Revised 6/19/14 sbe

1855 WEST CITY DRIVE*ELIZABETH CITY, NC 27909*252-338-3909*FAX 252-331-1213

Dear _____ ,

Welcome to our practice. We look forward to getting to know you and to being of service to you.

Your appointment date and time is _____.

On the day of your visit, remember to bring with you

1. Your completed New Patient Information packet.
2. List of all medicines you are currently taking.
3. Insurance cards (We participate with many insurance companies and will file your claim if we participate with your insurance company, co-pay/deductible is due at time of visit) a return check fee of $35.00 will be collected if insufficient funds.
4. Picture ID
5. Medicaid Recipients must present current card and your $3.00 co-payment (adults).
6. Carolina Access Medicaid must have prior authorization from your Primary Care Physician listed on your card before we can see you.
7. If you are not covered by an insurance we participate with, payment in full is expected at time of visit.
8. Payment for any procedure not covered by insurance will be collected at time of visit.
9. 24 hour notice of cancellation of appointment is required to avoid a $25.00 fee.

The enclosed papers are very important. Please read them carefully, and fill in all requested information. Your information will assist us in providing you with the best possible care.

Thank you for trusting us, “Your Eyes Are Our Focus”.

Sincerely,
Dr. Vince Verdi and Dr. Quentin Franklin

I, _____ have read the information packet. I understand and agree to Coastal Eye Center’s policies regarding patient confidentiality and payment for services. All of my signatures obtained and permissions granted to Coastal Eye Center in this medical record are perpetually valid and in force unless revoked in writing by me.

Signature _____ Date_____

Vincent J. Verdi, MD
Corneal Transplantation/
External Diseases
Cataract/Refractive Surgery
Comprehensive Ophthalmology
Diabetic Retinopathy

Quentin J. Franklin, MD
Comprehensive Ophthalmology
Cataract/Refractive Surgery
Glaucoma Management
Diabetic Retinopathy
LASIK

Revised 6/19/14 sbe

COASTAL EYE CENTER, P.L.L.C.
Patient Registration and Medical Review/History Form

PATIENT INFORMATION:
Name:_____ Date of Birth:___/___/___ AGE:___
LAST FIRST MIDDLE NICKNAME
Address:_____ Social Security #: _____ - ___ - _____
Street City State Zip Code

Status: Male / Female __Single __Married __Divorced __Widowed __Separated

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ ***E-Mail:_____***

Employer Name:_____ Employer Address:_____

Employer Phone Number: (____) _____ Occupation:_____

Emergency Contact:_____ Relation:_____ Phone: (____) _____

Family Dr._____ Dr. Phone_____

What Pharmacy do you use?_____ City_____ Phone_____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:
Father/Mother/Guardian's Name:_____ Phone: (____) _____

Employer's Name:_____ Work Phone: (____) _____

INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARDS AND/OR VALID REFERRAL)
Primary Insurance:_____ Policy #:_____ Group #:_____
Subscriber's Name_____ Relation to Patient:_____
Subscriber's Social Security #:_____ Subscriber's Birthdate:____/___/_____

Secondary Insurance:_____ Policy #:_____ Group #:_____
Subscriber's Name_____ Relation to Patient:_____
Subscriber's Social Security #:_____ Subscriber's Birthdate:____/___/_____

How did you hear about our office?_____

AUTHORIZATION FOR MEDICAL CARE AND NOTICE OF PRIVACY PRACTICES:
I hereby authorize treatment to the patient by the physician and/or staff of Coastal Eye Center, PLLC. I also authorize release of any medical information necessary to process the insurance and I authorize direct payment of all charges incurred, as well as attorney and collection fees of 40% should such action become necessary. By my signature, I also acknowledge that I have reviewed the Coastal Eye Center, P.L.L.C.'s Summary of Notice of Privacy Practices. (A copy of the privacy booklet is available upon request.)

SIGNATURE:_____ DATE:_____

FOR OFFICE USE ONLY:
REVIEWED BACK AND FRONT BY:_____ DATE:_____

COASTAL EYE CENTER, P.L.L.C.'s PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosers we have already made in reliance on your prior Consent.

Coastal Eye Center, P.L.L.C. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

*Protected health information may be disclosed or used for treatment, payment or health care operations
*Coastal Eye Center, P.L.L.C. has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
*Coastal Eye Center, P.L.L.C. reserves the right to change the Notice of Privacy Policies
*The patient has the right to restrict the uses of their information but Coastal Eye Center, P.L.L.C. does not have to agree to those restrictions
*The patient may revoke this Consent in writing at any time and all future disclosers will then cease

Family and Friends. It is the office policy of Coastal Eye Center, P.L.L.C. not to release confidential medical information regarding your treatment to family members or friends, except for 1) a parent/legal guardian, 2) other persons authorized by the patient, or 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, or 4) in emergency situations, or 5) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you anticipate that you will need or want your medical information (including but not limited to appointment times, prescriptions and payments) to be provided to family members, friends, or caretakers, or if you want us to leave a detailed message regarding your care, please indicate that below. By signing below, you authorize the following people/message systems to receive detailed information regarding your treatment or care: (If you wish to add names later on, please confirm this in writing, or call our staff.)

