



A US EYE COMPANY

Today's Date: \_\_\_\_\_

Patient Name: Mr. Mrs. Ms. Dr. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Contact Preference: ☐ Phone ☐ Email ☐ Mail

Contact Preference for Appointment Reminders: ☐ Phone ☐ Text Message ☐ Email

South Carolina Resident: ☐ Full Time ☐ Part Time If Part Time, please complete information below. From: \_\_\_\_\_ To: \_\_\_\_\_ Secondary Home Phone: \_\_\_\_\_

Secondary Address: \_\_\_\_\_

Northern Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Eye Doctor (if not Carolina Eye Physician): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Language: ☐ English ☐ Haitian Creole ☐ Russian ☐ Spanish ☐ Other: \_\_\_\_\_

Race: ☐ White ☐ American Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

How did you hear about Carolina Eye Physicians? ☐ Billboard ☐ Building/Marquee ☐ Doctor

☐ Family/Friend ☐ Insurance ☐ Online Search ☐ Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Ocular History:**

- |  |                      |  |                      |
|--|----------------------|--|----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cataracts            | <input type="checkbox"/> Yes <input type="checkbox"/> No | LASIK / Epi-LASEK    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cornea Transplant    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Macular Degeneration |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetic Retinopathy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Punctal Plugs        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Dry Eye Syndrome     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retinal Detachment   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma             | <input type="checkbox"/> Yes <input type="checkbox"/> No | YAG Laser            |
| <input type="checkbox"/> Other: _____                    |                      |  |                      |

**What is the reason for your visit today?**

- |   |       |                                   |       |                                  |       |
|---|-------|-----------------------------------|-------|----------------------------------|-------|
| <input type="checkbox"/> Blurred Vision   | RT LT | <input type="checkbox"/> Dry Eyes | RT LT | <input type="checkbox"/> Itching | RT LT |
| <input type="checkbox"/> Decreased Vision | RT LT | <input type="checkbox"/> Flashes  | RT LT | <input type="checkbox"/> Pain    | RT LT |
| <input type="checkbox"/> Discharge        | RT LT | <input type="checkbox"/> Floaters | RT LT | <input type="checkbox"/> Red Eye | RT LT |
| <input type="checkbox"/> Double Vision    | RT LT | <input type="checkbox"/> Headache | RT LT | <input type="checkbox"/> Tearing | RT LT |
| <input type="checkbox"/> Other: _____     |       |                                   |       |                                  |       |

**Immunization / Vaccination:**

- ☐ Yes ☐ No Influenza Date/s: \_\_\_\_\_
- ☐ Yes ☐ No Pneumococcal Date: \_\_\_\_\_

**Surgical History:**

- |  |                        |  |                     |
|--|------------------------|--|---------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Appendectomy           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemorrhoidectomy    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Carotid Endarterectomy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hysterectomy        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Gallbladder            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mastectomy          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Bypass           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Cancer Removal |
| <input type="checkbox"/> Other: _____                    |                        |  |                     |

**Allergies:** ☐ No Known Drug Allergies

<u>Allergy</u>	<u>Type of Reaction</u>
_____	_____
_____	_____

- ☐ Yes ☐ No Latex Please describe: \_\_\_\_\_
- ☐ Yes ☐ No Anesthesia Please describe: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Family History:**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cataracts            | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes             | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma             | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Macular Degeneration | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Retinal Detachment   | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____   | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |

**Social History:**

Occupation: \_\_\_\_\_ ☐ Retired ☐ Disabled ☐ Not Working

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Conditions: ☐ Alone ☐ Family ☐ Skilled Nursing ☐ Assisted Living

Hobbies: ☐ Computer ☐ Golf ☐ Reading ☐ Tennis ☐ Sewing / Knitting ☐ Walking

☐ Other: \_\_\_\_\_

Driving: ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasional / Social ☐ 1-2 Drinks / Day ☐ 3-4 Drinks / Day

Smoking / Tobacco: ☐ Never ☐ Former ☐ Light Smoker ☐ Heavy Smoker

**Past / Present Medical History:**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal Pain             | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Loss                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alzheimer's                | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack: Year _____         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety                    | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure/Hypertension |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular Heart Beat             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Autoimmune Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Failure                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Stones                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bruises                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine                         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea                           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson                        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cholesterol                | <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant: Current / Previously   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No COPD                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Psoriasis                        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dementia                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Seasonal Allergies               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes: Type 1 or Type 2 | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Rashes                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Aides              | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Ulcers                   |
|   | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease                  |

☐ Other: \_\_\_\_\_



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## MY LIST OF MEDICATIONS & DRUG ALLERGIES

Medical Record #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Pharmacy Address or Crossroads: \_\_\_\_\_

**Current Medications:** This list includes all prescribed medications, over-the-counter medications, vitamins and other supplements (herbal or non-traditional).

