Piedmont Eye Associates

Patient Information

Name:			Social Security Number:	
Email Address:			Home Phone:	Cell Phone:
Mailing Address:				
City:	State:	Zip:	Date of Birth:	Sex: M / F

Required Information

Marital Status (Circle One): Single Married Divorced Widowed	**Race (Circle One):** Asian African-American Caucasian Hispanic Indian Other: Decline
Ethnicity (Circle One): Hispanic Non-Hispanic Decline	**Language (Circle One):** English Spanish French Russian Japanese Chinese Other:

Primary Policy Holder Information

Name:	Date of Birth:
Social Security Number:	Phone Number:

Person Responsible (If Patient is a minor, Parent Information is REQUIRED)

Name:	Date of Birth:
Social Security Number:	Phone Number:
Street Address:	
City, State, Zip:	

Emergency Contact

Name:	Relationship:
Home Phone:	Other Phone:

Release

_____ (Initial) I **DO NOT** authorize any information to be disclosed to any other parties except to me as the patient.

_____ (Initial) I **authorize** the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Piedmont Eye Associates.

Name/Relationship:	Phone Number:
Name/Relationship:	Phone Number:

Patient Signature: _____ Date: _____

Piedmont Eye Associates

Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information: Your protected health information will be used by **Piedmont Eye Associates** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices: **Piedmont Eye Associates** is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. PLEASE REVIEW IT CAREFULLY.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your protected health information. **Piedmont Eye Associates** may or may not agree to restrict the use or disclosure of your protected health information (see authorization).

If **Piedmont Eye Associates** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices: **Piedmont Eye Associates** reserves the right to modify the privacy practices outlined in the notice. I understand Piedmont Eye Associates will notify me of these changes via the method I have authorized or upon my next appointment.

Signature: I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to **Piedmont Eye Associates** to use and disclose my health information in accordance with this consent and the notice provided.

I give **Piedmont Eye Associates** permission to access my medication history. _____ (Initials)

_____

Name of Patient (please print)

_____ _____

Signature of Patient (or person authorized to sign for patient) Date

Piedmont Eye Associates

Authorization for Release
Use of Cell Phone, Email & Voicemail Communications

Name: Date of Birth:

Preferred Method of Contact

Please circle one and write the number on the line below:

Home Phone	Mobile Phone	Other
_____	_____	_____

_____ (Initials) **I grant consent for Piedmont Eye Associates to contact me via wireless telephone calls.** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify Piedmont Eye Associates to the contrary in writing.

_____ (Initials) **I grant consent for Piedmont Eye Associates to contact me via email.** If at any time I provide my email address at which I may be contacted, unless I notify Piedmont Eye Associates to the contrary in writing,

_____ (Initials) **I understand that cell phone, e-mail, and the use of voicemail communications are not secure forms of communication** and that confidentiality of any cell phone, e-mail, and voicemail information cannot be ensured.

**Certain providers in our practice do utilize Patient Portal, an online website where you can access your health information and communicate with our practice in a secure environment. Ask our front office staff if your provider is a participant in Patient Portal and how you can enroll. **

By signing below, I consent to receive communications, including but not restricted to billing and payment for items and services and communication from Piedmont Eye Associates, clinic, hospital, affiliates, contractors, servicers, clinical providers, attorneys, or its agents including collection agencies.

Patient or Patient Representative Signature: _____
Date: _____

PER HIPAA REQUIRMENT, **THIS FORM MUST BE COMPLETED <u>ANNUALLY</u>.**

Piedmont Eye Associates

Medical History

Date: _____

Patient Name: _____ DOB: _____

Primary Care Physician (Family Doctor): _____

Pharmacy (Name, Street, City): _____

Reason for Today's Visit: _____

Patient Medical History

- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer: Type? When? (explain below)
- ☐ Cardiac Arrhythmia
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes: Type 1 or Type 2
- ☐ Dialysis
- ☐ Elevated Lipids (High Cholesterol)
- ☐ GERD
- ☐ Headaches, Migraines
- ☐ Heart Disease
- ☐ Heart Valve Disorder
- ☐ Hepatitis: A B or C
- ☐ Herpes
- ☐ HIV or AIDS
- ☐ Hypertension (High Blood Pressure)
- ☐ Irritable Bowel Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction (Heart Attack): When?
- ☐ Osteoporosis
- ☐ Plaquenil/Hydroxychloroquine: Started? _____
- ☐ Rheumatoid Arthritis
- ☐ Renal Disease (Kidney Disease)
- ☐ Seizure Disorder
- ☐ Sjogren's
- ☐ Stroke: When? _____
- ☐ Thyroid Disease: Type? (explain below)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Please use this space to further elaborate on the above medical conditions: _____

