Chart # _____

WELCOME TO MISSISSIPPI EYE ASSOCIATES

We are glad you are here today for your exam, and we will be with you shortly. Before we get started, our medical doctors, Ophthalmologists, wanted to remind you of a couple of things.

1. **We are happy to participate in a number of local vision plans such as VSP, Davis Vision, Always Care, Spectera, and Superior. These plans are for routine care, glasses, and contact lens exams.**
2. **IF DURING YOUR EXAM, A MEDICAL CONDITION IS DISCOVERED, ALL, OF THE ABOVE VISION PLANS REVERT COVERAGE BACK TO YOUR MEDICAL INSURANCE POLICY.**

Medical eye issues include things like cataracts, glaucoma, macular degeneration, both dry and wet, diabetes, diabetic retinopathy, hypertension, macular edema, and treatment with high risk medicines like Plaquenil or Methotrexate, or sending written letters / reports to your medical doctor.

This does not mean we cannot calculate a glasses or contact lens prescription, but the exam then becomes a medical exam. As a result, specialist copays and deductibles will come into play depending on the type of insurance you have, and will be are collected at checkout including charges for contact lens fitting, and your refraction.

We will do everything possible to keep you informed during the exam process so that there are no surprises at the time of checkout. We want you to be able to use your vision policy when it is appropriate.

Thank you for understanding, and allowing us to participate in your care.

Sincerely,

Your Mississippi Eye Associates Team

_____ _____

Signature **Date**

MISSISSIPPI EYE ASSOCIATES

James D. Sutton, M.D.

Benjamin W. Appelo, M.D.

Acct#: _____

PERMISSION OF CONTACT / HIPAA ACKNOWLEDGEMENT FORM

Date: ____/_____/_____

I, _____, give Mississippi Eye Associates, doctors and staff permission to contact me by phone or mail regarding appointment reminders, billing questions, test results, and information need to process insurance claims.

I also give Mississippi Eye Associates permission to contact me about payment on my bill.

I give Mississippi Eye Associates permission to talk to the following persons regarding my account.

_____	_____
Name	**Phone Number**
_____	_____
Name	**Phone Number**

FORM OF ACKNOWLEDGMENT..... HIPAA ACT OF 1996

By signing this form you are acknowledging that we have advised you of the Privacy Act as required by law. Mississippi Eye Associates adhere to the rules of the HIPAA ACT adopted to law in 1996.

_____ _____

MISSISSIPPI EYE ASSOCIATES

MEDICAL HISTORY

Name: _____ **Chart#:** _____

Date: _____/_____/_____

Check if you have/had problems with any of the following:

____ Lazy Eye
____ Corneal Disease
____ Blurry Vision
____ Muscle Surgery
____ Glaucoma
____ Red Eyes
____ Cataract
____ Chronic Eye Infection
____ Double Vision
____ Retinal Problems
____ Sty/Lid Infections
____ Eye Pain
____ Macular Degeneration
____ Dry Eyes
____ Mucous/Drainage
____ Corneal Transplant
____ Tearing

List any eye surgeries or injuries that you have had:

TYPE OF SURGERY/INJURY	TREATING PHYSICIAN	DATE

Do you wear glasses? ___Yes ___ No Do you wear Contact Lenses? ___ Yes ___ No
Date of last exam: _____/_____/_____
Do you have a family history of: ____ Diabetes ____ Glaucoma ____ Macular Degeneration ____ Other _____
Have you tested positive for HIV? ____ Yes ____ No
Do you smoke now? _____ Have you ever smoked? _____ How long? _____
Are you allergic to any medicines? _____ No _____ Yes If yes, please list: _____
_____
Name of your family doctor: _____
Name of Pharmacy(and Phone#):_____

R**eview of Systems (Please check if you have/had problems with the following):**

____ Diabetes
____ Skin Disorders
____ Thyroid Disorder
____ High Blood Pressure
____ Neurological Disorders
____ Fever/Weight Loss
____ Heart Attack
____ Allergy/Immune System
____ Ear/ Nose/ Throat
____ Stroke
____ Blood Disorders
____ Gastrointestinal

List any major surgeries that you have had: _____

List all medications you are currently taking, including eye drops:

MEDICATION	DOSAGE	FREQUENCY	INDICATION

MISSISSIPPI EYE ASSOCIATES

James D. Sutton, M.D.