Medication Name	Dose (i.e. 100 mg)	Times / Day	Date Updated	Medication is Taken (oral, injections, topical, etc.)

**Drug Allergies:** This list includes all known drug allergies and type of reaction.

☐ No known drug allergies.

Medication Name	Type of Reaction

Medication Name	Type of Reaction

**EMAIL COMMUNICATION OF HEALTH INFORMATION**  
**FACT SHEET AND CONSENT FORM**

As a patient of Carolina Eye Care, you may request that we communicate with you via unencrypted electronic mail (email). This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us, and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

***PLEASE READ THIS INFORMATION CAREFULLY***

Carolina Eye Care staff will make every effort to promptly respond to your requests for information via email, however, *if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.*

**Risks of using email to send protected health information include, but are not limited, to:**

- **Risk of Unauthorized Access by a 3rd Party:** Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.
- **Unique Difficulty in Verifying the Sender:** Email may be easier to forge than handwritten or signed papers. Carolina Eye Care will only send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

**Procedures**

- Emails are not checked outside of normal business hours – this includes overnight, on weekends or holidays.
- Please call Carolina Eye Care at 1-888-873-9348 to confirm that your request was received if you haven't received a response by email or telephone within 24-48 hours.
- If at any time you change your email address or wish to discontinue email communications altogether, you must notify Carolina Eye Care immediately in writing.

\*\*\*\*\* See Page 2 \*\*\*\*\*

**EMAIL COMMUNICATION OF HEALTH INFORMATION**  
**FACT SHEET AND CONSENT FORM**

**PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS**

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below, you agree to hold Carolina Eye Care harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

Client Email Address: \_\_\_\_\_

Client Signature \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Client Name (printed) \_\_\_\_\_ Date: \_\_\_\_\_

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:

\_\_\_\_\_



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## PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

Patient Name: \_\_\_\_\_ Patient Medical Record #: \_\_\_\_\_

### **Consent to Use and Disclose PHI & Acknowledgement of Receipt of Notice of Privacy Practices:**

**General consent to use and disclose personal health information to carry out treatment, payment for treatment and health care operations.**

With my signature below, I give Carolina Eyecare Physicians (CEP) permission to disclose my personal health information as necessary to carry out treatment, obtain payment for treatment provided to me and to carry out its health care operations.

A complete description of how CEP will use and disclose my personal health care information can be found in its Notice of Privacy Practices which has been made available to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices may be revised at any time by CEP and that I may view changes to the Notice of Privacy Practices at their website at [www.carolinaeyecare.com](http://www.carolinaeyecare.com) or by requesting a printed copy of revision from the Compliance department in writing. I hereby acknowledge that I have received, and have had the opportunity to ask questions regarding, a copy of the CEP Notice of Privacy Practices.

I have the right to request restrictions regarding how my personal health information is used or disclosed in the course of carrying out treatment, obtaining payment for treatment provided to me and carrying out health care operations. I may request restrictions by filling out the appropriate form which will be provided to me upon request. CEP is under no obligation to implement any of the restrictions that I may request but will be bound by any restrictions that it agrees to implement.

I understand that I may revoke this consent at any time notifying CEP in writing, except to the extent that action has been taken in reliance on it.

**Patient's / Patient's Legal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If signed by Representative, state relationship to patient:** \_\_\_\_\_

### **Authorization to Release Protected Health Information (PHI):**

I hereby authorize CEP to release my PHI to the following person(s) and understand that I may revoke this authorization in writing at any time. I understand that such disclosures may include, but not be limited to, discussing my medical condition(s) and treatment(s) with individuals that accompany me to my appointments and / or are responsible for my care-giving, leaving voice mail messages regarding appointments and / or balances due on my account, and any emergency situation which may arise in the course of my care.

