Shelley Eye Center
Welcome to Our Office
Invest in your vision. We do.

Shelley Eye Center is a medically oriented eye care practice.
We focus on your overall visual healthcare as well as your optical needs.

PLEASE FILL OUT COMPLETELY Date________________________

PATIENT: ____ DOB ____/____/_______ AGE __________

MAILING ADDRESS _______________________________CITY _________________STATE_______ ZIP _________

Home #______________ Work # ______________ Cell #______________ Email _________________________

SS# _______________________ Sex ☐ M ☐ F Married _____ Single _____ Divorced _____ Other __________

RESPONSIBLE PARTY - Who is responsible for the account? (Responsibility Party MUST be present and sign form)

NAME ____DOB ____/____/_______ SS# ______________________

ADDRESS____________________________________CITY _________________STATE_______ ZIP ________

INSURANCE INFORMATION -- **Please provide the insurance card(s) to receptionist**

Insured's Name________________________________ DOB ____/____/_______ SS# _______________________

Insured's Address ____Phone # _________________

Employer ____Phone #_________________

Medical Ins. Co. ____ ID#:_________________________

Supplemental Insurance____ ID#:_________________________

Vision Plan _________________________________Relationship to Member ___ Self ___Spouse ___Child ___Other

REASON FOR VISITING OUR OFFICE TODAY (please check all that apply):

- ❑ Annual Ocular Health Exam
- ❑ Contact Lens Exam
- ❑ Blurred Near and/or Distance Vision
- ❑ Foreign Body (something in the eye)
- ❑ Trouble Seeing at Night
- ❑ Headaches
- ❑ Eyes ___burn/itch ___ feel tired ___ feel dry
- ❑ Flashes of Light
- ❑ Floaters (black specks & spots)
- ❑ Eye Injury
- ❑ Discharge from eyes

Do you wear contact lenses? Y N

How long have you worn contacts? ___________

Type of Contacts

Soft Daily Disposable Gas Perm Other

Brand of Contacts _______________________

How long do you wear your contacts? ______hrs

Do you sleep overnight in your contacts? Y N

Do you have a backup pair of glasses?: Y N

How often do you wear your glasses? _______hrs

Do you regularly wear sunglasses?: Y N

Date of Last Eye Exam ___________________

Referral source: Dr. ______________________ Internet Friend/Family:________________ Other:______________

MEDICATION (Including Vitamins)	DOSAGE	FREQUENCY
List Allergies to Medication:		

Do you or an immediate family member (grandparent, parent, or sibling) have any of the following conditions:

	Self		Date of Onset	Family Member?		Self		Date of Onset	Family Member?
Diabetes***	Y	N			Blindness	Y	N		
Macular degeneration	Y	N			Cataracts	Y	N		
Glaucoma	Y	N			Digestive disease	Y	N		
Circulatory Problems	Y	N			Stroke	Y	N		
Respiratory Disease	Y	N			Tuberculosis	Y	N		
Heart Disease	Y	N			Blood Disease	Y	N		
Kidney Disease	Y	N			Thyroid Problems	Y	N		
Liver Disease	Y	N			Cancer	Y	N		
High Blood Pressure	Y	N			Arthritis, Rheumatism	Y	N		
Headaches	Y	N			Cortisone/Prednisone	Y	N		Applies to patient only
Allergies	Y	N			Chemotherapy	Y	N		
Dementia/Alzheimer's	Y	N			Venereal Diseases	Y	N		
Back Problems	Y	N			HIV/Aids	Y	N		

It is the standard of care in this office that if you are diabetic, you WILL BE dilated and your exam will be billed to your medical insurance -- NO exceptions.

LIFESTYLE QUESTIONNAIRE

Please answer the following questions to assist our Opticians in determining your eyewear needs.

1. Do you currently wear glasses? Y N Single Vision Progressive(no-line) Bi-Focal Other ________________
2. What do you like most about your current eyewear (style, color, fit, brand, etc.)? ____
3. What don't you like about your current eyewear (weight, thickness, dryness, glare, etc. ____

How will you settle your account today? Check Cash Visa MasterCard CareCredit

The above information is accurate to my knowledge. I personally guarantee payment for all services rendered. I authorize the release of any medical information to my insurance company in order to process claims related to my care.

