OPHTHALMOLOGY EYE ASSOCIATES, P.C. of Goldsboro

AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION/PRIVACY NOTICE

PATIENT:	DOB:	MRN:

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Ophthalmology Eye Associates of Goldsboro, its medical practices and providers including physicians, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Ophthalmology Eye Associates of Goldsboro.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the Ophthalmology Eye Associates of Goldsboro provider of service(s) furnished to me. I authorize Ophthalmology Eye Associates of Goldsboro to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Ophthalmology Eye Associates of Goldsboro. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through Ophthalmology Eye Associates of Goldsboro medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an Ophthalmology Eye Associates of Goldsboro billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with Ophthalmology Eye Associates of Goldsboro's approval, I understand that appropriate collection measures may be initiated. Please be aware, any collection fees are the patient's responsibility.

NO SHOW AND CANCELLATION POLICY: FEE: OFFICE VISIT ($35.00). SURGERY ($75.00) Our goal is to provide you with quality vision care in a timely manner. We have implemented a no show and cancellation policy that enables us to better utilize available appointments for our patients in need of our services. The following policy clarifies our protocol for those patients who fail to keep their scheduled appointment or who cancel without providing 24-hour notice. If you're a Medicaid recipient, you're prohibited from being charged a no-show fee. **If you're a Medicaid recipient you're exempt from the no-show cancellation policy portion of this form**.

Your Responsibility: In order to provide the best care to our patients, we request that you call the clinic promptly if unable to attend a scheduled appointment so that the time slot can be reallocated to someone who may have a more urgent need for treatment. Available appointments are in high demand and your early cancellation will give another person the possibility of more timely access to our care.

Policy: Patients who fail to show for their scheduled appointment and/or did not notify the office within 24 hours of their scheduled appointment time shall be subject to the "No Show/Cancellation" fee amount identified above. In the event of an actual emergency that prevented the proper notice to the office, you may ask for an exemption that will be reviewed to determine if a one-time exception could be granted. While a patient under care in our practice, we will request that you read and sign this form at least once annually to be stored in your chart as documentation that you have been informed of our policy.

ELECTRONIC PRESCRIBING: I understand that Ophthalmology Eye Associates of Goldsboro medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my Ophthalmology Eye Associates of Goldsboro providers and my pharmacy. I have been informed and understand that Ophthalmology Eye Associates of Goldsboro providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my Ophthalmology Eye Associates of Goldsboro providers to see this health information.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Relationship to Patient if Applicable

Witness to Signature

Date of Signing

OPHTHALMOLOGY
EYE ASSOCIATES, P.C.
of Goldsboro

PATIENT PRACTICE LETTER OF UNDERSTANDING

Welcome to our practice! We are pleased that you have chosen us to handle your vision care. Below are some guidelines that will help us build a strong and mutually beneficial physician-patient relationship.

PATIENT RESPONSIBILITIES: If you experience discomfort or do not feel well upon your visit, tell us right away so we can help. If you have questions about your care or would like to obtain information about alternative care methods not discussed, please ask. We care about your health and we're interested in your concerns. Also, if you perform self-care, please keep accurate records and provide them to us regularly so we may add notes to your confidential medical record. Lastly, feel free to ask what you can do to stay healthy and feeling your best. We would love to help!

PHYSICIAN/PRACTICE RESPONIBILITIES: Our providers will make every effort to see you at your scheduled time however, things do happen and our office may run behind. If the office is running behind our staff will keep you updated on your visit status. Your vision services provider may prescribe you with treatments related to your care plan to keep you seeing your best and our technicians work under the supervision of the physician to perform diagnostic tests and exams. Please feel free to ask our staff any questions you may have during your visit.

SAFETY AND RESPECT FOR YOUR FELLOW PATIENTS: Our office does not permit smoking, weapons, or illegal drugs in the clinic. Please wear clothes that are clean and appropriate for your visit and we ask that your do not swear, raise your voice, or make angry gestures to other patients or the care team. Please treat others as you would like to be treated and follow all infection control policies currently in place within the facility. Please refrain from touching any machines or equipment without permission.

