LAKE NORMAN OPHTHALMOLOGY, PLLC

Account Number: _____
Date: _____

Referring Doctor: _____ Primary Care Doctor: _____

PATIENT INFORMATION						
Patient's Name (First M Last)			Email			
Date of Birth	Age	Sex (check one) ___Male ___Female	Marital Status (check one) ___Single ___Married ___Divorced ___Widowed			
Mailing Address			City	State	ZIP code	
Street Address (if different from mailing)			City	State	ZIP code	
Home Phone Number	Work Phone Number		Mobile Phone Number			

INSURANCE INFORMATION	
Please Check One: ___ Patient IS the policy holder ___Patient IS NOT the policy holder ___Self Pay	
Primary Insurance Company:	Secondary Insurance Company:

POLICY HOLDER (IF DIFFERENT FROM PATIENT)		
Policy Holder's Name (First Middle Last)		Relationship to Patient
Social Security #	Date of Birth	Sex (check one) ___Male ___Female

Please be aware that if you are on an insurance that has a vision policy, it is your responsibility as the patient to make sure that this office participates with that particular company's vision insurance plan. Because Lake Norman Ophthalmology has board certified ophthalmologists on staff and not optometrists, most vision plans are not accepted. These plans are geared for well checks and glasses only. Please check with the billing department should you have a question about your insurance, prior to your visit.

It is customary to pay for professional services when rendered.
Any other arrangements must be made in advance.
A receipt will be provided so that you may file any vision insurance plan that this office does not participate with.

- I authorize Lake Norman Ophthalmology PLLC to release to the Social Security Administration, HCFA or its intermediaries or other carries, any information needed for this or a related Medicare claim.
- I permit a copy of this authorization to be used in place of the original and request benefits either to myself or to the party who accepts assignment.
- I understand that Medicare and most other carries DO NOT provide coverage for routine eye examinations or eye refractions and that there will be a charge for these services.
- I understand that even with vision coverage, most carriers DO NOT cover contact lens fittings or refitting fees, the contact lens fitting fee varies. The standard contact lens fitting is $45 annually and is not covered by insurance.

Medical History

Medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check is you have, or have been treated for:

___ cataracts
___glaucoma
___diabetic (insulin/non-insulin)
___stroke
___high cholesterol
___high/low blood pressure
___congestive heart failure
___thyroid disorder
___arthritis
___asthma
___emphysema
___COPD
___Pregnant___months

Do you wear contact lens? ___Yes ___No
If so, what brand _____

Allergies:

_____
_____
_____

Eye Surgeries:

_____
_____
_____

Other **(Surgical Procedures/Health Info):**

_____
_____
_____

1. Which of the following do you consider yourself?
__Hispanic or Latino ___Non Hispanic or Non Latino

2. Which category best describes your race?
___Black, African American ___White ___Asian
___Pacific Islander ___American Indian ___Other ___Decline

3. Which language do you prefer to use to communicate?
___English ___Spanish ___Hindi,Gujarati
___Chinese ___Japanese ___Korean ___Vietnamese

Signature: _____ Date: _____

Relationship to Patient:_____

Lake Norman Ophthalmology, PLLC

Financial Policy

Welcome to Lake Norman Ophthalmology, PLLC thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal care needed to maintain/restore your health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to contact our billing staff.

If you need to cancel an appointment, we ask for a 24 hour notice; or we do reserve the right to charge you for your missed appointment. We also reserve the right to dismiss you from the practice if you have three visits that have been cancelled or rescheduled **consecutively**.

Please present your current insurance ID card at your visit and if anything changes we ask that you contact us immediately. If you present to the office for your appointment without your current insurance, this visit will be treated as private pay. In the event we do not participate with your insurance plan you will be responsible for the entire bill.

As a service to you, our office makes every reasonable effort to obtain payment according to your coverage. Regardless of the type of insurance you have, you are ultimately responsible for paying your medical bills. If your insurance company rejects the claim or denies payment, the office will bill you for the entire amount. It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims.

All co-payments and deductible amounts are due and should be paid at time of service. This policy is in accordance with legal requirements for collecting patient responsibility amounts. Although it is your responsibility to know your insurance plan, our staff will try and obtain this information for you with the amounts prior to your procedure. Unresolved balances may be placed with an outside collection agency and may also be subject to finance charges, attorney fees and collection agency fees. In the case of an unpaid balance which has been turned over to a collection agency outside of our office, you will be dismissed from our practice.

A $25.00 fee will be charged for all checks that are returned to us by your financial institution and will be payable immediately via credit card or cash.

Failure to provide necessary referrals and /or authorizations will result in all charges for services becoming the sole responsibility of the patient/responsible party.

Our practice accepts Visa and MasterCard for your convenience. We also accept personal checks and cash. We will ask you for your co-payment at time of service, if you are unable to pay your co-payment we will need to reschedule your appointment.

Authorization: I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company(s). I authorize my insurance company(s), attorney or other parties to pay Lake Norman Ophthalmology, PLLC and /or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collection the account, including any necessary attorney fees.

I authorize Lake Norman Ophthalmology, PLLC to administer medical care as is necessary, including allowing release of records or medical reports on my condition to any party involved in my treatment.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

LAKE NORMAN OPHTHALMOLOGY, PLLC Chart:_____

How May We Contact You?

Please check all that apply and complete the necessary information:

___ Messages may be left on my home answering system. The number is: _____
___ My answering machine does not identify me by name, but it's OK to leave messages anyway.
___ Messages may be left for me at my work voicemail. The number is:_____
___ Messages may be left at home with my spouse. His/her name is:_____
___ Other persons authorized to receive messages on my behalf are:_____

_____ _____ _____
Signature of Patient or Guardian Relationship to Patient Date

Consent for Release of Protected Health Information (Please sign even if you do not list anyone)

I consent the disclosure of the following protected health information about me to the following person(s):

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Check all that may apply:

___ All my medical information
___ Information necessary to schedule appointments for me
___ Lab or test results
___ Information necessary to provide, call in or pick up prescriptions for me
___ Information necessary to help my family member(s) take care of me
___ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors.

My consent will remain in effect as long as I am a patient of Lake Norman Ophthalmology unless and until I notify Lake Norman Ophthalmology in writing of any changes.

_____ _____ _____
Signature of Patient or Guardian Relationship to Patient Date

Patient Acknowledgement and Consent

I have been given a copy of Lake Norman Ophthalmology's Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____ _____
Signature of Patient or Guardian Relationship to Patient Date