Patient Name: _____

Appointment Date: _____ Time: _____

Physician: _____

Welcome to your eye appointment!

Our team is dedicated to providing you and your family with the best possible medical 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 forms (enclosed)
- Insurance cards
- Insurance Co-Pay, if applicable
- Photo ID
- Medication List
- Glasses and/or contact lenses
- Insurance Referral from your Primary Care Doctor if applicable

Precautions Following Dilation:

- It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend not driving or operating dangerous machinery immediately after dilation. If you are uncomfortable driving, we recommend that you arrange to have someone drive you home.

Other Considerations:

- For patients coming for a cataract evaluation, it is required to discontinue contact lens wear prior to your visit.
    - Soft contact lenses: 10-14 days
    - Hard contact lenses: 1 month
- If you cannot keep an appointment, we ask that a 24-hour notice be given to the office at a minimum.

Thank you!

OPHTHALMOLOGY ASSOCIATES

Des Peres
12990 Manchester Rd. Suite 200
Des Peres, MO 63131
314.966.5000

St. Charles
3513 Harry S. Truman Blvd.
St. Charles, MO 63301
314.966.5000

Sullivan
965 Maddox Dr.
Sullivan, MO 63080
314.966.5000

OPHTHALMOLGY CONSULTANTS

Des Peres
12990 Manchester Rd. Suite 201
Des Peres, MO 63131
314.909.0633

South County
12692 Lamplighter Square
St. Louis, MO 63128
314.432.5478

St. Charles
3513 Harry S. Truman Blvd.
St. Charles, MO 63301
636.688.7500

Florissant
12240 Graham Rd. Suite 2007
Florissant, MO 63031
314.837.3667

GALANIS CATARACT & LASER EYE CENTER

7331 Watson Rd
St. Louis, MO
63119
314.633.8575

Patient Information

Date: _____

Patient Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of Birth: _____ **Social Security No.** _____

Cell Phone: _____ Home Phone: _____ Work Phone:_____

Preferred E-Mail Address: _____

Please complete the following information to meet requirements set forth by the Affordable Care Act:

Marital Status: ☐Married ☐ Single ☐ Widow ☐Divorced **Birth Sex:** ☐ Male ☐Female

Primary Language: _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (please circle one): White Black/African American Asian Hispanic or Latino American Indian Alaskan Hawaiian/Pacific Islander Greek Multi-racial

Primary Care Physician _____ Phone _____

Pharmacy _____ **Phone** _____

Referring Physician _____ Phone _____

How did you hear about us? ☐Clarkson Eyecare ☐Existing ☐Family/Friend

☐Independent OD ☐Medical Doctor ☐Insurance ☐TV_____ ☐RADIO_____

Person Responsible _____

Insurance Information: *You must provide us with your current insurance card(s).*

Primary Insurance _____

Secondary Insurance _____

Vision Insurance: * *Ophthalmology Consultants & Galanis practices only!*

ID# _____ Policy Holder _____ DOB _____

We accept assignment on Part B Medicare patients. You will be expected to pay your deductible and 20% coinsurance. We will only file to one secondary policy.

Medicare Authorization

I understand that my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HICFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of medical information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Name: _____ Date:_____/_____/_____

Signature: _____ Medicare Policy # :_____

Financial Contract Agreement

We are committed to your successful treatment. Please note that payment of your account is considered a part of your treatment.

- All co-pays are due on the day of service (we accept Checks, CareCredit, & most major credit cards.
- **If you do not have your current insurance card at the time of service you will be treated as a "self pay" patient.**
- All "self pay" patients to pay this visit fee in full at the time of service.
- All patients covered under an HMO plan must have a valid referral at the time of their visit.
- **All delinquent accounts, 90 days past due, may be placed in collections, you may be responsible for all additional charges incurred to collect this account, including court costs and legal fees.**
- We do not get involved with litigation, disputed workman's' compensation cases, divorce decrees, or auto accidents; you will be 100% responsible for full payment at time of service or within 90 days of service with prior arrangements.
- The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of account.

Telephone Consumer Protection Act (TCPA) I agree that Ophthalmology Associates, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

We accept assignment of benefits for insurance plans that we are contracted with. The balance is your responsibility. Please be aware that some or all of the services provided may be noncovered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. You are responsible for verifying the benefits of your policy.

If you have no insurance coverage and need financial help, our Business Office will be happy to work out an agreeable payment plan.

