CAROLINA EYECARE PHYSICIANS, LLC

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: _____

CAROLINA EYECARE PHYSICIANS, LLC

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Ocular History:

□ Yes □ No Cataracts
□ Yes □ No Cornea Transplant
□ Yes □ No Diabetic Retinopathy
□ Yes □ No Dry Eye Syndrome
□ Yes □ No Glaucoma
□ Yes □ No LASIK / Epi-LASEK
□ Yes □ No Macular Degeneration
□ Yes □ No Punctal Plugs
□ Yes □ No Retinal Detachment
□ Yes □ No YAG Laser
□ Other: _____

What is the reason for your visit today?

□ Blurred Vision	RT LT	□ Dry Eyes	RT LT	□ Itching	RT LT
□ Decreased Vision	RT LT	□ Flashes	RT LT	□ Pain	RT LT
□ Discharge	RT LT	□ Floaters	RT LT	□ Red Eye	RT LT
□ Double Vision	RT LT	□ Headache	RT LT	□ Tearing	RT LT

□ Other: _____

Immunization / Vaccination:

□ Yes □ No Influenza Date/s: _____
□ Yes □ No Pneumococcal Date: _____

Surgical History:

□ Yes □ No Appendectomy
□ Yes □ No Carotid Endarterectomy
□ Yes □ No Gallbladder
□ Yes □ No Heart Bypass
□ Yes □ No Hernia
□ Yes □ No Hemorrhoidectomy
□ Yes □ No Hysterectomy
□ Yes □ No Mastectomy
□ Yes □ No Prostate
□ Yes □ No Skin Cancer Removal
□ Other: _____

Allergies: □ No Known Drug Allergies

Allergy	Type of Reaction

□ Yes □ No Latex Please describe: _____
□ Yes □ No Anesthesia Please describe: _____

CAROLINA EYECARE PHYSICIANS, LLC

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History:

□ Yes	□ No	Cataracts	□ Mother	□ Father	□ Other:	_____
□ Yes	□ No	Diabetes	□ Mother	□ Father	□ Other:	_____
□ Yes	□ No	Glaucoma	□ Mother	□ Father	□ Other:	_____
□ Yes	□ No	Macular Degeneration	□ Mother	□ Father	□ Other:	_____
□ Yes	□ No	Retinal Detachment	□ Mother	□ Father	□ Other:	_____
□ Other:	_____		□ Mother	□ Father	□ 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:

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

□ Other: _____

CAROLINA EYECARE PHYSICIANS

A US EYE COMPANY

Notice of Non-Discrimination & Interpreter Services

Carolina Eye Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity). Carolina Eye Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity).

Carolina Eye Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters;
    - Written information in other formats (large print, audio, accessible electronic formats, other formats);
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters;
    - Information written in other languages.

If you need these services, contact our Compliance Officer/Section 1557 Coordinator.

If you believe that Carolina Eye Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity), you can file a grievance with:

Compliance Officer/Section 1557 Coordinator
Carolina Eye Care Physicians, LLC
8043 Cooper Creek Blvd
Suite 101
University Park, FL 34201
Phone: 941.373.6277
Fax: 941.373.6278
TTY number—711

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CAROLINA EYECARE PHYSICIANS

A US EYE COMPANY

Translation Services

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-856-0568.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame
al 1 888-856-0568.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1888-856-0568.**

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-856-0568.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화하십시오. 1-888-856-0568.

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-856-0568.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-856-0568.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-856-0568.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-856-0568.

Gujarati
જો તમે ગુજરાતી બોલો છો, તો મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. **1-888-856-0568** પર કૉલ કરો.

Arabic
إذا **كنت تتحدث العربية ، تتوفر**
خدمات المساعدة اللغوية
المجانية. اتصل بالرقم 1
.0568-856-888

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-856-0568.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-856-0568）まで、お電話にてご連絡ください。

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-856-0568.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-856-0568 पर कॉल करें।

Khmer-Cambodian

ប្រសិនបើអ្នកត្រូវការជំនួយភាសាជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខ 1888-856-0568។

NOTICE OF PRIVACY PRACTICES

Carolina Eyecare Physicians, LLC

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY:

Carolina Eyecare Physicians, LLC is required to comply with all applicable federal and state laws to maintain the privacy of your Protected Health Information (PHI'). PHI is defined as "any individually identifiable health information that relates to any physical or mental health or that can otherwise be used to identify the individual".

Carolina Eyecare Physicians, LLC is also required to provide you with this notice about our privacy practices, our legal obligations, and your rights concerning your PHI. This notice is effective January 15, 2026 and is subject to any amendments enacted by the governing statutes. Periodic amendments may also be made in order to clarify certain language of the applicable laws and statutes. We may tell you about any changes to our notice through a newsletter, patient portal, website or a letter.

