PATIENT FINANCIAL RESPONSIBILITY POLICY
Louisiana Center For Eyes, LLC

Patient Name:_____
DOB:_____

Payment for Services Rendered PLEASE BE AWARE THAT PAYMENT IS DUE AT CHECK-IN. Any charges for un-insured patients, any copayments, deductibles, co-insurance amounts or non-covered services are to be paid in full. If this is a scheduled visit and you are unable to meet your financial obligation, our staff can assist you in rescheduling the appointment. We accept cash, and the following credit cards: American Express, Discover, MasterCard and Visa. **_____ Patient initials _____ Date**

Vision Plans Routine examinations are covered by a vision plan, like VSP, Eyemed, Always, etc.. Those benefits are used to provide a Routine examination to measure and prescribe glasses and/or contact lenses for non-symptomatic patients.

Medical vs. Routine during a routine examination the doctor may determine that a medical condition exists that requires additional testing or treatment. You will be advised that the medical treatment is necessary and that your visit will be converted from a routine vision examination to a medical examination and treatment. If you elect to proceed with the medical visit, you will be responsible for any copayments, deductibles, or refraction fees. Payment of these amounts will be due at check-in. **_____ Patient initials _____ Date**

Insurance It is important for you to be an informed consumer who understands the specifications of your insurance policy (both medical and vision if applicable). Your Health/Vision policy is a contract between you and your insurance company or employer. In order for us to file claims with your insurance company, you must provide us with a current insurance card or vision plan information. If you do not have a current insurance card or the information necessary to file a claim, you will be responsible for full payment at the time of service.

Guarantor Any guarantor over the age of 18 will be held responsible for all charges incurred. If another party is responsible for your account, you must pay the balance of any deductible, copayment, co-insurance or materials (glasses or contact lenses) in full and negotiate repayment with them outside of the office.

HIPAA The Health Insurance Portability and Accountability Act and the subsequent privacy and security rules require that patients have access to a copy of our HIPAA policy for review. If you have not read our policy, please ask the front desk to provide you with a copy or you can find it on our website. A HIPAA form must be completed by each guarantor and for patients under age 18, by a parent or guardian, indicating who our staff can speak with regarding medical treatment or financial information.

Deductibles, Co-insurance and Non-covered
A deductible
Is an amount that you must reach prior to the insurance company paying benefits. Our insurance department verifies benefits and determines what portion of the deductible is met prior to your visit. If you have not met the deductible, your service would be paid in full at check-in, based on the fee schedule for your plan, and your charges will be filed with your insurance to apply toward the deductible.

Co-insurance is the percentage of a service that is your responsibility to pay once the deductible has been met. Those amounts vary based on whether the provider is “in network” or “out of network”.

Non-covered services

Are services provided that are not covered by your health or vision plan for whatever reason. It may be a specific exclusion for cosmetic services, such as Mibo flo Treatment, for a non-medical condition, or it may be testing related to a routine diagnosis that is not covered by your medical benefits.

High Deductible Plans

If you cannot provide proof via an explanation of benefits from your insurance company that you have met your deductible for medical services, **you will be asked to pay in full for all services rendered. Payments for surgical services are collected prior to the surgery for professional fees.**

Medicare

Medicare provides services to patients for medical conditions only. Those services are not limited if they are medically necessary. Medical conditions may include cataracts, glaucoma, diabetes, dry eyes, retinal issues, and visits after cataract surgery or other eye surgery as well as many other diseases and conditions. Medicare does not cover refractions (a refraction is the examination used to determine your prescription for glasses or contacts) If you elect to have a refraction done during a medical visit, or if one is required to determine your need for cataract surgery, you will be required to pay the fee for the refraction. All other tests as well as the examination will be billed to Medicare. If you do not have a supplement to your Medicare you will be required to pay all charges up to the deductible amount and the 20% co-insurance at check-in. If you have met your Part B Deductible, please bring a copy of your Medicare Explanation of Benefits with you to your visit. We will collect only the co-insurance amount in these cases. If your Medicare Supplement has a copayment or does not pick up the Part B deductible, you will be asked to pay these charges at check-out as well.

Billing/Collections

If for some reason the amount collected at check-in is less than the amount you should have paid, any amount due will be reflected on our monthly statement. Payment is expected when the statement is received. Patients who ignore statements, or our attempts to collect past due amounts may have their ability to schedule appointments hindered, may be dismissed from the practice or may be turned to a collection service for further action. Patients who are dismissed from the practice will be notified in writing and will be given 30 days to find alternative vision care. Appointments for emergency visits will be allowed during the 30 days but payment of an emergency visit will be collected at check-in with any additional amounts due collected at check-in.

Printed Name of Patient:_____

Signature of Patient or Legal Guardian_____ Date:_____

I understand that my medical insurance does not generally cover the $30.00 fee for a refraction necessary to obtain an updated glasses prescription and am aware that I will be responsible for this amount at check-in. _____(Please initial) Date:_____

I am aware that I am scheduled for a routine examination and, am aware that should my visit today be determined to be medical, I will be responsible for any copayment, deductible and co-insurance amounts PLUS the $30.00 refraction fee._____ (Please initial) Date:_____

Patient Regisration Form

Patient Name: _____ Social Security Number:_____-_____-_____

Date Of Birth:_____/_____/_____ Sex: Male/Female (Circle One)

Married/Single/Divorced/Widow

Address:_____

(Street) (City, State, Zip)

Cell Phone:(____)____-____ Alternate Number:(____)____-____ Email:_____

Primary care Physician: Pharmacy:

Primary care Physician:_____ Pharmacy:_____
Location
Emergency Contact:_____ Phone Number:(____)____-_____