Benjamin W. Appelo, M.D.

FINANCIAL POLICY

Acct# _____

Proof of Insurance:
Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk of any changes in insurance coverage or when the cause of treatment should be billed to an auto insurance, liability company or worker's compensation, instead of your regular primary insurance.

Payment is Due At Time of Service:
We accept cash, personal checks, debit and credit cards. All deductibles, co pays and non covered services are due at the time of service unless payment arrangements have been made in advance. If you have Medicare but Medicare may deem the treatment as "medically unnecessary" according to HCFA payment guidelines, you will be required to sign a waiver (Advanced Beneficiary Notice) prior to treatment and the service is due at the check out counter. All Medicare patients will be required to pay 20% co pay based upon the current Medicare Fee Schedule at the check out counter unless proof of a secondary policy is evident.

Billing, Payments, and Overpayments:
If an overpayment is made by you on the account, a refund will only be issued if there are no other outstanding debts on other accounts containing the same guarantor or financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change of address, phone, or employment. All balances are due in full within 14 days of billing date. If you cannot pay the balance in full within 14 days, please contact our office about arranging a payment.

Past Due and Delinquent Accounts:
Failure to meet your financial obligations may result in reporting you to a collection agency, who will report you to the credit bureau, filing for a judgment in small claims court of other collection action against you as determined by the collection agency; and you may be terminated as a patient from this facility. All collection fees, attorney fees, court costs, and other expenses related to collecting your account will be added to your outstanding balance.
******We will file your insurance for you, but after 90 days from date of service if payment has not been received from your insurance company, we will move that balance to the patient's responsibility. We do file as a courtesy to you, although any conflicts with your insurance company will have to be handled by you.
******Charges for refractions are due at the time of service. The refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance does not cover this as they consider it to be a routine service. Failure to pay for the refraction at the time of checkout will result in your prescription being held until payment is received.

Vision Plan Policy:
Each patient is responsible for understanding the benefits of his or her insurance policy or vision plan. If you have a medical eye diagnosis some vision plans **WILL NOT** cover your visit. The cost of your visit may need to be picked up by your medical insurance. If during your ophthalmic eye exam you are found to have a medical eye diagnosis your vision plan may still help in covering the cost of your new glasses or contact lens. There are many health care plans currently in the marketplace. We will help each patient navigate this complicated industry. **UNTIMATELY YOU ARE RESPONSIBLE FOR THE COST OF YOUR CARE.**

_____ _____/_____/_____

MISSISSIPPI EYE ASSOCIATES

James D. Sutton, M.D.

Benjamin W. Appelo, M.D.

PATIENT INFORMATION FORM

Today's Date: ____/____/____ Sex: _____M _____ F **Chart#:** _____

Name: _____ DOB: ___/___/___ Age: _____SS#:_____
Last First MI

Address: _____
Street (or Location) City State Zip Code

Home Phone: (_____)_____-_____ Cell: (_____) _____ -_____ Work#: (____) _____-_____

Alternate Phone #: (_____) _____-_____ **Email Address**: _____

Mailing Address: _____
Street (or Location) City State Zip

Employer's Name: _____ Employer's Address: _____

City: _____ State: _____ Zip Code: _____ Phone#: (____)____-_____

Marital Status: ____Single ____ Married ____ Divorced _____Widowed _____Separated
Please list the nearest relative (not living with you) _____ Phone#: (____) ____-_____

GUARANTOR INFORMATION

Responsible Party's Name: _____ Relationship to Patient: _____
DOB: _____/_____/_____ Sex: ____M ____F SS#:_____
Address: _____
Street (or Location) City State Zip Code
Employer's Name: _____ Address: _____

INSURANCE INFORMATION

Primary: Name of Insurance Company: _____
Insured Name: _____ Insured DOB: ___/____/____ SS#:_____
Policy #: _____ Group #: _____ Relation to Patient:_____

Secondary: Name of Insurance Company:_____
Insured Name: _____ Insured DOB: ___/____/____ SS#:_____
Policy #: _____ Group #: _____ Relation to Patient:_____

I hereby authorize Mississippi Eye Associates to complete the proper process of medical reimbursement from my insurance carrier (as assigned under my insurance policy). By signing this form, I also give the Physician(s) of Mississippi Eye Associates authorization to treatment me.

_____ _____/_____/_____
Signature of Patient or Parent / Guardian **Date**