_____

_____

Patient Ocular History

- ☐ Amblyopia (Lazy Eye)
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Glaucoma
- ☐ Herpes
- ☐ Keratoconus
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Retinal Tear
- ☐ Other: _____
- ☐ Other: _____

Patient Ocular Surgeries

Please circle L / R / or Both

- ☐ No Previous Surgeries
- ☐ Cataract Surgery: L / R / Both
- ☐ Corneal Transplant: L / R / Both
- ☐ Laser for Diabetic Retinopathy: L / R / Both
- ☐ Laser for Retinal Tear/Detachment: L / R / Both
- ☐ LASIK: L / R / Both
- ☐ Strabismus Surgery (Lazy Eye): L / R / Both
- ☐ YAG Capsulotomy: L / R / Both
- ☐ YAG Iridotomy (Glaucoma): L / R / Both
- ☐ Other:

***Continues on Next Page**

Piedmont Eye Associates

Current Medications

Please list or attach a list: _____

_____

_____

Eye Drops Used: _____

Patient Allergies

- ☐ Aspirin
- ☐ Beta Blockers
- ☐ Codeine
- ☐ Latex
- ☐ Penicillin
- ☐ Shellfish
- ☐ Sulfa
- ☐ Other: _____
- ☐ Other: _____

Patient Social History

- ☐ Do you smoke cigarettes? If yes, how many per day? _____ What age did you start? _____
- ☐ Do you smoke cigars? If yes, how many per day? _____ What age did you start? _____
- ☐ Do you use chewing tobacco? If yes, how much per day? _____ What age did you start? _____
- ☐ Do you drink alcohol? If yes, how many? _____ (Daily / Weekly / Monthly / Socially)
  What Kind? Beer / Wine / Liquor When was your last drink? _____

Family History

Please list family member's relation (ex. Mother, Father, Maternal/Paternal Grandmother/Grandfather, Brother, Sister)

☐ Adopted, Family History Unknown

Amblyopia (Lazy Eye): _____

Blindness: _____

Cataracts: _____

Corneal Disease: _____

Glaucoma: _____

Macular Degeneration: _____

Retinal Disease: _____

Other: _____

Arthritis: _____

Asthma: _____

Cancer: Type?: _____

Cardiovascular Disease: _____

Diabetes: _____

Renal Disease (Kidney Disease): _____

Seizure Disorder: _____

Stroke: _____

Thyroid Disease: _____

Other: _____

Have you had your flu shot this year? Yes or No

Piedmont Eye Associates

Review of Systems

Name: _____

Date of Birth: _____

Please check all that apply

Constitutional

- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss

HEENT

- ☐ exophthalmos (bulging eyes)
- ☐ hearing loss
- ☐ lump in neck
- ☐ sinus problems
- ☐ tinnitus (ringing)
- ☐ vertigo

Respiratory

- ☐ asthma
- ☐ cough
- ☐ dyspnea (labored breathing)
- ☐ wheezing

Cardiovascular

- ☐ calf pain
- ☐ chest pressure or discomfort
- ☐ irregular heartbeat /palpitations
- ☐ leg swelling
- ☐ tachycardia

Gastrointestinal

- ☐ abdominal pain
- ☐ constipation
- ☐ diarrhea
- ☐ heartburn
- ☐ jaundice
- ☐ nausea
- ☐ vomiting

