BLUE RIDGE EYE CENTER, P.A.

530 BY-PASS 123 - SENECA, SC 29678 PH (864) 985-1110 - FAX (864)985-1410

SCOTT C. MASSIOS, M.D., F.A.C.S.

Enclosed are the forms that we need to have filled out *and* brought with you on the day of your appointment. We will also need all insurance cards on the day of your appointment. If you do not have them with you on the day of your visit you will be made self pay or we will reschedule your appointment to the next available.

All Co-pays and refractions are due on the day of your visit.

Refraction fee $35.00 No Show Fee $25.00

Please bring your prescription glasses with you. We will need them to provide us with information for your records. If you wear contact lenses, please bring the box or container with you. If you do not have either, please provide us with the brand name and prescription

Your appointment is on _____@_____am/pm

We **DO NOT** participate with ANY vision plans or HealthCare Exchange Policies*

***Due to new healthcare regulations, you must bring your insurance cards and a picture ID on each visit

Patient's Name: BREC Acct #:

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving this health care item or service.

We expect that your insurance company will not pay for the item or service described below.

This service is not considered "medically necessary" for a specialist office, which we are. However, this service is required for all first time patients as a "base line" test for all eye exams. This test allows for current and future diagnosis for potential and current eye conditions. It also allows us to offer a prescription for eye glasses or contacts, should you need it.

Items or Services:
92015 (Refraction)
Because: **Medical Insurance companies considers a refraction routine eye care, therefore this is a non-covered service.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why insurance probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: **35.00**) in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**
I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items of services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

☐ **Option 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance.

Signature of patient or person acting of patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance, your health information on this form may be shared with your insuance company.

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PATIENT INFORMATION

Patient's Name_____
Last First Middle

Address_____ Phone_____

City_____ State_____ Zip Code_____

EMAIL ADDRESS:_____

Age_____ Date of Birth_____ Sex____(M)____(F) SS#_____

Employer/School_____ Phone#_____

Name of Spouse_____

Spouse's Employer_____ Phone#_____

Family Physician_____ Referred By_____

In case of emergency, notify_____ Phone#_____

WHO IS RESPONSIBLE FOR BILL:

Name_____ Relationship to Patient_____

Address (if different from above)_____

Phone#_____ SS#_____ Birthdate_____

Employer_____ Phone#_____

Are you currently enrolled in Hospice? _____ If so, where? _____

Are you currently "covered" or a resident of a Skilled Nursing Facility (SNF)?_____ If so, where? _____

INSURANCE INFORMATION:

Primary Insurance_____ ID#_____

Primary Insured's Name & Date of Birth _____ Relationship to Patient _____

Secondary Insurance_____ ID#_____

Primary Insured's Name & Date of Birth _____ Relationship to Patient _____

I request that payment of authorized Medicare or other insurance benefits be made for me or on my behalf to Blue Ridge Eye Center, P.A. for any services furnished to me by that physician. Certain procedures (for example: contact lens, refractions, cosmetic surgery, refractive surgery and glasses) may not be covered by Medicare and/or other insurance. I understand these charges as well as deductibles and co-payments will be my responsibility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and authorize any holder of medical information needed to determine these benefits payable for related services. I authorize Blue Ridge Eye Center, P.A. to transmit records electronically when necessary. If any records are received by another party in error, I absolve Blue Ridge Eye Center, P.A. of any liability relating to the transmission of such records.

By signing below, I authorize the above information regarding my insurance, billing and medical records AS WELL AS the release for Treatment to me by the Blue Ridge Eye Center, P.A. staff.

Signature_____ Date_____

This authorization form permits **Blue Ridge Eye Center** to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Birth Date _____

Person to receive information:

Give Name and Relationship: _____

Information to be disclosed: Please circle

Appointment Financial Clinical _____ Other _____

.....

Person to receive information:

Give Name and Relationship: _____

Information to be disclosed: Please circle

Appointment Financial Clinical _____ Other _____

.....

Receiving person or entity Voice mail Home: #_____	Description of used or disclosed information: ☐ Appointment time ☐ Financial ☐ Clinical ☐ Other _____
Receiving person or entity: Unencrypted or encrypted Email Address: _____	Description of used or disclosed information ☐ Appointment time ☐ Financial ☐ Clinical: please list: _____ ☐ Other _____
Receiving person or entity: Any Treating Facility	Description of used or disclosed information: ☐ Unencrypted Treatment information
Receiving person or entity: School or Employer: give name _____	Description of used or disclosed information: ☐ Appointment information ☐ Return to work or school

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses

Expiration date or event: This authorization shall be enforce until revoked by the patient or

_____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:

_____

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

.....

Office Use Only: Receiving Employee_____ Date received_____

☐ Copy given to patient

BLUE RIDGE Eye Centre, PA
530 By-Pass 123 Ste. C
Seneca, SC 29678
(864) 985-1110 Phone
(864) 985-1410 Fax

Patient's Name _____

If a minor, accompanied by, whom today: _____

Patient's DOB: _____

Primary Care Physician _____

Health History Questionnaire

Reason for visit: _____

Current Medications

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Prescription Drugs	Eye Drops	Allergies to Medications (hives, rash, itching):

Do you wear prescription eye glasses?_____ Contact Lens? _____ Drug store readers? _____
Please bring your corrective eyewear with you to your appointment.

Eye Health History

Eye Disease (glaucoma, macular degeneration, diabetic retinopathy, retinal tear/detachment, uveitis, iritis, trauma, and /or surgeries i.e. laser, lasik, cataract, cryo, scleral buckle):

Previous: _____

Current: _____

Past Medical History (heart disease, high blood pressure, diabetes, thyroid, arthritis, cancer, etc. _____

Previous Surgeries: _____

Social History:_____Alcohol _____Drugs _____Smoking _____Exercise _____ Driving

Do you have a history of blood transfusions? **YES NO** Occupation:_____

Have you ever been tested for HIV and / or Hepatitis? **YES NO** Was test: **POSITIVE / NEGATIVE**

FILL OUT BACKSIDE OF THIS PAPER

*Do you **currently** have any problems in the following areas? If **YES**, please provide additional information.*

	YES	NO	DETAILS
EYES (Decreased Vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight gain, unusually tired)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcer, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, cancer, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, stroke, MS etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, inching, hives, lupus, etc.)			
FEMALES are you pregnant? Nursing?			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had any of these diseases? (circle all that apply)

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease: _____

Acknowledgement of Receipt of Notice of Privacy Practices

For

Blue Ridge Eye Center, P.A.

530 By Pass 123 Suite C Seneca, SC 29678
(864)985-1110 FAX (864)985-1410

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____

_____

Employee preparing document Date

_____

Employee signature _____