MT. PLEASANT EYE SURGEONS
874 Whipple Road, Suite 200 • Mount Pleasant, SC 29464
Phone: (843) 277 - 6600 • Fax: (843) 405 - 0434
office@mtpes.com

NICOLE LEGARE, MD

PATIENT DEMOGRAPHICS

First Name:_____Last:_____MI:_____

Date fBirth_____SS#:_____Email:_____

Phone#_____Cell#:_____

Address:_____

City: _____State: _____Zip Code_____

Employer:

_____Work#:_____

Emergency Contact:

_____

Phone#:_____Relationship:_____

Primary Care Physician:_____Phone#:_____

Insurance:

Primary Insurance: _____ Policy Hold Name_____

Secondary Insurance: _____

Pharmacy: _____ Phone#: _____

How did you hear about us:_____

Signature: _____Date: _____

MT. PLEASANT EYE SURGEONS

874 Whipple Road, Suite 200 • Mount Pleasant, SC 29464 Phone: (843) 277 - 6600 • Fax: (843) 405 - 0434 office@mtpes.com

NICOLE LEGARE, MD

REFRACTION POLICY & ACKNOWLEDGEMENT OF RECEIPT

What is a refraction? Refraction is the test that determines how much optical error (nearsightedness, farsightedness, or astigmatism) is present in your eyes and determines your glasses prescription. More importantly, refraction gives your doctor valuable information about your best possible vision and provides essential medical information to help full assess your eyes and identify problems. A lack of refraction may limit your complete eye exam.

> Example: If your vision has declined, the refraction helps your doctor determine if the decrease in vision is from the need for glasses or another medical problem. It is also required prior to cataract surgery to have a refraction on file for your insurance company.

When is a refraction recommended? Typically, we recommend refraction for every new patient, at least once per year for established patients, and for anyone with a decrease in vision.

Will my insurance cover the refraction fee? The vast majority of *medical/health* insurance plans (including Medicare) do NOT cover the cost of the refraction. Some *vision* plans pay for a refraction, but we are not in network with all vision plans. We cannot file insurance on both the medical and routine vision plan for the same visit.

How much is a refraction? <u>We charge $45 for ALL refractions, regardless of whether or not you get a new glasses prescription.</u> The fee is in addition to any office co-pay or deductible for which you are responsible and is **<u>due at the time of service.</u>** Should your plan pay us for the refraction, we will reimburse you accordingly.

Can I decline a refraction? The technician or physician will inform you **BEFORE** a refraction needs to be performed and you will have the option to decline, with the understanding that declining the refraction may be limiting your physician's evaluation of your eyes.

> *Note: Should you decline refraction at your visit, and then lose or break your glasses, we will not be able to provide a replacement glasses prescription unless we have a current refraction done here within the last 1 year.*

Acknowledgement: I have read the above/attached information and understand that the refraction may be a non-covered service and I accept full financial responsibility for the cost of the service and understand it is due at the time of service unless it is covered by my insurance.

_____ _____

Patient's Name (printed) **Date**

_____ _____ _____

Patient Signature (Legally responsible applicable) **Relationship to patient** **Staff Witness**

Financial Policy Agreement

Thank you for choosing Mt Pleasant Eye Surgeons for your eyecare needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain good eye health; as with any type of medical care, understanding the financial impact and responsibilities associated with that treatment is also important. It is recommended that you read this financial policy agreement before receiving treatment.

Mt. Pleasant Eye Surgeons accepts cash, check and most credit cards. We will bill your insurance carrier as a courtesy to you.

To be treated by Mt. Pleasant Eye Surgeons, you must understand, agree and initial the provisions set forth below.

____I understand that if I need to reschedule my appointment, I must call the office 24 hours before said appointment. Failure to do so will result in a $25.00 fee.

____I understand that my healthcare policy is an agreement between myself and the insurance company. If the insurance company has not paid my claim within 60 days of treatment, I agree to contact them to facilitate payment.

____I understand that insurance co-payment and deductibles are due prior to receiving treatment.

____I agree that any payments sent directly to me are the property of the Provider. I agree to immediately forward the Provider all payments, explanation of benefits and correspondence sent directly to me from all third party payors related to the care rendered by the Provider. I agree that failure to do so will make me responsible for the entire charge (unless there are contractual obligations between Provider and Third Party Payor disallowing balance billing)

____I understand that all treatment charges are my responsibility whether the insurance company pays or not. I understand that not all services are a covered benefit and that I am financially responsible for and agree to pay all charges not paid by my insurance or third party payor within 60 days from time of service. This includes, but is not limited to, deductibles and co-insurance unless there are contractual obligations between provider and third party payor disallowing balance billing.

___I understand that I am financially responsible for any increased co-pays, deductibles and non-covered services provided on an out-of-network basis. As a courtesy to our patients, Mt Pleasant Eye Surgeons will obtain any pre-authorization and/or pre-certifications required prior to services being performed; however, I understand that it is my responsibility to ensure these pre-authorization and / or pre-certifications are obtained. This is not the responsibility of my provider. I also acknowledge that no guarantees have been made by any employee or the provider, physician or any other party about my treatment including whether it will be paid for by any third party payor and/or whether the provider is in or out of my network with my third party payor.

___I agree to fully cooperate with Providers to assist in their efforts to get claims paid on my behalf. It is my sole responsibility to determine what portion of the care rendered by the provider will be covered by my third party insurance and that by receiving said care; I agree to pay any and all charges not paid for by my third party payor within 60 days of receiving said care. I unconditionally guarantee payment of these charges.

___I agree to promptly notify provider of any changes in my health insurance plan and/or coverage including change in my address and/or phone number. I understand that my failure to do so will make me fully responsible for the charges as this is not the responsibilit5y of the provider. In consideration of the services furnished to me, I hereby agree to pay any balance due within thirty (30) days from presentation of my bill and that providers are not required to honor limiting notations I make on a payment.

We appreciate your trust in us and thank you for the opportunity to serve your health care needs. If you have any questions or concerns about our payment policies, please ask to speak with a financial counselor either by phone or in person.

ASSIGNMENT AND RELEASE: I authorize payment to be made directly to Mt.Pleasant Eye Surgeons and fully understand that I am the responsible party for all charges incurred by me or my dependents at the facility. I also authorize the release of any and all information required to collect and process my claims. If legal action becomes necessary, I agree to pay all collection fees.

Responsible Party (please Print) Date

HIPAA RELEASE & NOTICE OF DISCLOSURE

Mt Pleasant Eye Surgeons is authorized to release protected health information about the above named patient to the entities named below.

May we leave appointment reminders, prescription information, and messages to call our office back on your answering machine or voicemail?

☐Yes ☐No

May we share information with your Attorney?

☐Yes Attorney's Name: _____ ☐No ☐N/A

May we share information with your spouse, caretaker, or child(ren)?

☐Yes ☐ No

If yes, please list their name(s): _____

May we share information with your employer? ☐Yes ☐No

If yes, please list the contact person at your employer: _____

Rights of the patient: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by sending a written notification to Mt Pleasant Eye Surgeons. I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoke by the patient.

Acknowledgement of Receipt of Notice of Privacy Practice: I hereby acknowledge that I received a copy of the Mt Pleasant Eye Surgeons Notice of Privacy Practices. Copies follow this form.

_____

Patient or Patient Representative Signature

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient or Patient Representative Signature