Genitourinary

- ☐ genital lesions
- ☐ irregular menses
- ☐ urgency

Metabolic/Endocrine

- ☐ cold intolerance
- ☐ heat intolerance

Neurological

- ☐ balance disturbances
- ☐ dizziness
- ☐ focal weakness
- ☐ headache
- ☐ memory difficulty
- ☐ numbness of extremities

Psychiatric

- ☐ depressed mood
- ☐ insomnia
- ☐ irritability
- ☐ nervousness
- ☐ stress

Integumentary

- ☐ dry skin
- ☐ nail changes
- ☐ rash
- ☐ skin changes

Musculoskeletal

- ☐ back pain
- ☐ joint stiffness
- ☐ joint swelling
- ☐ muscle cramping

Hematologic/Lymphatic

- ☐ bleeding
- ☐ bruising
- ☐ tender lymph nodes

Immunologic

- ☐ environmental allergies
- ☐ food allergies
- ☐ seasonal allergies

Piedmont Eye Associates

Refraction Policy

This photo shows a patient seated in front of a phoropter, which is the instrument used to do a refraction

What is a refraction?

A refraction determines the eye's refractive error (the need for corrective glasses). This is the part of the exam where the technician flips various lenses and asks questions like, "which is clearer, 1 or 2?" These questions are asked until we have helped you achieve the best possible vision.

Why is there a $25 fee for this and is this new?

Most insurance, including Medicare DO NOT cover the charge of a refraction. A refraction has been a non-covered service since Medicare was created in 1965. Since around 2007, Medicare has been enforcing the policy of requiring eye doctors to charge separately for refractions.

Office Policy

Our policy is to charge $25 for refractions IN ADDITION to the office visit co-pay and/or deductible.

Payment is due at the time of service. Whether you receive a written prescription or not, the refraction fee along with your co-pay deductible is due and payable. Sometimes there is not enough change to warrant a new prescriptions. However, the refraction fee covers the doctor's and the technician's time and effort.

The doctor or the technician are the only ones qualified to tell a patient if a refraction is required. You can accept or deny this service. Your insurance will be billed according to the individual contracted fee schedule. A refund of $25 will be issued if your insurance does pay for the refraction fee.

By signing below, you are signing that you understand our refraction policy.

_____ _____

Patient or Patient Representative Signature Date

North Grove Medical Park 1330 Boiling Springs Rd., Suite 2400, Spartanburg, SC 29303 Phone: 864-583-5312 Fax: 864-582-1935

Revised February 2020

Piedmont Eye Associates

Statement of Patient Financial Responsibility (Insured Patients)

Our goal is to provide you with high-quality, efficient care. We appreciate the confidence you have shown in choosing us for your eye care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly it is important to get the proper information from you prior to billing.

Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know your coverage and benefits**. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. **It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at Piedmont Eye Associates.** If payment is denied for lack of authorization, I understand that I am responsible for payment in full. In order to make it easier for our patients, we accept cash, checks, money orders, VISA, Master Card, American Express and Discover. All may be given as payment at the front desk.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Please have your payment at each visit to avoid possibly needing to reschedule your appointment. Co-pays and deductibles will be collected upon check in on the day of your visit. ***I understand that I am responsible for co-payments and deductible/co-insurance as dictated by my insurance carrier.*** **Initials**_____

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I may also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due. ***All charges not paid in full within 120 days will be turned over to our collection agency.*** Please contact our billing department if you feel you cannot pay your bill in full and we can work with you on a payment plan. Patients actively paying on their accounts will not be turned over to collections. **Initials**_____

Cancellation/No Show Policy for Office Surgery and Cosmetic Procedures

You must call the office 24 hours prior to your procedure appointment time to cancel or reschedule your office procedure or cosmetic procedure. I understand if I miss my appointment without canceling 24 hours in advance, I will be charged a ***$50 no-show fee*** and I will not be allowed to schedule another appointment until that fee is paid in full. **Initials**_____

I have read the above policy regarding my financial responsibility to Piedmont Eye Associates for providing medical services to me. I authorize Piedmont Eye Associates to furnish information to insurance carriers concerning my care and I authorize my insurer to pay any benefits directly to PEA. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

_____ _____

Patient (or person authorized to sign for patient) Date

_____

Print Name of Patient