat you. We will provide other providers or hospitals with copies of your medical record to assist them in treating you, should that become necessary we will also use and disclose health

information about you to make appointments with you.

Kernersville Eye Surgeons will use your health information for payment. The information on a bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Kernersville Eye Surgeons will use your health information for regular health operations to assess the quality of your care.

Kernersville Eye Surgeons will disclose your health information to business associates, such as medical Transcription or billing Service, so that they can perform the job we have asked them to do.

Uses and disclosures that we may make unless you object: You have the right to object to certain situations is which Kernersville Eye Surgeons may disclose information from your medical record.

Disclosures Permitted without Consent: Kernersville Eye Surgeons is required by state and federal law to disclose health information from your medical record under specific circumstances

Uses and Disclosures Specifically Authorized by you: Kernersville Eye Surgeons expects to make other uses and disclosures of your protected health information only on the basis on specific written authorization forms signed by you.

To report a problem: You have the right, under federal law, to report a problem or file a complaint about how your personal health information is being handled you can do this directly with Kernersville Eye Surgeons or to the Secretary of Health and Human Services is Washington, D.C

Kernersville Eye Surgeons will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed Notice of Privacy Practice to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our office and have copies available for distribution.

KERNERSVILLE
EYE SURGEONS

Medical Information Release Form (HIPPA Release Form)

Release information to:

Check all that Apply:

- Spouse:_____

- Child(ren):_____
- Relative/ Friend/ Other:_____
- Information not to be released

I authorize the release of the checked information above, unless I revoke that right at any time in writing. Otherwise the Release of information will remain in effect. **Please be aware any person(s) not listed on your release form will not have the right to any of your information by law.**

Messages:

It is ok to leave a detailed voicemail: **YES** **NO**

Check all that apply:

- All information
- Financial
- Medical Information
- Appointment Time
- Lab Results
- Other Information as described:_____

Best Contact Number: **Check all that apply:**

- Home:_____
- Work:_____
- Cell:_____
- NONE

Please be aware the person(s) that you have designated on your HIPPA release form gives us permission to also leave information with him/her. Also, I **understand** that **Kernersville Eye Surgeons** may leave a voicemail of any information checked above on the number list.

Signature: _____Date:_____