SUMMIT Eye Care P.A.
Advanced Eye Care Solutions

Patient Information Form

Date______________________________ **Name of Referring Doctor**______________________________

Name of Family Doctor______________________________

Miss **Ms.** **Mrs .** **Mr.** **(Marital Status:** Single Married Div Widow Life Partner**)**

Name______________________________ (First / Middle / Last) **Birthdate**____________________ **Age**______________

Address______________________________ **County**______________________________

City______________________________ **State**______________ **Zip**____________________

Social Security #______________________________

Employer______________________________

Home Phone______________________________ **Occupation**______________________________

Cell Phone ______________________________ **Work Phone**______________________________

Email Address______________________________

Preferred Language
- o English
- o Spanish
- o Unknown
- o Other

Ethnicity
- o Hispanic or Latino
- o Not Hispanic or Latino
- o Refused / Declined

Race
- o Alaska Native
- o American Indian
- o Asian
- o Black or African American
- o Caucasian / White
- o Native Hawaiian or Other Pacific Islander
- o Multiracial
- o Refused / Declined

New Patient: How did you learn of our office?
O Family____________________ O Friend ____________________ O Insurance List____________________
O Yellow Page O Other

INSURANCE INFORMATION

Primary Insurance______________________________ **Secondary Insurance**______________________________
Primary Policy ID#______________________________ **Secondary Policy ID#**______________________________
Policy Holder Name______________________________ **Secondary Policy Holder Name**____________________
Relation____________________**Birthdate**______________ **Relation**____________________**Birthdate**______________
Vision Plan______________________________

UNDER 18 YEARS OF AGE OR A STUDENT
Name of Financially Responsible Person______________________________ **Relation**________________
Address____
Phone______________________________ **Alternate Phone**______________________________

EMERGENCY CONTACT Name______________________________ **Relation**______________ **Phone**______________

PRIVACY RELEASE: Due to the privacy regulations, permission is required before any information can be shared with others. If you have anyone who could possibly contact our office on your behalf and want us to share your health information, please list their names below.

Name______________________________ **Relation**__________ **Phone**____________________
Name______________________________ **Relation**__________ **Phone**____________________

Do we have permission to leave appointment confirmation on your answering machine? O YES O NO

Signature______________________________ **7/2013**

Vic Khemsara, M.D.
Keith Biggs, O.D.

DILATING DROPS

PURPOSE: dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the interior of the eye. This enables a better view of the optic nerve, retina and blood vessels in the eye. Detection of any changes is crucial in preventing loss of vision due to conditions such as diabetes, glaucoma, retinal tears/detachments, and macular degeneration.

SIDE EFFECTS:

- ***frequently blurs vision*** for a length of time which varies from patient to patient. This blurring of vision can last from 3 to 6 hours.
- ***may make bright lights bothersome***. It is not possible for your ophthalmologist to predict how much your vision will be affected. It is recommended that sunglasses be worn and a pair will be provided for you if needed.
- ***driving may be difficult*** immediately after an examination. Most patients drive themselves as the dilation blurs near vision and not your distance vision. However, if you are uncomfortable driving, please be sure to have someone come with you to your appointments as it is most likely you will be dilated.
- ***an adverse reaction*** such as acute angle-closure glaucoma can be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Vic Khemsara, Dr. Biggs and/or such assistants as may be designated to administer dilating eye drops. The eye drops are necessary to diagnose and/or follow my condition. This authorization is in effect until I deem otherwise.

______________________________________ __________________________

PATIENT /or person authorized to sign Date

3073 Trenwest Drive Winston-Salem, NC 27103 Tel: (336) 765-0960 Fax (336) 765-7453
www.summiteyecare.net

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Keith Biggs, O.D.

PATIENT CONSENT FORM

The Dept. of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as labs that only interact with physicians) and may have to disclose health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse treatment should you choose not to disclose your Personal Health Information (PHI).

If you give consent in this document, at some future time you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice. My signature below acknowledges that a copy of Privacy Practices for Summit Eye Care has been made available to me.

SIGNATURE_______________________________________ **Date**____________________

Authorization for Care and/or Treatment: Knowing that I am suffering from a condition requiring health care treatment, I voluntarily consent to such treatment including diagnostic procedures and medical treatment ordered by my physician. I also voluntarily consent to treatment provided by assistants as judged necessary by my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the results of treatments or examinations by my care givers. This form has been explained fully to me and I certify that I understand its contents. Consequently, I hereby release Summit Eye Care, its employees, agents, and representatives from such legal responsibilities regarding my knowledge of and consent to medical treatment and from such other legal responsibilities to the extent permitted by law.

Authorization for Release of Medical Information: The undersigned authorizes Summit Eye Care or its agents to disclose any medical information currently existing or developed during the course of treatment to: 1) the Social Security Administration or its intermediary, which may be needed for or related to a Medicare or Medicaid claim; 2) state or federal agencies that provide benefits and require such information; 3) a referring physician or facility to which the patient may be referred; 4) third party payers or others involved in processing a claim for benefits for services rendered; and 5) federal, state or local agencies as required to comply with laws and regulations.

Financial responsibility and assignment of Insurance Benefits: The undersigned guarantees payment to Summit Eye Care and/or Accent Optical of all charges for services provided to the patient. I authorize direct payment of surgical and medical benefits by insurance be made payable to Summit Eye Care and/or Accent for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by myself in applying for payment under title XVIII and XIX of the Social Security Act is correct. I also certify that the commercial insurance information I have provided is accurate and complete. If I do not obtain the proper required referrals, I understand that *I am personally responsible for any fees not paid due to incorrect information or lack of referrals* and for any *"routine"* exams performed which are not covered by my insurance.

SIGNATURE_______________________________________ **Date**____________________

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MEDICAL OR ROUTINE VISIT?

Eye Care practices are the only medical offices which deal with 2 different insurance plans. One is for medical problems and one is for examinations to determine if refractive corrections are required to improve vision.

Our insurance personnel's goal is to file claims properly to maximize the payments for our patients. Your assistance is required. Please help us by providing the following information.

- Present all current insurance cards at each visit.
- Obtain referrals if required from your Primary Care Physician. Bring a copy of the referral with you or follow up to be certain it has been sent to our office.
- Alert our office if your insurance plan requires precertification for procedures.
- It is necessary to let us know ***before*** your exam if you have a Vision Plan (such as VSP, Davis, Eyemed, etc.). Insurance carriers will not provide reimbursements for "medical" and "routine" examinations on the same day. Typically, medical issues are handled during one visit and the routine care is on a separate visit. (Insurance guidelines-not Summit Eye Care's)

  Medical exam*: Follow up appointment scheduled by eye care provider for medical diagnoses such as diabetic, glaucoma suspect, dry eye, discomfort, sudden decrease in vision, foreign body sensation, etc. which produces a medical diagnosis.*

  Routine eye exam*: defined by insurance companies as an office visit for the purpose of checking vision, screening for* ***eye*** *disease, and/or updating eyeglass or contact lens prescriptions.* ***Routine eye*** *exams produce a final diagnosis, like nearsightedness, farsightedness or astigmatism.*

Incorrect or incomplete insurance information may result in your being responsible for any unpaid claims. We value each patient and want to obtain the maximum insurance reimbursements on your behalf. Please let us know if we can assist in any way.

PLEASE HELP US HELP YOU.

Please initial the type insurance we will be using for today's exam:

Medical ____________________ Vision____________________

*Some insurance carriers will not cover routine and medical exam on same day.

Pt. Signature __________________________________

Date____

4/2019