Insurance Information

Vision Plan Name:_____Member ID Number:_____
Medical Insurance Plan:_____Member ID Number:_____
Medical Insurance Plan:_____Member ID Number:_____

Eye History

Date of Last Eye Exam:_____Currently Wear: **(circle one)**Glasses/Contacts
Is patient instrested in being fitted for Contacts: (circle one) Yes/No
How did you hear about Louisiana Center For Eyes, LLC:_____

Have you are a family member experienced or been Treated for, any of the following? Circle all that apply				**Are you currently experiencing or have experienced any of the following? Check all that apply:**	
Cataracts	Yes No	Family		____Blurry Vision	_____Sandy Gritty Feeling
Crossed Eye	Yes No	Family		____Burning	_____Dryness
Glaucoma	Yes No	Family		____Discharge	_____Glare Day Or Night
Lasik or RK	Yes No	Family		____Excess Tearing	_____Eye pain
Lazy Eye	Yes No	Family		____Floaters	_____Halos
Macular Degeneration	Yes No	Family		____Headaches	_____Itching
Retinal Dettachment	Yes No	Family		____Light Flashes	_____Light Sensitivity

Do you smoke:(circle one): Yes/No How many packs a day:_____ _____Eye Infection

I certify that I am (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Lousiana Center For Eyes, LLC to applied to my account for services rendered. I fully understand that I am financially resposible for charges incurred in the event that my insurance denies payment. I am aware there may additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges, plus any Deductibles, CoInsurance and uncovered charges that apply.

Patient Signature:_____
Date:_____

Medical History

Have you or a family member experienced or been treated for, any of the following? (Circle all that apply)

AIDS/HIV	Yes No	Family	Allergies	Yes No	Family
Arthrisits	Yes No	Family	Asthma	Yes No	Family
Blood/Lymph Disorder	Yes No	Family	Cancer	Yes No	Family
Diabetes	Yes No	Family	Heart Disease	Yes No	Family
High Blood Pressure	Yes No	Family	Lupus	Yes No	Family
Ear, Nose, Throat Condition	Yes No	Family	Kidney Disease	Yes No	Family
Gastrointestinal Condition	Yes No	Family	Seizures	Yes No	Family
High Cholesterol	Yes No	Family	Stroke	Yes No	Family
Neurological Condition	Yes No	Family	Skin Condition	Yes No	Family
Anxiety/Depression	Yes No	Family	Thyroid Disease	Yes No	Family

Current Medications

Current Medications: (Prescription and over the counter medications)
Drug
Allergies:

Allergies:_____
Medication Name:_____ Dosage:_____ How Often:_____
Medication Name:_____ Dosage:_____ How Often:_____
Medication Name:_____ Dosage:_____ How Often:_____
Medication Name:_____ Dosage:_____ How Often:_____

Privacy Practice

I Acknowledge that I was provided a copy of the Notice of Privacy Practice and that I have read(or had the opportunity to read if I so choose and Understand the Notice

Patient Name:_____ Parent or Authorized Representative_____
Signature:_____
Date:_____

Authorized to Disclose Protected Health Information

I Voluntarily authorize and request disclosure of all my medical records and other information related to my health care. I hereby give permission for Louisiana Center For Eyes , LLC to request and release my personal information. The Following person(s) or organization(s) are premitted to provide the information to eye and/or systemic health records: Primary Care Doctor:_____ Previous Eye M.D._____
Louisiana Center For Eyes, LLC is permitted to receive and use the informaion for diagnosis and treatment of the following patient:
Patient Name:_____ Date of Birth:_____
Signature:_____

Dry Eye Questionaire

Please answer the following questions by checking the box that represents your answer. Select only one answer per question.

1. Report the type of **Symptoms** you experience and when they occur:

Symptoms	At this Vist Yes	No	Past 72 hours Yes	No	Past 3 Months Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report The **Frequency** of your symptoms using the rating list below:

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0=Never 1= Sometimes 2=Often 3=Constant

3. Report the **Severity** of your symptoms using the rating list below:

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0= No Problems

1=Tolerable-not perfect
2=Uncomfortable-irritating, but does not interfere with my day
3=Bothersome-Irritating and interferes with my day
4=Intolerable-unable to perform my daily tasks

4. Do you use eye drops for lubrication? ____Yes ____No If yes how often:_____

Name:_____ Date:_____	**Yes**	**No**
Have you, caregiver or anyone in your household have travelled outside the US in the past 2 weeks (14 days) IF YES, WHERE _____		
Have you, caregiver or anyone in your household have travelled outside of Baton Rouge in the past 2 weeks (14 days) IF YES, WHERE _____		
In the past 2 weeks (14 days) have you, caregiver or anyone in your household had contact with any person suspected to have contracted coronavirus (COVID-19)? Including being tested for COVID-19, & being in self isolation for COVID-19		
In the past 2 weeks (14 days) have you, caregiver or anyone in your household had contact with any person confirmed to have contracted coronavirus (COVID-19)?		
Have you or caregiver currently been exposed to someone with flu-like symptoms (cough, shortness of breath or fever)		
Have you or Caregiver been hospitalized in the last 14 days, if so for what symptoms _____		
PLEASE CHECK IF YOU OR CAREGIVER ARE HAVING ANY OF THE SYMPTOMS BELOW		
FEVER		
COUGHING		
SORE THROAT		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
MUSCLE ACHES		
STOMACH PAINS		
VOMITING/DIARRHEA		
PINK/RED EYES		
RASH		
FATIGUE OR FEELING UNWELL		

Covid 19 Questionnaire

By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice.

Patient/Caregiver _____ Date _____

Patient/Caregiver:____________________________ Date:_________________________