You may request a copy of this notice (or any subsequent revision of this notice) at any time, even if you agreed to get this Notice by electronic means, you still have the right to ask for a paper copy. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information:

Carolina Eyecare Physicians, LLC may use and disclose your PHI to (1) facilitate your medical treatment, (2) obtain payment from your health insurance company for medical services, and (3) industry standard health care operations. Such use and disclosure of your PHI is considered under HIPAA as **"permissible use"**. Any and all "permissible use" of your PHI will be made within "**minimum necessary**" limitations, and only to facilitate specific activity directly relative to treatment, payment and / or operations.

Following are examples of permissible use of your PHI.

Treatment: Carolina Eyecare Physicians, LLC may use and disclose your PHI to provide, coordinate, or manage your health care and any related services as recommended by your medical provider. This includes the coordination or management of your health care with a third party or other physicians who may currently be involved with your medical care or whom it may be determined by your medical condition to be required with your medical care for the purposes of diagnosis and treatment (i.e. specialist, laboratory, hospital, or other facility). If you receive services through Telemedicine, we will also collect information as part of the services or information provided during the audio and/or video teleconference encounter itself, and to the extent applicable, through other telephonic communications. We may also collect information from the electronic medical record system (if applicable) of your selected provider in order to facilitate the provision of services.

Payment: Carolina Eyecare Physicians, LLC may use and disclose your PHI to obtain payment for your health care services. This may include providing copies of the pertinent medical record to your health insurance plan in order to determine eligibility and benefits, obtain pre-authorization on your behalf for recommended medical services, review of medical services provided to you to confirm medical necessity, and other health plan utilization review activities. For example, obtaining approval for a hospital admission may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: Carolina Eyecare Physicians, LLC may use and disclose your PHI in order to facilitate industry standard business and operational activities. These activities include, but are not limited to, daily clinic operations relative to scheduling, appointment reminders, assembly and maintenance of your medical record, and inter-departmental coordination of your medical care. These activities also include care coordination, case management, quality assessment and improvement activities, to the extent permitted by law. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name, call you by name in the waiting room when your doctor is ready to see you, or contact you by telephone or mail to ensure necessary continuum of care or other related activities.

Sharing your PHI with you. Carolina Eyecare Physicians, LLC must give you access to your own PHI. You have the right to inspect and obtain a copy of your PHI in the form and format you request, including an electronic copy, if it is readily producible in that form and format. If the PHI is not readily producible in the requested form or format, it will be provided in a readable alternative form or format. We will act on your request for access no later than 30 days after receipt of your request, unless a lawful extension applies. Any fees charged will be reasonable and cost-based, as permitted by law. Carolina Eyecare Physicians, LLC, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. The calls/texts may be about appointment reminders, appointment confirmations, treatment options, health-related benefits and services and to gather feedback regarding your experience. If you do not want to be contacted by phone or text, just let the caller know and we will add you to our Do Not Call list. We will then no longer call or text you. However, if you initiate communications using e-mail, we will assume (unless you have explicitly stated otherwise) that e-mail communications are acceptable to you. Communications via email over the internet are not secure. Although it is unlikely, there is a possibility information included in an email can be intercepted and read by other parties besides the person to whom it is addressed. You understand you must take reasonable steps to protect against the unauthorized use of electronic communications by others, and Carolina Eyecare Physicians, LLC is not responsible for breaches of confidentiality caused by you or an independent third party.

Carolina Eyecare Physicians, LLC may share your PHI with third party "**business associates**" that perform certain activities (i.e. billing, transcription services) for the company. Whenever an arrangement between our office and business associates involves “permissible use” of your PHI, your PHI is protected by a **Business Associate Agreement** that contains terms that will protect your PHI.

Uses and Disclosures Based On Your Written Authorization: Any other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. Your written authorization may be revoked in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Health information that has been properly de-identified is not protected by the HIPAA Privacy Rule and may be used for research and other statistical purposes.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify as an emergency contact, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Uses and Disclosures Required by Law:

Research; Death; Organ Donation: Your (de-identified) PHI may be used or disclosed for research purposes in limited circumstances. Your PHI may be disclosed to a coroner, protected health examiner, funeral director, or organ procurement organization under specific circumstances.

Public Health and Safety: Your PHI may be disclosed to the extent necessary to avert a serious and imminent threat to your personal health or safety, or the public health or safety of others. Your PHI may be disclosed to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: Your PHI may be disclosed to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: Your PHI may be disclosed to a public health authority that is authorized by law to receive reports of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: Your PHI may be disclosed to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable state and federal laws, your PHI may be disclosed, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: Your PHI may be disclosed when we are required to do so by law. For example, we must disclose your PHI to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your PHI when authorized by Workers' Compensation or other similar laws.

