KERRY SOLOMON, MD

CAROLINA EYECARE PHYSICIANS

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: _____

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

Ocular History:

□ Yes □ No	Cataracts	□ Yes □ No	LASIK / Epi-LASEK
□ Yes □ No	Cornea Transplant	□ Yes □ No	Macular Degeneration
□ Yes □ No	Diabetic Retinopathy	□ Yes □ No	Punctal Plugs
□ Yes □ No	Dry Eye Syndrome	□ Yes □ No	Retinal Detachment
□ Yes □ No	Glaucoma	□ 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	Hemorrhoidectomy
□ Yes □ No	Carotid Endarterectomy	□ Yes □ No	Hysterectomy
□ Yes □ No	Gallbladder	□ Yes □ No	Mastectomy
□ Yes □ No	Heart Bypass	□ Yes □ No	Prostate
□ Yes □ No	Hernia	□ 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: _____

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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: _____

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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

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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 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

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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.

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.

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.

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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 $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.

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: _____

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