*Computer Users: Download & open in Acrobat before filling out **Phone Users: Download Adobe Acrobat Reader app

# The South Eastern Eye Center

## Patient History

Welcome to The South Eastern Eye Center! Please review the information listed below and complete it in its entirety. If information does not pertain to you simply put NA or mark it with NO. Keep in mind that our goal is to see you as efficiently as possible so all appointment concerns will be managed as listed below. Our facility reserves the right to treat medical eye problems as determined by the information provided below. **If you have a medical issue but do not provide your medical insurance you will be required to pay for those additional services prior to leaving the office today or you may be asked to return with a referral based on your insurance structure to cover those service needs.**

Name: ______________________________ Address: _______________________________ City: _________________ State: __________

Zip: ___________ Date of Birth: _____________ Occupation: _________________________ Social Security #: ______________________

List All Medical Insurance: ___________________________________________________________________________________________

(Hm/Wk) Phone: ________________________ Cell Phone: _____________________ Email: _____________________________________

Contact Preference: **Please number preference order:** Home ( ) Work ( ) Cell ( ) Email ( )

Emergency Contact

Name: _____________________________________ Contact: ___________________________ Relation: ____________________________

How did you hear about our office: Listed as insurance provider Newspaper, TV, Radio White Pages Yellow Pages

Referred By ______________________________________________ Other ____________________________________________________

Previous Eye Doctor_______________________________________________ Last Eye Exam __________________________________

Family Doctor___________________________________________________ Last Medical Exam___________________________________

**Please tell us if you have the following non-medical eye concerns. Check all that apply:** blurred distance vision, blurred near vision, blurred intermediate vision, trouble seeing the board at school, frontal headaches, temporal headaches, poor focusing ability, blurry vision at night, failed school screenings, failed pediatrician vision screening, failed other vision screening

Other___________________________________________________________________________________________________________

**Please tell us if you have the following medical eye concerns. Check all that apply. Fees may apply in the treatment of these issues:**

double vision, dryness, discharge (colored or clear like tears), redness, pink eye, burning, itching, tearing, foreign body sensation, sand in the eye, glare, light sensitivity, light flashes, floaters, headaches, pain in eye, pressure in eye, trauma (explain below), material in the eye, sleep with eyes open, blood in the eyes, colored spots on the eye, colored spots on the eyelid, loss of eyelashes, eyelash in the eye, eyelash turned the wrong way, bump on the eyeball, bump on eyelid

Other___________________________________________________________________________________________________________

Please list if **YOU** or **ANY FAMILY MEMBER** has any of the following conditions: **DO NOT LEAVE BLANK MARK Yes or No**

| Condition | Yes | No | Who |
|---|---|---|---|
| Autism | Yes | No | Who: ________________________________________ |
| Bone/Joint Disease (arthritis, other_________) | Yes | No | Who: ________________________________________ |
| Cancer | Yes | No | Who: ________________________________________ |
| Cataracts | Yes | No | Who: ________________________________________ |

| | | | |
|---|---|---|---|
| Diabetes | Yes | No | Who: _______________ Last Blood Sugar ______ A1C_______ |
| Eye Injuries, You | Yes | No | ____________________________________________________ |
| Glaucoma | Yes | No | Who: _______________________________________________ |
| Heart Disease | Yes | No | Who: _______________________________________________ |
| High Blood Pressure | Yes | No | Who: _______________Last Blood Pressure_______________ |
| High Cholesterol | Yes | No | Who: _______________________________________________ |
| Kidney Disease | Yes | No | Who: _______________________________________________ |
| Lazy Eye | Yes | No | Who: _______________________________________________ |
| Macular Degeneration | Yes | No | Who: _______________________________________________ |
| Migraines | Yes | No | Who: _______________________________________________ |
| Psychiatric Disease | Yes | No | Who: _______________________________________________ |
| Respiratory Problems (asthma, sleep apnea, other_____________________) | Yes | No | Who: _______________________________________________ |
| Skin Disease | Yes | No | Who: _______________________________________________ |
| Stomach Disease | Yes | No | Who: _______________________________________________ |
| Surgery, You (eye or in general) | Yes | No | ____________________________________________________ |
| Thyroid Disease | Yes | No | Who: _______________________________________________ |
| **Other Medical/Ocular /Behavior Issues** | Yes | No | Who: _______________________________________________ |