Process and Proceedings: Your PHI may be disclosed to legally authorized law enforcement officials in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Carolina Eyecare Physicians, LLC may disclose PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or who has escaped from lawful custody.

Accreditation Organizations: Disclosure to accreditation organizations for quality purposes. Any accreditation organization would be considered a Business Associate and would enter into an agreement with us to maintain confidentiality and protect the privacy of your PHI.

Disaster Relief: To respond to a disaster relief organization inquiry that seeks your PHI to coordinate your care or notify family or friends of your location or condition in a disaster.

USES AND DISCLOSURES OF PHI THAT REQUIRE YOUR AUTHORIZATION OR ATTESTATION

The following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures of PHI for marketing purposes; and
- Use and disclose genetic information of you or your dependents for underwriting purposes.

For certain kinds of PHI, federal and state laws may require enhanced privacy protection, and we can only disclose such information with your written permission except when specifically permitted or required by law. This includes PHI that is:

- Maintained in psychotherapy notes and mental health notes.
- About alcohol and drug abuse prevention, treatment and referral (except as permitted by 42 C.F.R. Part 2)
- About HIV/AIDS testing, diagnosis or treatment.
- About venereal and/or communicable diseases(s).

• About genetic testing.

Certain uses and disclosures of health information may be subject to additional restrictions under applicable federal or state law. Where such laws apply, Carolina Eyecare Physicians, LLC will comply with those requirements.

You may revoke your authorization at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI
You have the following rights, subject to certain limitations, regarding your PHI:
• Inspect and obtain a copy of your PHI that is included in paper or electronic records we maintain. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
• Request restrictions in how the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by law to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply. Further, we will honor your request, to the extent permitted by law, not to disclose information to us, an insurer or a third party about a medical visit, service or prescription for which you pay the full amount out of your pocket at the time of service.
• Request an accounting of disclosures we have made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee and will notify you in advance for responding to these additional requests.
• Request confidential communications whereby we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.
• Receive notice of a breach in the event of a breach of any of your PHI.
• Request an amendment of your PHI that you believe is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided below and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment and will inform you of the reason for the decision within 60 days.

Questions and Complaints:

If you want more information about our privacy practices or if you have questions or concerns, please contact Carolina Eyecare Physicians, LLC's HIPAA Privacy Officer indicated below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, please submit your concerns in writing to the Carolina Eyecare Physicians, LLC's HIPAA Privacy Officer indicated below. You also may submit your concerns to the U.S Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

HIPAA Privacy Officer:

Attention: Privacy Officer
Office: 8043 Cooper Creek Blvd
Suite 101
University Park, FL 34201
Email: useyecompliance@useye.com

You may also contact the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. Your complaint can be sent by email, fax, or mail to the Office of Civil Rights. U.S. Dept. of Health, OCR, 200 Independence Avenue SW, Washington, D.C., 20201. For more information, see their website at: http: www.hhs.gov/ocr/privacy/hipaa/complaints/.

No action will be taken against you for filing a complaint.

CAROLINA EYECARE PHYSICIANS, LLC

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 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 take 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

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

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:** _____

Internal Use Only

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Carolina Eyecare Physicians, LLC (CEP) are privately-owned medical facilities that provide 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. A 3% convenience fee will be applied to all credit card transactions. In addition, CEP offers financing options through third party vendors.

No Show/ Appointment Cancellation Policy: This policy is designed to help us serve all patients as effectively as possible.

To keep things running smoothly, appointments are necessary. When appointments are missed or cancelled late, it affects more than just our schedule—it limits the availability of care for other patients who could have used those time slots. These disruptions can lead to delays in healthcare for others.

If you need to cancel your appointment, please let us know at least 24 hours in advance. We understand that emergencies happen, but because missed appointments are becoming more common, we must strictly enforce this policy. Consistent no-shows without timely notice may result in a fee for each missed appointment or possible dismissal from our practice. Late arrivals may need to be rescheduled, and the missed appointment fee may apply.
Please keep in mind that this fee is not covered by insurance.

We value your understanding and recognize that medical emergencies can happen unexpectedly. Each case will be reviewed individually.

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, LLC. 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.

Patient Name Printed	Patient / POA Signature	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.

CAROLINA EYECARE PHYSICIANS, LLC

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.

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

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.

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

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.

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.

The refraction is **not** a covered service by Medicare and many other medical insurance plans. **The fee for the refraction** is **$70** 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.

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 $70 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: _____

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.

Patient Name Printed	Patient / POA Signature	Date

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.

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:

_____

CAROLINA EYECARE PHYSICIANS, LLC

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