SPOUSE:_____ PARENT:_____

CHILD:_____ OTHER:_____

May we leave a detailed message on your home/cell answering machine? YES NO

Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:_____

Signature of patient/parent if minor OR person with power of attorney:_____

Printed name of party above:_____ Date: ___/___/___
Patient Date of Birth:_____

Received By:_____
Printed name – Coastal Eye Center, P.L.L.C. Representative

Assignment of Benefits, Refractions, and Financial Policy Agreement

1. As long as you provide us with your insurance documentation on the date of your visit, Coastal Eye Center will file the insurance claim with the primary, secondary and tertiary insurance carriers as a courtesy to you. However, an insurance policy is a contract between the patient and their insurance company. **You acknowledge that you will be responsible for all charges not paid by the insurance company, except as otherwise specified by law.**

2. It is the patient's responsibility to provide referrals from primary care physicians and other necessary documents, if applicable, no later than the day on which we provide care.

3. All payments are due at the time of service for medical services or date of order for optical services. Such payments include but are not limited to co-pays, deductibles, charges related to insurance plans with which we do not participate and charges for self-pay balances.

4. Accounts with outstanding balances will be turned over to a collection agency if not paid in full by **90 days** following the date of service. However, exceptions (that reduce or extend this 90 day period) may be made when reasonable in our judgment on a case-by-case basis or when dictated by requirements set forth by the insurance carrier. Before turning any account over to collections, we will attempt to contact the patient or their responsible party. **PLEASE NOTE: If the account balance is forwarded to a collection agency, the patient could be released from the care of Coastal Eye Center.**

5. After 30 days of contacting patient their optical orders are ready for pick up, if monies are still owed on order unclaimed, it will be applied to lab expenses. If optical orders are modified after orders are placed with optical labs, patients may owe a balance on the original order if our optical lab has already cut lenses, etc.

6. If your account is referred to an attorney or other collections agency, you agree to pay all collections costs including attorney fees of forty percent (40%) of the principal amount turned over for collections.

7. You hereby assign to Coastal Eye Center its services to you any benefits available for such services under insurance policies, workers compensation, governmental agency, disability, or other programs. Similarly, you hereby assign to Coastal Eye Center any proceeds from settlements, judgments or verdicts in your favor from third party liability claims for your injuries treated by Coastal Eye Center. With respect to such third party liability proceeds, Coastal Eye Center will be deemed to have a claim in an amount equal to its normal charges for services rendered, together with attorney fees, costs, and interest, as applicable. Coastal Eye Center will be deemed to have a lien against the proceeds in such amount. You agree that Coastal Eye Center will be authorized to receive direct payment of all assigned benefits/ proceeds, and that any attorney, insurance carrier or agency handling or disbursing such benefits or proceeds is hereby authorized and directed to withhold and promptly pay over to Coastal Eye Center the lesser of the full amount of its charge or the total proceeds or benefits available, without offset.

8. To the extent necessary to determine liability for payment and to obtain reimbursement, you agree that Coastal Eye Center may disclose your record to any appropriate party related to the Social Security Administration, insurance or benefit payer.

9. Coastal Eye Center requests that patients give **24 hours notice** when they will not be able to keep a scheduled appointment. If appropriate notice is not given, Coastal Eye Center may charge a **$25.00 No Show Fee**. Certain circumstances may allow this fee to be waived by the administrator.

10. X_____By initialing on this line, I agree to pay $35.00 toward my refraction charge at the time this service is rendered and/or the prescription is dispensed. The refraction is a separately billable service that consists of the technician or doctor placing different lenses in front of your eyes to give the best vision for glasses and/or contact lenses. The refraction is deemed a non-covered service by most insurance, including Medicare, Medicaid, and supplemental plans. If your insurance does cover this test, then you will be refunded once they have provided payment. There are a select few insurances for which we will not collect this fee at the time services are rendered; however, this does not release you from payment if the insurance guidelines change. Further details of the need for this test can be provided by your technician or doctor.

By signing below, you represent that you have read and fully understand this agreement, and that Coastal Eye Center has made no representations not stated on this financial policy. Photocopies of this agreement will be deemed to be duplicative originals for all purposes.

Signature: _____ **Date:**_____