List all medications you take including vitamins:

________________________________________________________________________________________________

________________________________________________________________________________________________

List all **food, drug, and or seasonal allergies**_____________________________________________________________

If you are currently pregnant, list how many months? _________________________, or nursing: yes no

Do you smoke? Y N Have you ever smoked? Y N When did you stop?____________ How many packs per day? ___________

Do you drink? Y N How much?_________________________ Do you use recreational drugs? Y N

Do you want to be evaluated for contacts? Y N What type were worn in the past?__________________________________________

Please Note: Insurance may cover only part of your charges, or may be payable directly to you. Please give any forms or insurance cards to the receptionist in order to process your claim. If your insurance company does not pay as expected, you are ultimately responsible for all charges. Filing your insurance is a courtesy service we provide for our patients.

Your signature below shows your understanding and acknowledgment of our office's HIPAA documentation. * This signature also authorizes the release and payment of any medical or other information to process claims filed pertaining to services rendered at this office. I understand and agree that profession services are **NONREFUNDABLE.**

Parent/Patient Signature _____________________________________________ Relation ____________________Date ________________

Sponsor's Name ____________________________________ Sponsor's Social Security # ________________ Date of Birth ____________

Method of Payment today**: Cash Visa MasterCard Star Card Care Credit Amex**

A service charge of 1 ½ % per month, 18% APR may be added to overdue accounts. You will also be liable for legal and collection costs.

***Your signature above is acknowledgment of the fact that you have been given the rights to review a copy of our office's HIPAA document and non-payment of outstanding balances will be transferred to you and or the guarantor or your command if necessary.**

# THE SOUTH EASTERN EYE CENTER

## Insurance Disclosure

Dear Patient,

To provide you with "Superior Service and Superior Eye Care", we reserve the right to bill both your medical and vision insurance to comprehensively evaluate your eyes. At our office, we strive to deliver superior eye care, and this extends beyond routine eye exams to include caring for the overall health of your eyes. We are unable to know before your visit what may be uncovered during an examination and for this reason it is best to have all insurances available to assist with alleviating potential out of pocket expenses for yourself. Below you will find a breakdown of the differences between medical and vision insurance, and the ways in which our office utilizes them.

<u>Medical Insurance</u>- Insurance that covers expenses incurred for medical reasons such as illness or injury that may or may not require therapeutic treatment. In our office examples of these matters include but are not limited to trauma to the eye, dry eyes, glaucoma, diabetic eye examinations, allergies and many others. **Use of this benefit may require a copay.**

<u>Vision Insurance</u>- Vision insurance is used to offset the costs of an annual eye examination that helps to determine what potential vision correction you may need to wear. These types of exams produce prescriptions for eyeglasses, contacts, and or prescription sunglasses that may be prescribed by your eye doctor.

We appreciate your cooperation by providing us **<u>with all your insurance</u>** so that we may continue to determine eligibility and bill accordingly. If you have any further questions or new insurance that we need to be aware of, please speak with the receptionist. By working together, we will be able to deliver "Superior Service and Superior Eye Care" with every visit.

With Appreciation,

The South Eastern Eye Center

Please acknowledge that you have read and understand the contents of this disclosure.

