Patient Information

◦Date: ___/____/_____ ◦Race/Ethnicity: ____ /____

◦Name: _____ ◦DOB: ____/_____/_____

First **Middle** **Last** ◦Preferred Language: _____

◦SSN: _____ ◦Gender: O Male O Female

O Married O Widowed O Separated O Divorced O Single O Minor

***(MINOR)** Patient's parent/legal guardian's NAME & DOB: _____*

- Relationship to patient: _____

◦Home Address: _____
◦City: _____ ◦State: _____ ◦ZIP: _____

● **Contact Information** ***Preferred Method Of Contact: Voice(V) Email(E) Text(T) Do Not Contact(D)***
(Please Circle One of the Above)

Home Phone: (___) ____-_____ Cell Phone: (___) ___-_____ Work Phone: (___) ___-_____
E-Mail Address: _____

O **Employed** O **Non Employed** O **Retired**

(If Employed) Occupation: _____ Employer Name: _____
(If Retired) Retired Date: ____/_____/_____

In Case Of Emergency
Name: _____ Relationship: _____
Home Phone: (___) ____-_____ Cell Phone: (___) ____-_____

Referring Doctor: _____ Phone # (____) ____-_____
Primary Care Doctor: _____ Phone # (____) ____-_____
Other Physicians: *(ex. Optometrist, Endocrinologist, Rheumatologist, Cardiologist, etc.)*

● Name: _____ ● Name: _____

Office #: (___) ____-_____ Office #: (___) ____-_____

● **Pharmacy NAME, PHONE # & STREET LOCATION:**_____
_____

● **Mail-In Pharmacy Name & Phone #:** _____

Insurance Information

Vision Insurance:
Insurance Co. Name: _____
ID/Member #: _____ Group #: _____
Subscriber's Name: _____
DOB: _____ SSN: _____ Relationship to Patient: _____

Medical Insurance #1:
Insurance Co. Name: _____
ID/Member #: _____ Group #: _____
Subscriber's Name: _____
DOB: _____ SSN: _____ Relationship to Patient: _____

Medical Insurance #2:
Insurance Co. Name: _____
ID/Member #: _____ Group #: _____
Subscriber's Name: _____
DOB: _____ SSN: _____ Relationship to Patient: _____

Information and Consent for Refraction

1) **What is a refraction?**
    a. A ***refraction*** is the procedure to determine your eyeglass **AND** contact lenses prescription.
    b. We always check your vision but a refraction will be done if you request an eyeglass or contact lenses prescription or if you want to know if a new eyeglass prescription is needed.
2) **Why do I have to pay for it?**
    a. CMS, the department of federal government that controls Medicare and Medicaid, has decided that refractions are not a payable part of an eye exam.
    b. CMS, directly under the control of the US Congress, has determined this is a "non-covered" service. That means you have to pay for that portion of the eye exam.
    c. Further, CMS has declared that if we do not charge you for this extra service, we could receive various forms of punishment.
3) **What does it do?**
    a. This instrument determines your need for lenses to correct your refractive error, also referred to as your refraction or your eyeglass/contact lenses prescription.
    b. This is the part of the exam where the doctor or other staff member flips various lenses inside the phoropter and asks questions like "better 1 or better 2?" We keep asking these questions until we have helped you achieve the best possible vision.
4) **Is this new?**
    a. Refraction (CPT code 92015 has been a **"non-covered"** service since Medicare was created in 1965.
    b. Since about 2007, Medicare has been enforcing the policy of requiring eye doctors to charge separately for refractions.
    c. As many private insurance carriers adopt the policies of the federal government, many of our contracts with private insurance carriers require us to collect the money from you as well.

The purpose of this form is to help make you an informed choice about whether or not you will need a refraction. The charge for a refraction is **$25** and is due at the time of service with any co pay.

***** IN ORDER TO GET A PRESCRIPTION FOR GLASSES OR CONTACTS YOU MUST BE REFRACTED!*****

I understand that a refraction is a non covered service & I accept full responsibility for the cost of this service in addition to any co payments or deductible due.

Would you like to have a refraction performed today? ___ **Yes** ____ **No**

_____	_____	_____
Patient Name	Patient Signature	Date

O'BYRNE EYE CLINIC

Responsibility for Payment and Treatment/Receipt of HIPAA Notice/Patient Communication

I understand that I am fully responsible for all fees due to O'Byrne Eye Clinic or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless Clinic agrees to accept assignment of my Medicare, Medicaid or other insurance benefits. If I have insurance coverage other than Medicare: I understand that assigning benefits to the Clinic and the filing of an insurance claim on my behalf is a courtesy to me and this is not absolving me of my responsibility to pay for services if the insurance company fails to pay for these services or if deductibles and/or co-pays are due. I understand that my insurance policy may not cover the full cost of services, or may consider it an uncovered service or medically unnecessary, or I may not have coverage benefits for these services. I therefore agree to be responsible for those charges incurred, as well as for my co-pay and/or any deductible that has not been met. I further understand that any verification of my insurance benefits by the Clinic is not a guarantee of payment by my insurance company. If my insurance company does not pay for the services I have received, I understand that the Clinic will bill me for these services and I agree to pay any amounts due for these services. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by my insurance company and the actual charge for that service. If I am covered under Medicare or a Medicare Advantage health plan: I understand that I will be responsible for my co-pay and/or any deductible that has not been met either through my Medicare coverage or any supplemental policy that I may also have. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by Medicare and the actual charge for that service. I further understand that I will be notified in advance by an Advanced Beneficiary Notice of Non-coverage if Medicare likely will not pay for items or services. I will then have the right to make an informed choice whether or not to receive the items or services. If I choose to receive the items or services, I am aware that I will be responsible for paying for such items or services. I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Clinic for any services furnished to me subject to any regulations pertaining to their assignment of benefits. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services, Social Security Administration and its agents, intermediaries or carriers, or to any other third-party sources or insurance companies and its agents any information or documentation needed to determine these benefits or the benefits payable for related services. A copy of this authorization may be used in place of an original and this authorization shall remain in force until revoked by me in writing. I certify that the insurance information

given by me is current and accurate to the best of my knowledge and I understand and agree to abide by the terms outlined above.

Authorization/Consent for examination and treatment: I hereby acknowledge that I have voluntarily presented myself, or my child (if patient is a minor) for medical treatment at **O'Byrne Eye Clinic**.

Information /Consent for dilating eye drops: Dilating drops are used to enlarge or dilate the pupils of the eye to allow the doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements to not drive yourself unless you feel able to do so. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from dilating drops. This is extremely rare but treatable with immediate medical attention. The eye drops are necessary to diagnose my condition. I hereby authorize doctors, associates or assistants as may be designated by them to administer dilating drops.

I further acknowledge that I have been offered to receive a copy of the Clinic's Notice of Privacy Practices. I also agree to receive appointment and treatment reminders via text and voicemail:

YES/ NO

_____ _____

Patient Name (Please Print) **Date**

_____

Signature of Patient/Responsible Party