CHANGE OF INSURANCE: Please let us know right away if your health insurance plan or carrier changes. It is your responsibility to give us updated health insurance information. If you cannot afford what your plan doesn't cover, please notify us and we will try to help the best we can.

By signing this agreement, I agree I have read it and will respect myself, my healthcare team, and my fellow patients. I understand that failure to follow these guidelines could result in dismissal from the practice.

PRINT NAME _____ DOB _____

SIGNATURE _____ DATE _____

RELEASE OF MEDICAL INFORMATION

By signing below, I authorize Ophthalmology Eye Associates of Goldsboro and affiliates or subsidiaries to disclose information regarding my eye care and treatment to the individuals listed below:

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

SIGNATURE_____ DATE _____

OPHTHALMOLOGY
EYE ASSOCIATES, P.C.
of Goldsboro

MEDICARE CHECKLIST AND FACTS

PATIENT:	DOB:

1. **DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY:**

Problems with Glare	Change in vision	Dry eyes	Red eyes
Glasses don't work well	Problems driving at night	Watery Eyes	Itchy eyes
Glasses don't fit well	"Laugh lines"	"Crows Feet"	Droopy eyelids

2. **DO YOU HAVE DIFFICULTY, EVEN WITH GLASSES, WITH ANY OF THE FOLLOWING? CIRCLE ANY THAT APPLY:**

Writing checks or filling out forms	Reading small print such as labels on medical bottles
Reading a newspaper or book	Recognizing people when they're close to you
Watching Television	Reading traffic, street, or store signs
Seeing steps, stairs or curbs	Seeing a golf or tennis ball
Playing games such as bingo	Doing handwork like sewing or carpentry

3. **ARE YOU CURRENTLY TAKING ANY OF THESE MEDICATIONS?** FLOMAX (TAMSULOSIN)
PLAQUENIL (HYDROXYCHLOROQUINE) TOPAMAX (TOPIRIMATE) GILENYA (FINGOLIMOD)

Our primary concern is to provide you with the best care possible. The following information will explain Medicare's rules for paying and help you understand what to expect out of pocket. Your Medicare Part B coverage is what will cover your bills in office for surgeries, diagnostic tests, and office visits. Ophthalmology Eye Associates of Goldsboro is a participating provider with Medicare therefore you will receive a savings for your services.

Here is an example to help you understand what that means based on the 2021 Medicare guidelines:

TYPE OF SERVICE	OUR NORMAL CHARGE	MEDICARE GUIDELINE	YOUR SAVINGS
Comprehensive exam	$160.00	$122.54	$37.46

* After your 2021 deductible of **$148.50** is met Medicare pays 80% of the guideline amount for covered services. The other 20% is applied to your out of pocket and billed to you or your supplemental insurance if you have one.

* All doctors in Virginia are required by Medicare to collect any patient responsibility left after Medicare and your supplemental insurance processes your bill. This may include a co-pay for your visits due at time of service.

MEDICARE DOES NOT COVER THE FOLLOWING

Your out-of-pocket Refractions: $39.00

Eye glasses: Costs may vary Contact lenses: Costs may vary

DO YOU CURRENTLY WEAR CONTACT LENSES: YES NO

By signing below, you acknowledge that you have received and understand the above.

SIGNATURE: _____ DATE: _____

OPHTHALMOLOGY
EYE ASSOCIATES, P.C.
of Goldsboro

Statement to Authorize Payment of Medicare Benefits

I request that payment of authorized Medicare benefits be made on my behalf to:

OPTHALMOLOGY EYE ASSOCIATES OF GOLDSBORO

For services furnished to me at this location during my lifetime.

I authorize any holder of medical information about me to release to the Centers for Medicare Services and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. By signing below, I understand that my signature on file is good for a lifetime.

_____

Patient's signature

_____

Patient's name (please print)

_____

Date