Clemson Eye
Visual Health & Surgery

Financial Policy

We are dedicated to providing our patients with the highest quality ophthalmic care and to running our clinic efficiently. Please assist us in achieving these goals by complying with our financial policy. Payment is due at the time the service is provided. It is your responsibility to verify insurance and determine the status of coverage (co-pay and deductible) prior to your visit.

Forms of Payment Cash, check, major credit card, or payment plan

Co-Pays & Deductibles All Medicare, Medicaid, and other insurance plan co-pays and deductibles are payable upon Check-Out. It is your responsibility to know your portion payable at the time of service.

Medicare We accept assignment and will file all Medicare claims. At the time of service you are responsible for 20% of the Medicare allowable fee, plus the deductible and any service charge not covered by Medicare. Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(I) of the Medicare law. If Medicare denies payment, by signing you agree to be personally and fully responsible for payment. You also agree that payment of authorized Medicare/Medigap benefits be made payable to Clemson Eye, PA for services rendered by that physician/supplier. Your signature will also authorize any holder of medical information about you to release to the Heath Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Medicaid A current copy of the Medicaid card is required prior to treatment or the patient will be rescheduled.

Workers Comp Workers Compensation authorization is required prior to the appointment.

Private Ins & Managed Care If you participate in a plan that we accept we will be happy to file your insurance claims for you. Otherwise payment in full is your responsibility. Please note that you are ultimately responsible for payment if your private insurance company denies payment.

Self-Pay Payment is expected at Check-In prior to being seen by the doctor. You may call our office for an estimate of our fees. Any refund or balance due will be calculated at the Check-Out. If you are not prepared to cover your exam, then we can offer you coverage through a payment plan or reschedule your appointment.

Non-Covered Services Several non-covered services are essential for the physician to properly evaluate and treat you during your eye exam. They include Refraction, Corneal Topography, Corneal Cell Check, Surgery kits, etc. Medicare and most insurance plans do not cover these fees which will be payable upon Check-out. You may choose to defer these or any services.

Drivers Form We will be happy to complete a Drivers' Form for you for a nominal fee.

Other Forms For any additional insurance forms or dictated letters from our doctors, a nominal fee per form will be charged. Documents will be ready in 2-3 business days.

Other Information Any check returned to our office for non-payment will generate an additional processing fee of $30.00. We can assist you with setting up a payment plan in order to pay an outstanding balance. Accounts turned over to a collection agency will also incur an administrative fee as well as any additional fees associated with that effort, including court costs.

Refunds Credit balances under $50.00 will remain as a credit on your account to be applied to your next visit unless a refund is requested.

I have read and accept the terms of Clemson Eye, PA's Financial Policy. I agree to pay for services rendered by Clemson Eye, PA that are not covered or paid by my insurance company, including Medicare and Medicaid.

Name (print): _____ Date: _____
Patient / Guardian / Guarantor

Signature: _____

Clemson Eye
Visual Health & Surgery

Patient Information

Patient Information

Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Cell: _____ Email: _____

Birth date (Mo/Day/Yr): _____ Age: _____ Sex: _____ Social Security #: _____

Family physician: _____ Tel: _____

Referring physician: _____ Tel: _____

Emergency contact: _____

Relationship: _____ Tel: _____

Employer: _____ Tel: _____

Employer's address: _____

City: _____ State: _____ Zip: _____

Billing Information

If policy holder is other than patient, please complete.

Name of insurance: _____ Primary ☐ Secondary ☐

Policy holder name: _____

Birth date (Mo/Day/Yr): _____ Age: _____ Social Security #: _____

Bring insurance cards to your visit or mail a copy to expedite your registration.

Work Comp/Voc Rehab: _____

Patient Acknowledgement of Privacy Practices

By signing this form, I acknowledge receipt of the Notice of Provider Privacy Practices of Clemson Eye, which outlines how they may use and disclose my protected health information. I understand that their Notice of Provider Privacy Practices is subject to change and that I may obtain a copy of the revised notice or ask any questions by contacting Clemson Eye at (888) 654-6706. I hereby authorize Clemson Eye to release my health information for purposes of treatment, payment and healthcare operations as described in Clemson Eye Visual Health and Surgery's Notice of Provider Privacy Practices.

