PATIENT DATA SHEET	NEW	PATIE	NT: Y	Y or N									
1. PATIENT DEMOGRAPHICS													
First Name	Last Name	Middle Initial			☐ Male ☐ Female								
Address	City		State/2	Zip Code									
Social Security Number	Birth Date	1	Age	Race	Ethnicity	Language							
Home Phone	Work Phone	<u> </u>	Cell PI	Phone									
Email Address				1									
2. EMERGENCY CONTACT													
In case of emergency contact:				Relation to patier	nt								
Home Phone	Work Phone			Other Phone (specify )									
3. I WAS REFERRED BY □ Doctor	☐ Family ☐ Frie	end 🗆	Self	☐ Second Opinio	on 🗆 Media	/ Other							
Please provide name or media source::													
4. MY CURRENT EYE DOCTOR IS: Optometrist / Ophthalmologist		Δ	ddress/	Phone									
5. EMPLOYMENT INFORMATION		,											
Occupation / Student			PHONE NUMBER										
Employer / School			Address										
6. INSURANCE INFORMATION				CO-PAY I	S COLLECTED	ON ARRIVAL							
PRIMARY Insurance	<u> </u>			Primary Doctor:									
1-800 #	1-800 #			Primary Doctor PHONE#:									
SELF PAY ACKNOWLEDGEMEN	T		INS	URANCE ACKN	OWLEDGEME	ENT							
I am aware of my responsibility to p				n payment of m									
for any services rendered. Any services will be considered an out of pocket expense payable in cash,			the above named physician and UltraVision for all										
check or credit card. Care credit is a	services rendered. I understand that I am responsible for all charges whether or not paid by said insurance.												
My refractive screening is complimentary, however, if I am a candidate AND I choose to proceed with surgery, I understand my pre-op exam will be \$200.00 which will be deducted from my total surgery fee. Any unpaid balance will be deferred to a collection agency with an additional fee of 33% added to my balance. In the event of promotional discounts, only			I further understand that I must keep the office updated										
			with current insurance information and any changes that may occur. Should a filed claim be rejected due to inactive coverage, I understand that I will be responsible for all charges due. Should the account go unpaid it will be referred to a collections agency and an additional 33% collection fee will be added to the total balance.										
							one per person and can not be combined with any insurance.		I consent to the release of any medical information necessary to process any and all insurance claims. I give my consent for a personal photograph for office				
									Signature	?			Date
							( you will be asked to update this infor	mation every year)					

### **Ultravision**

# INFORMATION ABOUT REFRACTIONS & WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, but they typically do not cover the eye service called "refractions".

#### What is Refraction?

Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

#### When Does Insurance NOT Pay for a Refraction?

Most health insurances were not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs and most private policies will not pay for refraction. Almost all insurance payors consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

#### When DOES Private Insurance Pay for Refraction?

Most health insurances will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, refraction will be performed as part of your eye evaluation. Refraction in this instance is necessary to learn your eye's best vision capability at the time of the examination. That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated. *It is a necessary part of the exam for both medical and legal purposes*. In this care, it is possible that the refraction may be covered by your insurance. However, Medicare typically will not cover refraction under any circumstance.

#### Who Has Made This Distinction for Insurance Coverage?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore if you any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

#### What Is Our Policy?

At Ultravision, we are dedicated to providing our patients with the very best medical and surgical eyecare in the region. Therefore, a refraction will be performed when medically necessary (typically *this includes <u>all new patients</u>, those <u>presenting with decreased vision, and on a yearly basis thereafter</u>). Additionally, we are happy to perform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.* 

Our fee for the refraction is <u>\$45.00</u>, and is collected at the time of your visit in addition of any co-payments or deductible due for the medical portion of your exam.

I have read the above information and understand that the refraction is a <u>non-covered</u> service. I accept full financial responsibility for the cost of this service. The co-payment and deductible are separate from and not included in the refraction fee.

Patient Signature or Signature of person acting on patient's behalf	Date	_

## **Notice of Privacy Practices**



We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your health care.