_____ Name of Authorized Person	_____ Relationship	_____ Daytime Phone Number
_____ Name of Authorized Person	_____ Relationship	_____ Daytime Phone Number

### **Emergency Contact Information (To be completed if different from above):**

I hereby authorize CEP to contact the following person in any emergency which may arise in the course of my care.

_____ Name of Authorized Person	_____ Relationship	_____ Daytime Phone Number
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**Patient's / Patient's Legal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If signed by Representative, state relationship to patient:** \_\_\_\_\_

### **Documentation of Good Faith Efforts (To be completed if patient unable or unwilling to sign above):**

On this day, patient presented for treatment and was provided a copy of the CEP's Notice of Privacy Practices. Although a good faith attempt was made to obtain a written Acknowledgement of Receipt and Authorization to Release, signatures were not obtained because:

- \_\_\_\_ Patient / Legal Representative refused
- \_\_\_\_ Patient / Legal Representative unable due to medical disability
- \_\_\_\_ Emergency medical condition required immediate attention (signature to be obtained at next appointment)

**Printed Name of CEP Employee:** \_\_\_\_\_

**Signature of CEP Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Carolina Eyecare Physicians, LLC (CEP) is a privately-owned medical facility that provides medical services on a fee-for-service basis. CEP relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. CEP receives no federal, state, or other third-party funding; as such, CEP does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

For the convenience of our patients, CEP participates with most medical insurance companies and vision plans. CEP will submit claims for all medically necessary services to your insurance company. Please note that payment is ultimately due from you if your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, non-participating status, etc. If we do not participate with your medical or vision insurance(s), we will provide you with an itemized receipt so that you may file with your insurance company for any out-of-network benefits to which you may be entitled.

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore, coinsurance percentages cannot always be accurately calculated for pre-payment. A CEP statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

***Please note that CEP medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.***

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom CEP will seek reimbursement for medical services, prohibit the routine discounting of published fees, "insurance-only billing" or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) CEP and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e., cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc.), CEP accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

CEP does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

CEP is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

For your convenience, CEP accepts cash, check, money order and credit cards. In addition, CEP offers financing options through third party vendors.

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**I understand all the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Carolina Eyecare Physicians. I hereby authorize the provider and its employees, agents, and assignees, to contact me via e-mail, text message and to my cellular device.**

**I hereby assign all medical / surgical benefits to Carolina Eyecare Physicians, LLC for services rendered to me by the medical providers contracted under Carolina Eyecare Physicians, LLC, and request that payment of authorized benefits be made to assignee on my behalf. I authorize release of any medical information as may be required by Medicare and / or my other health insurance company to determine my benefits and issue payment to assignee for related medical claims.**

**My signature below constitutes my Financial Agreement, Assignment of Benefits, and Lifetime Signature Authorization.**

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Patient Name Printed

---

Patient / POA Signature

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Date

***Failure to honor your financial obligations to CEP in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care.***



The refraction is **not** a covered service by Medicare and many other medical insurance plans. **The fee for the refraction is \$65** and unless your plan covers the refraction fee, it is collected at the time of service in addition to any copayment your plan may require. Separate vision plans will cover a refraction fee. Should your plan pay for the refraction, we will reimburse you accordingly.

### **Section 3: Contact Lens Management & Fee:**

If you are having an eye examination and currently do not wear contact lenses, your Physician may provide contact lenses as an option to, or in addition to, wearing glasses. In addition to the comprehensive eye exam and the cost of the contact lens, a professional management fee is charged. Management fees vary and are determined by the complexity of your medical diagnosis and required prescription and include 60 days of follow-up care related to your new contact lenses.

If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine the present appropriateness of your lenses. **Contact lens prescriptions generally are valid for one to two years.** An evaluation is performed every year in order to manage your prescription. *Additional fees will apply regardless of changes to your contact lens prescription.*

Contact lens management fees are collected at the time of service in addition to any copayment your plan may require. Some vision plans provide limited coverage for contact lens fitting. Should your plan pay for the management fee, we will reimburse you accordingly.

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### **Section 1: Coding & Billing for Your Comprehensive Eye Exam:**

I understand that I am here today for a comprehensive eye exam and I have checked with my insurance to understand my medical and/or routine benefits. I understand that the exam will be coded as routine or medical based on the results, diagnosis and suggested treatment of the comprehensive eye exam performed by my doctor.