I understand and agree to this Financial Contract Agreement as stated above:

Signature: _____ **Date:**_____

Release of Information/Assignment of Benefits/Consent to Treat

I authorize the use of this form on all of my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this insurance authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on dispute claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider.

Signature: _____ **Date:**_____

Receipt of Notice of Privacy Practices/Written Acknowledgement Form

I have received a copy of Notice of Privacy Practices dated 5/2024

The above authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.

HEALTH HISTORY FORM

NAME:_____ **DOB:**_____ **DATE:**_____

MEDICAL HISTORY-Have you been diagnosed with any of the following?

☐Asthma/COPD
☐Anxiety/depression
☐Alzheimer
☐Dementia
☐Cancer:_____
_____
☐DM, type_____,yrs_____
☐Parkinson's
☐Pregnant-currently
☐Head/spinal injury
☐Heart disease_____
☐Stroke
☐Seizures/fainting
☐Hepatitis
☐HBP
☐Other_____
☐High cholesterol
☐HIV/AIDS
☐Migraines
☐Autoimmune diseases:
_____
_____
_____
_____

SURGICAL HISTORY-(Include date and type of each procedure)

_____

_____

Heart Defibrillator? ☐ Yes ☐ No **Pacemaker? ☐ Yes ☐ No** **Heart Stent? ☐ Yes ☐ No**

EYE HISTORY- Have you been diagnosed with any of the following? If so, date?

☐Blepharitis_____
☐Cataract_____
☐Corneal disease_____
☐Diabetic retinopathy_____
☐Dry eye syndrome_____
☐Glaucoma_____
☐Macular DGen_____
☐Ocular allergies_____
☐Thyroid eye disease_____
☐Other_____
☐Other_____
☐Other_____

Previous Eye Surgery? ☐No ☐Yes If yes, what and when:_____

Previous Eye Injury? ☐No ☐Yes If yes, what and when:_____

MEDICATIONS- (including eye drops) include the dosage, attach list if possible or fill in boxes.
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, health plan, and other healthcare providers: Int._____

***ALLERGIES to MEDICATIONS*: name/reaction-**_____

SOCIAL HISTORY

Use of Tobacco?☐Never ☐Former smoker/quit date_____ ☐Current Packs/Day_____

FAMILY HISTORY-Has any of your **blood relatives** had any of the following? Note which relative.

☐Autoimmune disease_____
☐Cataract_____
☐Corneal disease_____
☐Cancer_____
☐Diabetes_____
☐Glaucoma_____
☐Heart Disease_____
☐Macular DGen_____
☐Stroke_____
☐Thyroid_____
☐Other_____

Patient Signature: _____ **Date:** _____

MEDICAL EXAMS ● REFRACTIONS ● PRESCRIPTION RELEASE

What is Refraction? The refraction is the testing completed to obtain an eyeglass prescription, or to determine if eyeglasses are needed. Majority of medical insurance companies do not cover refractions because it is considered routine. **Refractions will be billed to the patient with the fee of $50.00**. In addition, exam charges (including co-payments) 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/paper copy. If possible, a digital copy will be 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. I understand that refraction is a **non-covered** service. I accept full financial responsibility for the cost of this service in addition to any co-payments or deductible.

_____ _____

Patient/Legal Representative Signature Date

PERMISSION TO RELEASE HEALTH INFORMATION/EMERGENCY CONTACT

I understand the person(s) I list to authorize to disclose information to those involved in my care, will be listed as my emergency contact. If this information is to change, the front office will need to be notified.

To whom may we talk to about your medical and billing information?

- ☐ Spouse_____ Phone Number_____
- ☐ Parent _____ Phone Number_____
- ☐ Child _____ Phone Number_____
- ☐ Other _____ Phone Number_____
- ☐ Other _____ Phone Number_____

I wish to be contacted in the following manner (check all that apply)

☐ Home Phone ( ) _____
- ☐ Leave message with Detailed Information
- ☐ Leave message with Call Back Number Only

☐ Cell Phone ( ) _____
- ☐ Leave message with Detailed Information
- ☐ Leave message with Call Back Number Only
- ☐ Send text message

☐ Work Phone ( ) _____
- ☐ Leave message with Detailed Information
- ☐ Leave message with Call Back Number Only

Written Correspondence

☐ O.K. to mail to my home address/EMAIL ☐ O.K. to fax to: ( ) _____

_____ _____

Patient/Legal Representative Signature Date

***Please complete the backside of this form as well.**