Patient/Guardian Signature ____Date ________________

By signing below, I affirm that I, and/or my dependent(s), have medical insurance coverage and/or vision coverage as stated herein. I assign directly to Dr. Brent E. Shelley & Associates, all insurance benefits, if any, for all services rendered. I authorize the use of my signature on all claims submitted to the insurance company(ies) I have listed above. Southwest Vision Specialists, PA may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits and as allowed by the federal law.

- I may request a copy of the Shelley Eye Center Notice of Privacy Practices although it is displayed in the office and available online at www.shelleyeyecenter.com,
- I am financially responsible for ***all*** charges incurred today,
- I am financially responsible for any charges that my insurance or vision plan ***does not*** pay, including, but not limited to, any deductibles, co-pays, and/or services not covered by my insurance or vision plan,
- If I have any questions regarding payment or non-payment, I MUST contact the insurance company directly,
- It is my responsibility to know what my medical insurance and vision plan coverage is,
- Professional fees (exam, testing and contact lens fitting fees) and optical materials are ***NOT*** REFUNDABLE (absolutely NO exceptions),
- The information I have provided is accurate to the best of my knowledge.

ALL MEDICAL SERVICE FEES, GLASSES FEES and CONTACT LENS EXAM FEES ARE DUE UPON COMPLETION OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

We gladly offer interest free financing through WWW.CARECREDIT.COM
By signing below I affirm that I have read, received, and understand the billing policies of Shelley Eye Center.

____ ____
Printed Name (**and** guardian name if applicable)   Signature and Date (or guardian signature)

OUR OFFICE DOES NOT MAKE THE RULES
THEY ARE DETERMINED BY YOUR SPECIFIC MEDICAL INSURANCE OR VISION PLAN

Advanced Beneficiary Notice:

Refraction Policy

Refraction is the process of determining the eye's refractive error (e.g. "glasses prescription). It is an essential part of an eye examination; however, it is ***not*** a covered service by Medicare or most insurance plans. Our office fee for refraction is $40.00 and this fee is collected in addition to the patient co-pay.

Acknowledgment

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refractive fee.

____ ____
Patient Signature (Parent for minor)   **Date**

******IT IS IMPERATIVE THAT YOU READ OUR BILLING POLICIES IN FULL*******

THIS PRACTICE FOLLOWS STANDARD BILLING PRACTICES AND GUIDELINES AS DEFINED BY THE CENTERS FOR MEDICARE SERVICES

I understand and agree that I am financially responsible for any and all charges for services rendered or not paid by my insurance(s). This includes any medical service or visit, preventative exam/physical, lab or diagnostic testing, and any other screening ordered by the doctor or doctor's staff.

I understand that Shelley Eye Center does **not** accept Medicaid, whether it is my primary or my secondary insurance, and that I am solely and wholly responsible for any and all fees.

I understand that it is my responsibility and not the responsibility of the doctor or staff, to know if my insurance will pay for such medical services, preventative exam/physical, lab or diagnostic testing, and any other screening ordered by the doctor or doctor's staff.

I understand that while my insurance may confirm benefits, confirmation of benefits does not mean that the insurance company will pay the doctor, and that I am responsible for **any** unpaid balance.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the service I receive and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may result in claims being denied or higher out of pocket expenses to me.

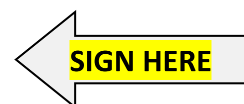
I understand that the office will file my insurance but if for any reason the insurance has not made payment within 45 days, the balance becomes my responsibility. Any money received from the insurance company after the 45 days will then be reimbursed to me. It is my responsibility to let the office staff know of any insurance changes so that claims can be filed correctly. If insurance is not active at time of service, I will be charged the balance in full.

Most Medicare Secondary plans receive the secondary claim directly from Medicare therefore; it is your responsibility to inform the front desk and to provide them with your secondary insurance card. The only secondary plan we directly submit to is VSP. If for any reason you have two commercial insurances, we will only bill the primary. If we do not obtain the proper secondary insurance information from you, this office will not bill the secondary. It will then be your responsibility to file the claim and request payment.

As per page 1.8 of the VSP Manual, VSP is considered SECONDARY to any and all medical insurances, including but not limited to Medicare, BCBS, Lovelace, Cigna, Aetna, Tricare, Presbyterian, Lovelace, Health Smart, Principal, etc. As such if you have diabetes, cataracts, macular degeneration, use medications that have potential ocular side effects, glaucoma, or any other medically related eye condition, your medical insurance is PRIMARY, while your vision plan is SECONDARY. Under no circumstances does VSP cover any form of exam requiring medical treatment of the eye or a prescription for medication.