Initials: \_\_\_\_\_

### **Section 2: Refraction Service & Fee:**

I understand the refraction is an important and necessary part of a comprehensive eye exam and that some insurance plans, including Medicare, do not cover this cost. I understand the cost is \$65 and is due at the time of service.

Initials: \_\_\_\_\_

### **Section 3: Contact Lens Management & Fee:**

I understand that contact lens fitting is an additional service to a comprehensive eye exam and is not covered by most insurances. The cost of the contact lens fitting is dependent on the type of contact lenses I am being fit for and the time, measurement and trials that go into that particular lens fitting. I understand I will be made aware of the cost of the fitting by my doctor and this cost will be due upon checkout after my comprehensive eye exam.

Initials: \_\_\_\_\_

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I have read and understand the above information. I authorize Carolina Eyecare Physicians, LLC. to file claim(s) with my appropriate insurance(s). I accept full financial responsibility for the cost of a refraction and / or contact lens management, if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction fee or contact lens management fee. My signature below constitutes my understanding of this explanation of coverage and Lifetime Signature Authorization.

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Patient Name Printed

---

Patient / POA Signature

---

Date

## EXPLANATION OF COVERAGE

### Section 1: Coding & Billing for Your Comprehensive Eye Exam:

At Carolina Eyecare Physicians, LLC. (CEP), we ask that patients take some time to fully understand the coverage and benefits of their medical and vision insurance(s). Routine and medical benefits are very different in terms of the services they cover. Vision plan coverage is designed for routine eye exams which may include an annual eye exam to evaluate the health of the eyes, determine of the need for glasses / contact lenses and certain benefits to help pay for glasses or contact lenses.

It is the responsibility of the patient to notify CEP prior to their exam if they have routine coverage or a separate vision plan. **If a medical diagnosis is identified (or suspected) during a routine eye exam and additional testing and treatment is medically indicated, the provider reserves the right to evaluate and treat such medical issues.** CEP is required by our medical insurance and vision plan contractual relationships to submit the claim(s) to the appropriate carrier. To minimize out-of-pocket expense to our patients, we will submit the routine exam to your vision plan (which typically imposes a lesser copayment). However, any medical evaluation, diagnostic testing and treatment will be billed to your medical insurance and you will be financially responsible for any applicable deductibles, co-insurances and non-covered services in accordance with the benefits of your medical insurance.

The chart shown below helps illustrate the coding process for comprehensive eye exams.

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#### **Comprehensive Eye Exam includes:**

- A health, medication and vision history
- A refraction (best visual acuity test) – See the Refraction Service & Fee section below.
- An examination of the front of the eye which includes the sclera, cornea, pupil iris, eyelid and conjunctiva
- A dilated examination and / or diagnostic image of the back of the eye which allows the Physician to observe your retina and optic nerve

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Based on the results of the exam, the Physician determines if the visual changes you are experiencing are due to refractive error or are disease-related changes. The Physician may order additional testing, refer you to another specialist or advise other treatments as needed.

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#### **Routine Coding:**

If you have vision changes of normal refractive error, including nearsightedness, farsightedness or astigmatism your exam will be coded as routine.

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#### **Medical Coding:**

If the Physician diagnoses a medical condition such as high blood pressure, diabetes, or an eye disease such as, cataracts, glaucoma, infections, dry eyes, allergy, etc. your exam will be coded as a medical comprehensive eye exam.

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Comprehensive exams that are billed **medically** are not covered under your routine or vision plan coverage and will be submitted to your medical insurance company. Please note that even if your exam is billed to your medical insurance, any glasses / contact lens benefits that you may have would still be available to you. In the event you want a routine exam for a glasses or contact lens prescription only, it is your responsibility to immediately inform the Physician and understand that any medical complaints or findings will be addressed at a separate visit.

### Section 2: Refraction Service & Fee:

A refraction is a vision test that is routinely performed during an eye exam and is vital to determine your best potential vision. A refraction evaluates the function of your eyes and provides essential information to determine if you would benefit from a prescription for glasses and / or contact lenses. This important part of your eye exam helps the Physician to better understand the full potential of your visual system, identify any medical concerns that may be impacting your vision and determine your correct prescription.