

LIBERTY OPTHALMOLOGY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

Patient Information

Date _____

SOCIAL SECURITY # _____

PATIENT'S NAME: _____
Last Name

_____ First Name _____ Middle Initial

ADDRESS _____

CITY _____

STATE _____ ZIP _____

E-mail _____

Sex M F Age _____ BIRTHDATE _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Whom may we thank for referring you? _____

Spouse/Parent/Guardian _____

Birthdate _____ SS# _____

Employer _____

Insurance

WHO IS RESPONSIBLE FOR ACCOUNT? _____

Relationship to Patient _____

Insurance Co. _____

ID # _____ GROUP # _____

SUBSCRIBERS' NAME _____

BIRTHDATE _____ SS# _____

Relationship to Patient _____

Is patient covered by additional insurance? Yes No

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company (s)

Dr Eric W. Lothes, MD and insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed and all claims have been submitted and paid.

Signature of Patient, Parent, Guardian or Representative

Printed Name of Patient, Parent, Guardian or Representative

Date _____ Relationship to Patient

Phone Numbers

HOME (_____) _____ CELL (_____) _____ DAYTIME PHONE (_____) _____ Ext _____

Spouse/Partner Cell (_____) _____ Spouse/Partner Daytime Phone (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home (_____) _____ Cell (_____) _____ Daytime Phone (_____) _____ Ext _____

Eye Health History

<p>Date of last eye exam _____</p> <p>Name of eye doctor: _____</p> <p>Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> All the time <input type="checkbox"/> Occasionally</p> <p><input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV</p> <p>Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type _____</p> <p>Hours/Day _____</p> <p>Describe any problems you have with your contacts _____</p>	<p>Place a mark on "Yes" or "No" to indicate if you have had any of the following:</p> <table border="0"> <tr> <td>Bloodshot Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Floaters or Spots</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision Distance</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Glaucoma</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Blurred Vision Near</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Headaches</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Burning Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Itching Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Cataracts</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Light Sensitive</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Color Vision, Poor</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Loss of Vision</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Crossed Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Migraine Headaches</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Discharge from Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Night Vision, Poor</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Dizzy Spells</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Red Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Double Vision</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Seeing Halos</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Dry Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Seeing Flashes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye Infection</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Temporary Loss of Vision</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye Injury</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Twitching Eyelid</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Eye Strain</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Vision Poor</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Fainting Spells, Blackouts</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Watering Eyes</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning 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General Health History

Medical Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	<u>Yourself</u>	<u>Family Members</u>		<u>Yourself</u>	<u>Family Members</u>
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please State) _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please State) _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes/Cigars <input type="checkbox"/> Smokeless

Medications (If None State So)

List any medications you are currently taking, including eye drops:

Allergies (If None State So)

List allergies to medications or other substances:

Family History of Eye Disease

List any history of eye disease related to you parents, grandparents and/or siblings.

Medicare / Medicaid / Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr Eric W. Lothes, MD for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Guardian or Personal Representative	Date
Please print name of Patient, Guardian or Personal Representative	Relationship to Beneficiary



Liberty Ophthalmology Practices and Financial Policies

Welcome

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible care and successful treatment. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your overall treatment. In order to keep your cost of health care to an absolute minimum, we have adopted the following policies.

Fees and Payments

Fees are standardized and are based on the complexity of your visit or procedure. Payment of co-payments and any outstanding balance is required at the time of service. We accept cash, personal checks and money orders, Discover Card, American Express, Visa and MasterCard for payment.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. In order for us to file a claim, you must present a current copy of your insurance card and a photo ID (patient or guarantor) at each visit and communicate any changes in your personal contact information.

We will assist you in filing secondary insurance claims. If you have a secondary plan you may be responsible for submitting information to your secondary carrier as required by that carrier. If Medicare is your primary insurer and you have authorized Medicare to forward claims to secondary insurers, they will automatically send claim information to any secondary carrier you have on file with them so no additional filings are necessary. If you are Medicare covered and not authorized Medicare to forward claims, please take a moment to contact Medicare and update your coverage information.

Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This is accomplished through any combination of co-payments, coinsurance, and/or deductibles. Co-payments are due when you check in for your appointment. Coinsurance and deductibles are determined by your insurance company and reported to us on an explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a Statement of Charges and Payments. This billing is payable upon receipt. When payments are received from the patient, they will be automatically applied to the oldest outstanding balance. If you would like a payment to be applied in a certain way to a patient account(s), please notify our staff at the time of payment.

Insurance Plans

Although we accept most medical insurance plans, it is your responsibility to check with us before your appointment and to call your insurer to verify that we are a plan provider. **Exclusive vision plans** that we **do not** accept are, but not limited to: Vision Service Plan (VSP), Eye Med, Vision Plus (MedBen) and Vision Care Plan (Humana CompBenefits).

Your insurance coverage is a contract between you, your employer (if applicable), and the insurance company; we are not a party to that contract. Medicare/Medicaid insurance is a contract between you and the provider of those plans. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify the physician and the facility that you are scheduled with participates with your plan and that the services that you intend to receive are covered.