If you are a Medicare recipient and provide us your with a standard Medicare card, and your insurance is declined because you opted into a Medicare HMO or PPO plan, you will be financially responsible for the entire bill. We will not re-file a claim on your behalf. It is your responsibility to provide us with the proper insurance card at the time of service.

Ultimately, it is your responsibility to know what your insurance and vision plans cover. The doctors and staff of Shelley Eye Center sincerely appreciate your compliance with these policies



____ ______________________
Patient's Signature (Parent and/or Guardian) Date

There are many different types of insurance plans offered now. Many insurance policies have high deductibles in order to have lower premiums. As such we have made changes to account for these plans:

1. **MEDICAL INSURANCE vs VISION CARE PLANS**
   a. **Medical Insurance**: When a medical condition or diagnosis is present such as cataracts, glaucoma, high blood pressure, diabetes, or any other condition related to the health of the eye, it is necessary for the doctor to provide you with a comprehensive ocular health exam. In this case, we will file a claim to your major medical insurance carrier. Most carriers will pay a portion of some diagnostic tests needed to determine, diagnose, and treat medical conditions related to your ocular health.
   You will be dilated if:
      - You have been referred by another practitioner
      - You have a systemic condition that directly affects the eyes (Diabetes, Lupus, rheumatoid arthritis, etc)
      - You take medications that directly affect the eyes (spironolactone, Plaquenil, hydroxychloroquine, prednisone, etc.)
      - You have been previously diagnosed with an ocular health condition

   If you are diabetic, you WILL BE dilated and your exam WILL be billed to your medical insurance without exception.

   b. **Vision Care Plans**: Vision coverage through most vision plans is designed to determine the prescription for glasses or contact lenses ONLY. This CATEGORICALLY EXCLUDES a detailed examination of the health of the eye or any diagnostic tests needed to determine medical conditions.

2. **Co-payments and Deductibles:** Co-payments will be collected at the time of service. If you have not met your deductible, we will collect the entire cost of the visit. Since each insurance has different allowable amounts per type of office visit, we will estimate what your insurance will allow and collect that amount. If we overestimate, we will apply that amount toward your next visit, or write you a refund check after all insurance has cleared. If we underestimate, you will be billed for the balance. We accept checks, cash, Visa and MasterCard. There is a **$35.00** charge for all returned checks. **Professional fees & Co-pays/Co-shares are NOT refundable**

3. **Refractions:** Refraction is a procedure incorporated into an ocular exam used to determine your best possible vision, and if applicable your eyeglass prescription. It is considered to be a “non-covered” service by Medicare, secondary supplemental insurances and most major medical commercial insurance companies. You are asked to pay the refraction fee of $40 at the time of service whether or not a new prescription is written.

4. **Insurance:** in order to avoid being responsible for payment in full, you are required to present a current insurance card at each visit. If you do not present a card, you will be charged for the services and any diagnostic tests.

5. **Missed Appointments**: Please notify us as soon as possible if you need to cancel an appointment since someone else may need the time that we reserved for you. A **$25 charge** will be billed to your account for any and all missed appointments. We will attempt to notify you of your appointment, but ultimately it is your responsibility to call us to cancel if you are unable to keep your appointment. After 2 missed appointments, you can be dismissed from the practice.

6. **Phone calls:** We are glad to answer brief questions for you over the phone. However, when phone advice becomes extensive, it often takes the place of an office visit. There will be a charge of $25 - $78 for extended phone advice with a doctor during normal office hours.

7. **Forms and Letters:** We are happy to fill out vision reports and work/school excuse forms at the time of the visit. It saves us time to fill out these forms as the visit is being completed and the chart is open. Please give these forms to the technician at the beginning of the visit. There will be a **$10.00** charge for filling out forms that are not direct medical correspondence between this office and another healthcare provider.

8. **Medical Records:** The charge for record transfer or medical record copies is **$25.00**. There is a **$10.00** charge to print year-end financial summaries. We issue receipts at each visit to help you avoid this charge.

9. **Billing Balances:** Any balances uncollected will be sent to a collection agency. We will provide you with billing statements and a courtesy call before sending any remaining balances to collections.

______________________________________ ________________________

Patient’s Signature (Parent and/or Guardian) Date