OPHTHALMOLOGY
associates

Sullivan
965 Maddox Dr.
Sullivan, MO 63080

Des Peres
12990 Manchester Rd.
Suite 200
Des Peres, MO 63131

St. Charles
3513 Harry S. Truman Blvd.
St. Charles, MO 63301

Phone: 314-966-5000

Fax: 314-909-6666

Welcome to Ophthalmology Associates

Our team is dedicated to providing you and your loved ones with the best treatment. Together, we can reach your health goals.

Patients are seen by appointment only. While we will work to honor your scheduled appointment time, please understand that medical emergencies occur. We ask for your patience during those times.

What to bring to your first appointment:

- ☐ Completed enclosed forms
- ☐ Insurance card(s)/Photo ID
- ☐ Medication List
- ☐ Glasses and/or contact lenses
- ☐ Ability to pay co-pay if applicable

Dilation

It may be necessary to dilate your eyes during your appointment. Dilation allows the physician to accurately look at the back of your eye to assess the health of the entire eye. Dilation may cause:

- Sensitivity to light
- Inability to see at close range for several hours
- Uncomfortable driving conditions

It is recommended to bring sunglasses for light sensitivity. We recommend not driving or operating machinery immediately after dilation. It is recommended that someone drive you after your appointment or you wait until your eyes return to normal to resume driving safely.

Other Considerations

For patients coming for a cataract evaluation, it is required to be out of contact lenses 10 days prior to visit.

If you cannot keep an appointment, we ask that a 24 hour notice be given to the office at a minimum.

Thank you,

The Doctors and Staff of Ophthalmology Associates

Patient Name: _____
Appointment Date: _____Time: _____
Physician: _____

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Des Peres Location – Located in the Eye Surgery and Laser Center Building
12990 Manchester Rd., Suite 200
Des Peres, MO 63131

From I-270 North

Take exit 9 to Manchester West. Use the second lane from the right and keep left at the fork. Continue on Manchester in the left lane. Take the "Manchester Rd East" exit. Merge to the far right lane. Take a right turn after "Aloha Pools and Spas" to enter the parking lot for St. Louis Eye Survey and Laser Center Building.

From I-270 South

Use the right lane to take exit 9 for Manchester. Keep right at the fork to merge onto Manchester West. Merge to the far left lane. Take the "Manchester Rd East" exit. Merge to the far right lane. Take a right turn after "Aloha Pools and Spas" to enter the parking lot for St. Louis Eye Survey and Laser Center Building.

If you pass the building

Stay in the far right lane and take the exit for "Des Peres Rd/Manchester Rd West." Turn left on Des Peres Rd. Take a left at the second stop light onto Manchester West. Merge to the far left lane. Take the "Manchester Rd East" exit. Merge to the far right lane. Take a right turn after "Aloha Pools and Spas" to enter the parking lot for St. Louis Eye Survey and Laser Center Building.

St. Charles Office
3513 Harry S. Truman Blvd.
St. Charles, MO 63301

From I-70 West

Take exit 225 Cave Springs/Truman Rd. Keep right at the fork on the ramp. Merge onto Truman Rd and move into the left lane. Continue 0.5 miles down the road and the office is on the left.

From I-70 East

Take exit 225 Cave Spring/Truman Rd. Keep left at the ramp. Take a left on Truman Rd. Continue 0.5 miles down the road and the office is on the left.

Sullivan Office – Missouri Baptist Hospital
965 Maddox Dr.
Sullivan, MO 63080

From I-44 West

Take exit 225 from I-44 and turn left on to Missouri D. Turn right on Old Rte 66. Follow Old Rte 66 to Missouri D. After about a mile, turn right onto Sappington Bridge Rd. Turn right onto Maddox. Turn right into the parking lot and look for Specialty Clinic Building B.

From I-44 East

Take exit 225 from I-44 and turn right on to Missouri D. Turn right on Old Rte 66. Follow Old Rte 66 to Missouri D. After about a mile, turn right onto Sappington Bridge Rd. Turn right onto Maddox. Turn right into the parking lot and look for Specialty Clinic Building B.

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Please circle who is filling out this form: Patient / Guardian / Custodial Parent

Demographics

Last Name | **First Name** | **Middle Initial** | **Preferred Name**

Date of Birth (/ /) | **Social Security No.** | **Sex Assigned at Birth**

Address | **City** | **State** | **Zip Code**

Cell Phone | **Home Phone** | **Email Address**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other_____

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino | **Primary Language**

Race
☐ Asian ☐ Black or African American ☐ Hispanic
☐ Native American or Native Alaskan ☐ Native Hawaiian or Pacific Islander ☐ White
☐ Multi-Racial ☐ Other: _____

Emergency Contact*

Emergency Contact Name | Phone Number | Relationship to Patient

*Emergency contact will not be contacted without a signed and current Release of Information

Please complete if patient is under 18 or under guardianship

Parent/Guardian Legal Name | Relationship to Patient

Address (If different than above) | City | State | Zip Code

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Legal Name: _____ Date: _____

Insurance – Insurance Cards Must Be Presented at Time of Visit

Primary Insurance	ID No.	Group No.
Policy Holder	Policy Holder Date of Birth	Relationship to Patient
Secondary Insurance (If applicable)	ID No.	Group No.
Policy Holder	Policy Holder Date of Birth	Relationship to Patient

Referral Information

How did you hear about us?