Some insurance plans require referrals from a primary care physician before you can be seen by another doctor or have procedures performed; please ask your insurer if your plan requires a referral, what services require a referral and how to obtain a referral from your PCP. **It is your responsibility to obtain all necessary referrals, in writing, and to ensure that they are on file with our office prior to your appointment.** If you are seen by our office without your necessary referral(s) on file then all charges for that appointment shall become your responsibility as stated by your insurance company's Explanation of Benefits.

Patients Name: _____ Date of Birth: _____

Some Insurance plans cover routine eye exams differently than a medical exam. If your plan has this coverage please inform the receptionist at check-in/out. Please be aware that if during the course of a routine exam a medical condition is recognized that requires testing or treatment your examination will not be able to be billed as routine and will be submitted as a medical diagnosis for insurance consideration.

Some services require a Prior Authorization, Pre-Certification or Pre-Notification before rendering. Our office will take the responsibility for obtaining those from your insurance carrier. Upon approval you will be notified.

Policy Regarding Custody of Minor Children Regarding Consent for Treatment and Payment of Professional Fees

The Parent who brings a minor child to the office shall be responsible for giving consent for treatment, authorizing payment for services and payment of all professional fees incurred in the office. The parent who brings in a minor child shall be responsible for the payment of any and all co-pays at the time of the appointment. This person shall be responsible for any deductibles, co-insurance and/or non-covered expenses. If surgery is indicated, the non-custodial parent shall be informed by the custodial parent. No information shall be released to a non-custodial parent without the written consent of the custodial parent.

We will attempt to submit a request for payment for professional services to any applicable insurance carrier providing we are a member of the network in cases of HMO, PPO or POS plans. It shall be the responsibility of the custodial parent to obtain the necessary referrals prior to the office evaluation and treatment.

Our office shall not be responsible for the enforcement of any custody arrangements. This is the responsibility of the parent who brings the minor child to the office for evaluation and/or treatment. We are **NEITHER** an agent of any court nor a part of any ongoing litigation between parents.

Services Not Covered

Not all services are a covered benefit in all plans so it is very important that you understand the provisions of your individual policy. Some insurance companies arbitrarily select certain services they will not cover and so we cannot guarantee payment of all claims by your insurance company. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Refractive Screening Procedures

Refraction, or testing of your vision to determine your ability to clearly see at distance and up close, is a service sometimes not covered by commercial Insurance plans and never covered by Medicare. This test is often needed to determine your best potential acuity or vision and is also used to determine the effects a disease of the eye has on your ability to see. Refractions not covered by insurance are billable to the patient.

It is important that you check with your insurance company to determine your ophthalmic screening benefits. Please note that if you are scheduled for a routine screening exam and any condition or medical diagnosis is treated (Glaucoma, Allergies, Cataracts, Macular Degeneration, etc.), both the screening diagnosis and the treated condition are required to be reported as a medical diagnosis (non-routine). This will change all or part of your exam from a routine visit to a medical diagnosis. Some insurance plans including Medicare have different coverage for screening versus medical diagnostic procedures so it is important that you understand your benefits carefully and inform our staff of any specific insurance conditions.

Patients Name: _____ Date of Birth: _____

Making and Keeping Appointments

If you need to cancel your appointment, please call at least 24 hours in advance. This allows us to accommodate other patients who need to be seen. Excessive no shows may result in a charge being added to your account and you may also be dismissed from the practice.

Payment Terms

Accounts are payable upon your receipt of your Statement of Charges and Payments for services rendered. These are sent out at the beginning of each month.

Non-Payment of Outstanding Accounts

Accounts that are not paid after 90 days may be charged a \$10.00 late fee per month until paid in full. We may also send these accounts to an external collections agency and the debt reported to the credit bureaus. If this occurs, you may also be dismissed from the practice. In addition to your outstanding balance, you may also be responsible for any fees or charges that we incur from the external collections agency while attempting to collect your balance.

Administrative Fees

Forms Charge: If your employer requires Family Medical Leave Act or Disability paperwork to be completed by your provider, the turnaround time is five business days and there is a \$25 fee for this service, payable in advance.

Medical Records Charge: If a collaborating physician (primary care or specialist) requests portions of your chart to assist in your care, there is no charge. If you would like a copy of your medical records sent to yourself or another physician, these copies are billed on a per page basis, payable in advance, in accordance with HIPAA and Ohio state law. The fee is \$1.00 per page with a \$25 minimum charge.

Returned Check Charge: Any returned check including but not limited to Non Sufficient Funds (NSF) and closed account denials of payment are subject to a \$20 service fee (in addition to fees from your bank)

Acknowledgement

I _____ have read, understand and accept all practices and financial policies of Liberty Ophthalmology as written above.

Print - Name of Patient, Parent, Guardian or Guarantor

Signature of Patient, Parent, Guardian or Guarantor

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

LIBERTY OPHTHALMOLOGY ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

Relationship to Patient _____

Patient's Name _____

(If different than person signing form)