WELCOME

Thank you for choosing Charleston Cornea & Refractive Surgery for your ophthalmological needs. We look forward to seeing you during your visit.

Please complete the enclosed forms and bring them with you to your appointment. We will also need to make a copy of your insurance card and photo ID.

Please be prepared to be in our office for approximately 1 ½ - 2 hours as we perform extensive testing to make sure you receive the highest quality of care. We cannot always prepare for patient visits that may take longer than appointed, however we promise that you will receive the same amount of time and care when you see Dr. O'Day.

Thank you for trusting us with your vision. We care about you and will do everything possible to help you see clearly once again. We look forward to meeting you. For any questions prior to your appointment please call (843) 856-5275.

Sincerely,

David O'Day, MD

David G. O'Day, M.D.
Medical Director and Founder

(843) 856.5275
CharlestonCornea.com

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

DOB: __________ SS#: __________ ❍ Male ❍ Female

Race (Optional): __________ Ethnicity (Optional): ❍ Not Hispanic/Latino ❍ Hispanic/Latino

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Preferred contact number: ❍ Home ❍ Work ❍ Cell

Employment Status:

❍ Employed (full time) ❍ Employed (part time) ❍ Self Employed ❍ Retired

❍ Student (full time) ❍ Student (part time) ❍ Active Duty Military ❍ Not Employed

Place of Employment: ______________________

Marital Status:

❍ Single ❍ Married ❍ Widowed ❍ Divorced ❍ Other

Emergency Contact: ______________________ Phone: __________

Relationship to Patient: ______________________

Primary Insurance: ______________________ Policy #: __________

Insured Name: ______________________ DOB: __________

If you are a Medicare policy holder:

Are you still employed? ❍ Yes ❍ No Is your spouse still employed? ❍ Yes ❍ No

Secondary Insurance: ______________________ Policy #: __________

Insured Name: ______________________ DOB: __________

Our office will file primary insurance claims with contracted insurance companies. Please be advised that the services rendered may or may not be covered under your individual policy. Claims remaining unpaid after 60 days will become the responsibility of the patient. Co-pays and deductibles are due at the time of service.

I authorize the release of medical information necessary to process any insurance claim. I authorize payment of medical benefits directly to Charleston Cornea & Refractive Surgery.

I hereby acknowledge that I have received a copy of the Charleston Cornea & Refractive Surgery notice of privacy practices.

______________________ __________

Patient/Guardian Signature Date

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MEDICAL HISTORY

Patient Name: ______________________ DOB: ______________

Date of Last Eye Exam: ______________________

Family Physician: ______________________ Physician Phone: ______________

Pharmacy: ______________________ Pharmacy Phone: ______________

Do you wear glasses? ❍ Yes ❍ No How long have you had your current lenses? ______________

Do you wear contacts? ❍ Yes ❍ No If yes, for how long? ________ Do you wear them overnight? ❍ Yes ❍ No

EYE HISTORY

Please mark any of the following problems that you have had in the past or currently experiencing.

- ❍ Ocular Headache/Migraine
- ❍ Loss of Side Vision
- ❍ Mucous Discharge
- ❍ Itching/Burning
- ❍ Foreign Body Sensation
- ❍ Night Vision Impairment
- ❍ Macular Degeneration
- ❍ Iritis
- ❍ Loss of Vision
- ❍ Infection of Eye/Lid
- ❍ Redness
- ❍ Tearing/Watering
- ❍ Eye Pain/Soreness
- ❍ Cataracts
- ❍ Corneal Disease
- ❍ Other
- ❍ Blurred Vision
- ❍ Double Vision
- ❍ Tired Eyes
- ❍ Styes/Chalazion
- ❍ Light Sensitivity
- ❍ Retinal Disease
- ❍ Glaucoma
- ❍ Distorted Vision (halos)
- ❍ Dryness
- ❍ Sandy/Gritty Feeling
- ❍ Eye Injury
- ❍ Problems with Glare
- ❍ Crossed Eyes
- ❍ Fluctuating Visual Acuity

Explanation: ____

____

EYE INJURIES OR SURGERIES

Please list dates and types of any previous eye injuries and surgery.