____________________________________ ____________

Patient Signature Date

# Message from The South Eastern Eye Center Management Team

Thank you for choosing our office for your eye health needs. We are so glad that you are here today!  Please sign below stating you acknowledge the following :

- Please keep in mind that our office functions based on you and we truly appreciate our patients. 😊  We do have an on-site optical store and would like to show you our selection.  To continue to service the community we do require **optical sales to stay in business**.  Our business  is a local business but our quality and selection are excellent!!   If you chose to take your prescription elsewhere, document printing fees may occur.  Additional copies of your prescription requested after the initial visit **may** incur **a REPRINT fee and take up to 24 hours to be released.** All documents re-released must be approved by our provider and this process takes time.
- Unfortunately, we are unable to provide you with a PD measurement. This is not a procedure completed during your eye examination today, and we **DO NOT** work with or recommend any online eyeglass vendors.
- Your provider provides medical eyecare when needed which may not be covered by your routine insurance benefits.  **If treatment is rendered outside of your routine coverage additional out of pocket fees may apply.**
- **There is no food or open drinks past the reception area.**
- We are attempting to improve our practice & are asking for your feedback via text message, online review on Facebook (**The South Eastern Eye Center**), Google, Yelp, etc. We would love to hear how we can make things better or if you have had great service, help us tell others!!!   This is one of our quality measures to help us provide you with Superior Service & Superior Eye Care.

______________________________ _______________

Patient Signature Date

# NON-COVERED SERVICE WAIVER FORM and INSURANCE VERIFICATION

I hereby agree to accept full financial responsibility for the following medical care received from **The South Eastern Eye Center** which is a non-covered service based on my current insurance benefits according to my policy. Your signature below acknowledges the fact that you have been told prior to any of the following services being completed that they may or may not be covered by your insurance.

## Service Description

- Contact lens fitting ($55-$75) for soft contacts, price to be determined for hard contacts.
- Contact lens re-fit ($25)
- Full examination with discount ($75-$90)
- Co-payments, deductibles, co-insurance and any unpaid amounts by insurance
- Office visits (starting at $50)
- Refraction ($45)
- No Call/No Show Fee/ Missed Follow up Fee ($25)
- **Eyewear prescription request service fee ($30)**
- Any other service not covered by your insurance that you have been verbally informed of prior to the service be rendered listed here-in or not listed here-in.

These non-covered services will be rendered to you on this day as notated with your signature or your guardians signature below.

### Additional Notes for Tricare Beneficiaries

- Tricare Prime/Select (Active Duty Soldiers) All services are cash pay. In order to use your benefits, you would need to schedule an appointment at Winn Hospital or the TMC, all contact lens fittings are completed at our facility.
- Tricare Prime (Active Duty Dependents) Coverage for 1 comprehensive eye exam every year. Excluding Contact lens fittings.
- Tricare Prime (Retiree and Dependents) Coverage for 1 comprehensive eye exam every 2 years unless you have a referral from your PCM.
- Tricare Select (Active Duty Dependents) Coverage for 1 comprehensive eye exam every year; however, patient must meet all deductibles and pay all cost shares that apply.
- Tricare Select (Retiree and Dependents) coverage for 1 eye evaluation per year. Tricare payment if medical diagnosis found. If no medical diagnosis found the patient is responsible for the cost of the exam.
- Tricare for Life/ Medicare- Coverage for 1 eye evaluation per year. The exam follows Medicare guidelines. A $45 refraction cost is billed to patient after sent through insurance first.

- Tricare Prime/ Select (Active Duty Deceased Family Member) Coverage is the same as Active Duty Dependents as listed above for up to 3 years after death. After 3 years, plan shifts to Retiree status outlined above.

Your claim will be denied by Tricare if:

- You are out of your region
- You have multiple insurances
- You have not updated your information in DEERS
- You have services performed before your eligible date, if applicable.

Please note: Insurance may only cover part of your charges or may be payable directly to you. Please give any forms or insurance cards to the receptionist to process your claim. If your insurance company does not pay as expected, you are ultimately responsible for all charges. Filing your insurance is a courtesy service we provide to our patients.