Name (print): _____ Date: _____
Patient / Guardian / Guarantor

Signature: _____

Patient Survey Question

How did you hear about us?
Friend/Family ☐ Referring doctor ☐ Internet ☐ Advertising ☐ Radio ☐ Other ☐

Clemson Eye
Visual Health & Surgery

Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

CLEMSON EYE, PA must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

We reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

Without your written authorization, we can use your health information for the following purposes:

1. Treatment: For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.

2. Payment: In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for your medical bills.

3. Health Care Operations: We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

In addition, we may want to use your health information for appointment reminders or to re-schedule appointments. For example, we may look at your medical record to determine the date, time and type of your next appointment with us, and then send you a reminder or re-scheduling letter or have our automatic telephone appointment reminder system call to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you. For example, we may contact patients who are potential candidates for Laser Refractive Surgery (LASIK), BOTOX, or certain Plastic Treatments or Procedures. Furthermore, we may want to use information found in your medical record, such as your name, address, phone number and treatment dates, to contact you for our fund-raising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation.

4. As required or permitted by law: Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.

5. For public health activities: We may be required to report your health information to authorities to help prevent or control disease, injury, or disability.

This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

6. For health oversight activities: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.

7. For activities related to death: We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

8. For organ, eye or tissue donation: We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.

9. For research: Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

10. To avoid a serious threat to health or safety: As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

Please turn over

11. For military, national security, or incarceration/law enforcement custody: If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

12. For workers' compensation: We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

13. For CLEMSON EYE, PA's directory (should one exist): Unless you object, we may use your health information, such as your name, location in our facility, and your general health condition (e.g., "stable," or "unstable") for our directory. It is our duty to give you enough information so you can decide whether or not to object to release of this information for our directory. The information about you contained in our directory will be released to people who ask for you by name. We may allow you to agree or disagree orally regarding the use of your health information for directory purposes.

14. To those involved with your care or payment of your care: If people such as family members, relatives, close personal friends or other persons or organizations are helping care for you or helping you pay your medical bills, we may release important health information about you to those people in person, by letter, by telephone, by facsimile (fax), or by electronic mail (e-mail). The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is our duty to give you enough information so you can decide whether or not to object to release of your health information to others involved with your care.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to the Privacy Officer at CLEMSON EYE, PA.

Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Privacy Officer at CLEMSON EYE, PA. Specifically, you have the right to:

1. Inspect and copy your health information: With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.

2. Request to correct your health information: If you believe your health information is incorrect, you may ask us to correct the information. You will be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

3. Request restrictions on certain uses and disclosures: You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or, you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction. If you receive certain medical devices, (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the medical device.

4. As applicable, receive confidential communication of health information: You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

5. Receive a record of disclosures of your health information: In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

6. Obtain a paper copy of this notice: Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically. The Notice of Provider Privacy Practices may be found on the web site of CLEMSON EYE, PA, www.clemsoneye.com, and is available electronically.

7. Complain: If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact the Privacy Officer of CLEMSON EYE, PA, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact the Privacy Officer of CLEMSON EYE, PA. Effective Date: January 1, 2010.

Clemson Eye
Visual Health & Surgery

Medical History

Your Information

1. What is your name?: _____ Today's date: _____

Medical History

2. Primary care doctor: _____ Tel: _____

3. Do you now, or have you ever had: Diagnosis date:

a. Diabetes . . . . . Yes ☐ No ☐ _____
Treatment: diet control ☐ oral agents ☐ insulin ☐ other ☐
Medical complication: kidney ☐ vascular ☐ eye ☐ other ☐
b. Heart attack . . . . . Yes ☐ No ☐ _____
Angina or chest pain . . . . . Yes ☐ No ☐ _____
Heart failure . . . . . Yes ☐ No ☐ _____
Irregular or rapid heart beat . . . . . Yes ☐ No ☐ _____
Cardiac pacemaker inserted . . . . . Yes ☐ No ☐ _____
c. High blood pressure . . . . . Yes ☐ No ☐ _____
d. Stroke or TIA . . . . . Yes ☐ No ☐ _____
e. Anemia . . . . . Yes ☐ No ☐ _____
f. Asthma . . . . . Yes ☐ No ☐ _____
Emphysema and/or bronchitis . . . . . Yes ☐ No ☐ _____
Pneumonia . . . . . Yes ☐ No ☐ _____
Tuberculosis . . . . . Yes ☐ No ☐ _____
g. Liver disease or jaundice . . . . . Yes ☐ No ☐ _____
h. Stomach or duodenal ulcer . . . . . Yes ☐ No ☐ _____
i. Kidney stones / other kidney diseases . . . . . Yes ☐ No ☐ _____
j. Arthritis: rheumatoid ☐ osteo ☐ . . . . . Yes ☐ No ☐ _____
k. Cancer or tumor . . . . . Yes ☐ No ☐ _____
Type: _____
Treatment: _____
l. Thyroid disease: underactive ☐ overactive ☐ . . . . . Yes ☐ No ☐ _____
Treatment: _____
m. Migraine . . . . . Yes ☐ No ☐ _____
n. Blood clot in legs . . . . . Yes ☐ No ☐ _____
o. Bleeding disorders . . . . . Yes ☐ No ☐ _____
p. Transfusions of blood or plasma . . . . . Yes ☐ No ☐ _____
q. HIV positive, AIDS. . . . . Yes ☐ No ☐ _____
r. Other medical problems . . . . . Yes ☐ No ☐ _____
Please describe: _____