- ☐ Clarkson Eyecare OD
- ☐ Existing Patient
- ☐ Family/Friend
- ☐ Independent OD
- ☐ KMOX Charlie Brennan
- ☐ KMOX Dave Glover
- ☐ KMOV TV Channel 4
- ☐ KYKY Jen Myers
- ☐ Online Ad
- ☐ Medical Doctor
- ☐ Billboard
- ☐ Other: _____

Name of Primary Care Provider _____ Name of Optometrist/Referring Doctor _____

Family History

Please check the box next to any applicable medical history of a blood related relative. Please list

- ☐ Glaucoma: _____
- ☐ Macular Degeneration : _____
- ☐ Diabetes: _____
- ☐ Cancer: _____
- ☐ Autoimmune disorder: _____
- ☐ Thyroid Disease: _____
- ☐ Ketatoconus: _____
- ☐ Fuch's: _____

Social History

Alcohol Usage	☐ Never	☐ Rarely	☐ Moderately	☐ Daily
Tobacco Usage	☐ Never	☐ Former Smoker Date Quit: _____	☐ Current Smoker Per Day:_____	
Drug Usage	☐ Never	☐ Currently Using	Type: _____ Frequency: _____	

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Legal Name: _____ Date: _____

Past Medical History

☐ I will provide a copy of my medical history

☐ Thyroid Disease	☐ High Blood Pressure	☐ Heart Disease	☐ Stroke History
☐ Hepatitis	☐ Diabetes Type: ____	☐ Cancer	☐ Rheumatoid Arthritis
☐ Migraines	☐ Multiple Sclerosis	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____

Do you have a cardiac defibrillator or pacemaker? ☐ Yes ☐ No

Past Surgical History

☐ I will provide a copy of my surgical history

Surgery: _____ Surgery: _____

Date: _____ Date: _____

Surgery: _____ Surgery: _____

Date: _____ Date: _____

Past Ocular History

☐ I will provide a copy of my ocular history

☐ Cataracts	☐ Fuch's Dystrophy	☐ Glaucoma	☐ Macular Degeneration
☐ Keratoconus	☐ Dry Eye Syndrome	☐ Blepharitis	☐ Diabetic Retinopathy
☐ Thyroid Eye Disease	☐ Ocular Allergies	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____

Past Ocular Surgical History

☐ I will provide a copy of my ocular surgical history

Surgery: _____ Surgery: _____

Date: _____ Date: _____

Surgery: _____ Surgery: _____

Date: _____ Date: _____

Notes .

Please use the area below for any comments or topics you would like to discuss with the physician.

_____

_____

_____

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Legal Name: _____ Date: _____

Medications

Medication	Dosage	Purpose

Pharmacy Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Allergies

Allergen	Reaction

I hereby certify that the information above, to my knowledge, is accurate and complete.

Printed Patient Name	Patient Signature	Date
Parent/Guardian Name (If applicable)	Parent/Guardian Signature	Date

OPHTHALMOLOGY associates

Consent to Treat • Consent to Communications • HIPAA
Patient Financial Responsibility • Assignment of Benefits

_____ _____

Patient Name (Please print) Date of Birth (MM/DD/YYYY)

Thank you for trusting us with your eye care needs. Our team is committed to providing you with expert, compassionate medical care. Please read through this document, ask us any questions you may have, and sign at the bottom. Please understand that payment of your bills is considered part of your treatment. We are happy to provide you with a copy of this document upon request.

General Consent to Care I, the undersigned, for myself, a minor child, or another person for whom I have authority to sign, hereby consent to medical care treatment, as ordered by a provider, which such as medical treatment is provided through my provider's practice, which is part of the Ophthalmology Associates, LLC network (the "Practice"). This consent includes my consent for all medical services rendered under the general or specific instructions of the provider. I agree and acknowledge that Ophthalmology Associates, LLC is not liable for the actions or omissions of, or the instructions given by the provider(s) who treat me while I am a patient. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.

I understand that I have the right to discuss the treatment plan with my physician about the purpose, potential risks, and benefits of any tests ordered for me. If I have concerns regarding any test or treatment recommended by my provider, I understand that am encouraged to ask questions.

HIPAA Privacy Policy I acknowledge that the Practice has made available to me the "Notice of Privacy Practices" in compliance with current HIPAA regulations.