We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are also required to follow the terms of the Notice currently in effect.

#### How We May Use and Disclose Health Information About You

We WILL NOT use or disclose your health information WITHOUT your authorization, except for treatment, payment or healthcare operations.

#### **Notification & Communication of Family:**

- You may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition.
- We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

IF YES, THEN ONLY TO THE FOLLOWING P	ERSON(S):	

To inspect or copy your health information. You must submit your request in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Patient Name:	Patient Name: DOB:						
Past Surgeries:							
	Past Eye Surgeries:			Last Eye Exam:			
Reason for your Visit Tod	ay:						
PATIENT'S MEDICAL HISTORY  ☐ Diabetes Type I II x yrs			☐ Migraines ever on IMETREX?				
<ul> <li>☐ Hypertension</li> <li>☐ Heart Disease pacemaker?</li> <li>☐ Heart Attack/Surgery</li> <li>☐ Kidney Disease dialysis?</li> <li>☐ Arthritis (Rheumatoid or Osteo?)</li> <li>☐ High Cholesterol</li> <li>☐ Gastrointestinal Problems</li> <li>☐ Acne (ever on Accutante?)</li> <li>☐ Dry Mouth</li> <li>☐ Pregnant or currently Nursing?</li> </ul>		□ Asthma   □ Thyroid Disease Hyper / Hypo?   □ Hearing Problems hearing aid?   □ Depression/Anxiety   □ Cancer type?   □ Genetic Condition / Syndrome?   □ Prostate Condition?   □ Smoke (How much?   □ Alcohol (How much?   □ Other					
Family History  ☐ Genetic condition / syndrome ☐ Diabetes ☐ Hypertension ☐ Heart Disease  CONTACT LENS WEARERS			☐ Rheumatoid Arthritis ☐ Cancer ☐ Other				
What Type and Brand do you we							
What is your Contact Lens Power	r? WEAR Tori	cs?					
MEDICATION ALLERGIES:  Pharmacy Name: Pharmacy Phone Number:							
Name of Medicine	How much	Reason for Medicine		Name of Medicine	How Much	Reason for Medicine	
		<u> </u>				<u> </u>	

Patient Name:	Г	Date: ULT			
Patient Name: Date:  NOTICE OF EXCLUSION VISION					
<b>NOTE:</b> Your insurance may D	ENY any of the	e service(s) that are described below.			
Some insurance does not pay for ALL health care costs. Your insurance only pays for covered items and services when rules set by your insurance are met. A Claim will be submitted for all services rendered, however, you should be informed of the possibility that these items may be denied. Should your doctor see it necessary to request any of the following items, you will be previously informed.					
\$40.00					
\$300.00Specular Microscopy (endothelial cell count) \$100.00Complete Visual Fields (glaucoma, droopy lids, patients on plaquenil)					
· ·	\$150.00				
\$50.00After hours office visit					
\$45.00 Refraction					
PLEASE CHECK <b>ONE</b> OPTION.	SIGN AND	DATE YOUR CHOICE.			
I have been informed my insurance above services please submit my c rendered medically necessary until expect a refund of any payments m	e may not cover laim regardless my insurance hade to you tha	deems it necessary for diagnoses and treatment.  er these services. In the event that the doctor requests any of the s. I understand I am financially responsible for services reaches a decision cover or not. If my insurance pays, I will at are due to me. If my insurance denies payment, I agree to be d I can personally appeal my insurance's decision in case of			
□ No, I am not financially prepared to receive the above services, EVEN IF necessary.  I DO NOT want to receive these services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay. Furthermore, I understand that the above services could be necessary in my diagnostic evaluation and treatment and the doctor may not be able to perform adequate or complete patient care to meet my needs. By refusing said services I may be hindering future medical care with this facility and I do not hold Ultravision liable.					
Print Name	date	Signature of patient or person acting on patient's behalf			

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. Your health information which your insurance sees will be kept confidential by your insurance.