Your signature below shows your understanding and acknowledgement of our office HIPAA documentation. * This signature also authorizes the release and payment of any medical or other information to process claims filed pertaining to services rendered at this office. I understand and agree that professional services are **NONREFUNDABLE.**

A service charge of 1.5% per month, 18% APR may be added to overdue accounts. You will also be liable for legal and collection cost.

*Your signature below is also acknowledgement of the fact that you have been given the right to review a copy of our office's HIPAA document.

Your signature below is proof that you have provided our staff with ALL insurance documentation for ALL insurance(s) you have at the time of this visit. Your signature is an indication that you understand that with-holding insurance information for avoiding co-payments, deductibles, or other reason can be deemed fraud by outside entities and may result in legal action against you or your sponsor. Willingly having other health insurance (OHI) and not using it is unacceptable insurance practice and may result in improper insurance claim submission and you paying for your exam out-of-pocket. PLEASE present ALL insurance information to the receptionist.

______________________________________ __________________

(beneficiary or legal guardian's signature) (Date Signed)

## Diabetic Patient Blood Sugar Consent Form

Diabetes is a general health condition with a multitude of potential complications. As part of your routine diabetic care, we will complete a comprehensive eye exam on you today during your visit and to successfully evaluate your diabetic state we would like to measure your blood sugar level. Studies show that prolonged and elevated glucose levels can increase your risk of diabetic retinopathy and intensify its damaging effects on the eyes. Consistent review of your blood sugar numbers is very important to the proper management of your condition. After the finger-prick test has been completed by our technician, the number will be reviewed by the doctor along with your other exam results to provide you with a clear picture of your diabetic eye health.

Please sign your name below giving our office staff the permission to check your blood sugar level today in office. Prior to signing this document please speak with the receptionist if you have any questions.

Signature_______________________________________________________ Date_______________

# The South Eastern Eye Center, Pembroke

## CareCredit Program

We are excited to offer supplemental medical service coverage through the CareCredit Program. The CareCredit program is different from a regular credit card. It helps you pay for out-of-pocket expenses not covered by medical insurance by extending special financing options that you can't get when using your Visa or MasterCard.

Pay for health, and wellness care at over 200,000 enrolled providers across the nation. Once you've applied, you can use it again and again at any location that accepts CareCredit.

With shorter term financing options of 6, 12, 18 or 24 months no interest is charged on purchases of $200 or more when you make the minimum monthly payments and pay the full amount due by the end of the promotional period. If you do not, interest is charged from the original purchase date.

***Details and Terms**

CareCredit also extends longer term healthcare financing for 24, 36, 48 or 60-month periods with Reduced APR and Fixed Monthly Payments Required Until Paid in Full. Purchases of $2,500 or more qualify for the 60-month offer with a 16.9% APR (24, 36 and 48 financing terms are for purchases of $1,000 or more with a 14.9% APR).**

For complete details, see the CareCredit account agreement within your application. Ask your provider to find out which promotion is right for you. You do not need to select a promotion before you apply.

**Ways to apply**

- On your device @ www.carecredit.com
- Online @ www.carecredit.com
- In office application

It is simple, easy and your information is safe! Speak to our staff at the front desk for additional information!!!!

______ Yes, I am interested in signing up for CareCredit

Patient Name: ________________________________

# The South Eastern Eye Center

345 Lindquist Road Building 71

Fort Stewart, GA 31314

(PH) 912-876-1101

(FX) 912-877-4244

**Do you want a non-surgical option to stop wearing glasses and or contacts?**

If you are nearsighted, Corneal Refractive Therapy (CRT) just might be the right solution for you!!! CRT is FDA approved for the correction of myopia (nearsightedness) by gently and reversibly reshaping your cornea while you sleep.

Please let us know if you're interested in learning more about CRT by signing your name below. You could throw your glasses away today!!!!!

_______ Yes, I am interested in learning more about CRT.

________________________________

Please Print Name

Click the submit button to
send us your completed form.