Consent to Call, Email & Text By signing below I agree and authorize Ophthalmology Associates (and entities or individuals working on Ophthalmology Associates behalf) to deliver or cause to be delivered calls, text messages, and/or emails using an automatic telephone dialing system or an artificial or prerecorded voice at the numbers(s) and/or email address(s) I have provided to schedule an appointment, remind me I am due for an appointment, remind me of an upcoming appointment, contact me that my eyewear or contact lenses are ready, contact me regarding outstanding payments or bills due, contact me about my account, and/or provide me messages containing advertisements or telemarketing. I understand that I may be charged by my phone provider or a third party provider for such communications and that I can revoke my consent at any time. I understand that I am not required to provide such an authorization as a condition of purchasing any property, goods, or services from Ophthalmology Associates.

Insurance We participate with most insurance plans, including Medicare. If the undersigned or the patient for whom the undersigned has authority to sign is insured by a plan we accept but does not have an up-to-date insurance card, payment in full for each visit is required until coverage can be verified. A quote of benefits is not a guarantee of benefits or payment. Charges not covered by insurance company or benefit plan, as well as any co-payments, deductibles, and co-insurance amounts, are the undersigned's responsibility. If the undersigned has questions about what the applicable insurance or benefit plan will cover, please contact the insurance or benefit plan directly. Ultimately, it is the undersigned's responsibility to understand the applicable coverage. Therefore, we strongly encourage the undersigned to check with your insurance company regarding coverage prior to any office visit or procedure.

Referrals Some insurance plans require the patient to obtain a referral for services. Please review your insurance policy to see if a referral is required prior to the office visit. If a required referral is not on file at the time of the visit, the appointment could be rescheduled or the patient will be responsible for all charges incurred on this date.

Assignment of Benefits I request that payment of authorized insurance benefits for Medicare and other health insurance benefit plans be paid directly to the Practice for all medical, surgical, medication, diagnostic testing, laboratory services, supplies, and equipment provided to me during all courses of treatment and care provided by the Practice. I also understand and agree this Assignment of Benefits will continue for as long as I am being treated or cared for by the Practice and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the organization of all applicable and eligible coverage benefits for all subsequent and continuing treatment, services, supplies, and/or care provided. I also realize that I am responsible for paying any non-covered services, co-payments, deductibles, or co-insurance amounts due.

Patient Financial Responsibility I understand that I am financially responsible to the Practice for any charges not covered by health care benefits. It is my responsibility to notify the Practice of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Practice and/or my health care insurer if the submitted claims or any part of them are denied for payment. All copays and non-covered services are expected to be paid at the time of service. In some cases, deductibles and co-insurance will be collected prior to service.

I understand that by signing this form, I am accepting financial responsibility as explained above for payment for all services and products received.

This consent and authorization will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. I certify that I have read and understand the above statements.

Our practice is committed to providing the best treatment to our patients. **A comprehensive Financial Policy can be provided upon request.**

_____ _____

Patient/Legal Representative Signature Date

MEDICAL EXAMS • REFRACTIONS • PRESCRIPTION RELEASE

The type of care you need will be billed to your medical insurance.

1. Medical insurance covers medical eye exams relating to any *health issues* affecting your eyes.
2. We do not accept vision insurance.

Only medical insurance will be billed at each visit.

Refraction The refraction is the testing completed to obtain an eyeglass prescription, or to determine if eyeglasses are needed. Please be advised that the majority of medical insurance companies do not cover refractions, it is billed to the patient in addition to the exam charge and the fee of $50.00 is payable at the time of service. If you have questions or concerns regarding the need for a refraction, please address them with the technician at the beginning of your exam.

I understand that my eye doctor is required by the Federal Trade Commission to provide me with a copy of my eyeglass prescription at the conclusion of my exam process, whether or not I desire it or ask for it.

Once a final prescription has been determined I will receive either a digital or a paper copy. If possible a digital copy will be made available in the patient portal. I acknowledge that I have previously accessed the patient portal, or if that is not the case, then I understand that I can register for the patient portal using the Patient Portal.

_____ _____

Patient/Legal Representative Signature Date

Authorization to Disclose Information to Those Involved in My Care

I authorize Ophthalmology Associates, LLC to disclose or provide my Protected Health Information including, but not limited to:

- Health and Billing Information
- Appointment times & Dates
- Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared unless written exclusion is on file.

I understand the person(s) I list to Authorize to Disclose Information to those Involved in my Care, will also be listed as my emergency contact. If this information is to change, the front desk will need to be notified.

To the following people: (please print full name)

Name:_____

Relationship: _____Phone number:_____

Name:_____

Relationship: _____Phone number:_____

Name:_____

Relationship: _____Phone number:_____

Is there any protected health information you would like to exclude from disclosure to the parties listed above? If yes, fill in here:_____

This authorization has No Expiration unless revoked or terminated—in writing—by the patient or patient's personal representative.

_____ _____

Patient/Legal Representative Signature Date

This form replaces all prior disclosure authorizations as of the date above.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

I give my permission to allow my healthcare provider to obtain by medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescription that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

_____ _____

Patient/Legal Representative Signature Date