

**PATIENT DATA SHEET**

**NEW PATIENT: Y or N**

**1. PATIENT DEMOGRAPHICS**

First Name	Last Name	Middle Initial	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Address	City	State/Zip Code			
Social Security Number	Birth Date / /	Age	Race	Ethnicity	Language
Home Phone ( )	Work Phone ( )	Cell Phone ( )			
Email Address					

**2. EMERGENCY CONTACT**

In case of emergency contact:	Relation to patient	
Home Phone ( )	Work Phone ( )	Other Phone (specify )

**3. I WAS REFERRED BY**  Doctor  Family  Friend  Self  Second Opinion  Media / Other

Please provide name or media source::

**4. MY CURRENT EYE DOCTOR IS:**

Optometrist / Ophthalmologist	Address/ Phone
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**5. EMPLOYMENT INFORMATION**

Occupation / Student	PHONE NUMBER
Employer / School	Address

**6. INSURANCE INFORMATION .....CO-PAY IS COLLECTED ON ARRIVAL**

PRIMARY Insurance	SECONDARY Insurance	Primary Doctor:
1-800 #	1-800 #	Primary Doctor PHONE#:

**SELF PAY ACKNOWLEDGEMENT**

I am aware of my responsibility to pay UltraVision for any services rendered. Any services will be considered an out of pocket expense payable in cash, check or credit card. Care credit is also available. 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 one per person and can not be combined with any insurance.

*(you will be asked to update this information every year)*

**INSURANCE ACKNOWLEDGEMENT**

I hereby assign payment of medical insurance benefits to the above named physician and UltraVision for all services rendered. I understand that I am responsible for all charges whether or not paid by said insurance. 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. 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 identification.

Signature

Date

# 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 all new patients, those presenting with decreased vision, and on a yearly basis thereafter). 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 **\$45.00**, 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 non-covered 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.

\_\_\_\_\_ YES

\_\_\_\_\_ NO

IF YES, THEN ONLY TO THE FOLLOWING PERSON(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.*