4. Are you allergic to any medications or foods? . . . . . Yes ☐ No ☐ _____
If yes, please describe substance(s), with type of reaction: _____

Medications

5. Please list all medications you are using at present in the spaces provided below:

Eye medication(s)				All other medication(s)		
Name	Dose	Frequency	Eye	Name	Dose	Frequency

Please turn over

Eye Care History

6. Eye doctors seen: _____
   Have you ever had any eye injuries? . . . . . Yes ☐ No ☐
   If yes, please describe injuries and dates: _____

7. Have you ever had any previous eye surgery or laser treatment? Yes ☐ No ☐
   If yes, please give name of operations and dates: _____

8. What other operations have you had? Please give types and dates: _____

Systems Review

9. Are you **currently** having problems with any of the following. Please complete and give details:
   a. Unexplained weight gain or loss greater than 10 lbs . . . . . Yes ☐ No ☐ _____
   b. Fever, chills, night sweats . . . . . Yes ☐ No ☐ _____
   c. Decreased vision, eye pain, double vision . . . . . Yes ☐ No ☐ _____
   d. Decreased hearing, ringing in ears . . . . . Yes ☐ No ☐ _____
   e. Nasal congestion, nose bleeds, sinus congestion . . . . . Yes ☐ No ☐ _____
   f. Hoarse voice, sore throat . . . . . Yes ☐ No ☐ _____
   g. Chest pains or heaviness, shortness of breath, leg pain when walking, ankle swelling, irregular heartbeat . . . . . Yes ☐ No ☐ _____
   h. Cough, wheezing, coughing up blood or sputum . . . . . Yes ☐ No ☐ _____
   i. Heartburn, nausea, stomach pain, diarrhea, constipation . Yes ☐ No ☐ _____
   j. Problems with kidneys, urination, bladder . . . . . Yes ☐ No ☐ _____
   k. Skin rashes or lesions, breast lumps . . . . . Yes ☐ No ☐ _____
   l. Headaches, dizziness, muscle weakness . . . . . Yes ☐ No ☐ _____
   m. Joint Pain, stiffness, swelling . . . . . Yes ☐ No ☐ _____
   n. Depression, nervousness / anxiety . . . . . Yes ☐ No ☐ _____
   o. Lymph node swelling, infections . . . . . Yes ☐ No ☐ _____
   p. Itching, sneezing / allergy symptoms . . . . . Yes ☐ No ☐ _____

Social and Family History

10. a. Are you a smoker? Yes ☐ No ☐ cigarettes per day: _____ When did you stop? _____
    b. Alcohol use? None ☐ Social ☐ 2-3x week ☐ with dinner ☐ other ☐
    c. Occupation: _____ Live alone: Yes ☐ No ☐
    d. Exercise? None ☐ Occasionally ☐ Weekly ☐ Daily ☐
    e. Do you drive? . . . . . Yes ☐ No ☐ _____

11. Among your blood relatives, is there any history of any of the following? List: mother, father, sister, brother, etc.
    a. Glaucoma . . . . . Yes ☐ No ☐ _____
    b. Cataracts . . . . . Yes ☐ No ☐ _____
    c. "Lazy eye" or muscle imbalance . . . . . Yes ☐ No ☐ _____
    d. Retinal disease or macular disease . . . . . Yes ☐ No ☐ _____
    e. Migraine . . . . . Yes ☐ No ☐ _____
    f. Night blindness/color blindness . . . . . Yes ☐ No ☐ _____
    g. Unexplained vision loss . . . . . Yes ☐ No ☐ _____
    h. Diabetes mellitus . . . . . Yes ☐ No ☐ _____
    i. Tumor or cancer . . . . . Yes ☐ No ☐ _____
    j. High blood pressure . . . . . Yes ☐ No ☐ _____
    k. Heart disease . . . . . Yes ☐ No ☐ _____
    l. Bleeding disorder . . . . . Yes ☐ No ☐ _____

12. If applicable, are you pregnant? . . . . . Yes ☐ No ☐ _____

13. Interested in Laser Vision Refractive Surgery (LASIK)? . . . . . Yes ☐ No ☐ _____

Patient signature: _____ Doctor signature: _____ Technician signature: _____