____

____

____

____

EYE MEDICATIONS

Please list any eye drops you use (prescription and over the counter).

____

____

____

PLEASE CONTINUE ON OTHER SIDE ➜

______________________ ______________

Physician's Signature Date

HEALTH HISTORY

Please mark any of the following problems that you have had in the past or currently experiencing.

- ❍ Seasonal Allergies
- ❍ Chronic Cough
- ❍ Neurological Disease
- ❍ Psychiatric Disorder
- ❍ Stomach/Intestinal
- ❍ Shortness of Breath
- ❍ Prostate/Bladder
- ❍ Pregnant or Nursing
- ❍ Sinus Congestion
- ❍ Dry Throat/Mouth
- ❍ Arthritis
- ❍ Migraines
- ❍ Stroke
- ❍ Temporal Arteritis
- ❍ TB/Brochitis
- ❍ Lupus
- ❍ Runny Nose
- ❍ Lung Disease
- ❍ Diabetes
- ❍ HIV/AIDS
- ❍ Fainting
- ❍ Prosthesis
- ❍ Seizures
- ❍ Thyroid
- ❍ Post-Nasal Drip
- ❍ Kidney Disease
- ❍ Sarcoid
- ❍ Heart Disease/Angina
- ❍ Asthma
- ❍ Head or Spinal Injuries
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Cancer
- ❍ Excessive Confinement from Illness or Injury
- ❍ Permanent Defect from Illness, Disease or Injury

Explanation/Other: ______________________________

____

SURGICAL HISTORY

Please list dates and types of any previous medical surgery.

____

____

____

OTHER MEDICATIONS AND VITAMINS

Please list ALL medications and vitamins you are taking. You may attach a list if you brought one.

____

____

Please list ALL significant allergies: ______________________________

FAMILY HISTORY

Please note if any of your immediate family has been diagnosed with any of the following and their relation to you.

Blindness: __________ Cataracts: __________ Macular Degeneration: __________

Glaucoma: __________ Heart Condition: __________ Diabetic Retinopothy: __________

Diabetes: __________ Stroke: __________ Retinal Detachment: __________

Other: ______________________________

SOCIAL HISTORY

Employment Status:

❍ Employed (full time) ❍ Employed (part time) ❍ Self Employed ❍ Retired

❍ Student (full time) ❍ Student (part time) ❍ Active Duty Military ❍ Not Employed

Marital Status:

❍ Married ❍ Widowed ❍ Seperated ❍ Divorced ❍ Never Married

Do you spend more than 50% of your day at a computer? ❍ Yes ❍ No

Do you smoke? ❍ Yes ❍ No

Do you drink alcohol? ❍ Yes ❍ No

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SPEED II Questionnaire

Total Score: _____ /35

First Name: ______________________ Last Name: ______________________

DOB: ______________________ ❍ Male ❍ Female Today's Date: ______________________

Report the FREQUENCY of these symptoms using the rating system below.

SYMPTOMS	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness				
Grittiness/Scratchiness				
Burning/Soreness/Irritation				
Watering				
Eye Fatigue				

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Report the SEVERITY of these symptoms using the rating system below.

SYMPTOMS	None (0)	Tolerable (1)	Uncomfortable (2)	Bothersome (3)	Intolerable (4)
Dryness					
Grittiness/Scratchiness					
Burning/Soreness/Irritation					
Watering					
Eye Fatigue					

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Do you use drops and/or ointment? ❍ Yes ❍ No

If yes, what do you use? ______________________

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FINANCIAL POLICY

Thank you for choosing us for your eye care needs. The following is our financial policy for you to read and sign prior to any treatment. This information is also available on our website at www.charlestoncornea.com.

PATIENT REGISTRATION

- You will be asked to complete a registration form each year, update and confirm the accuracy of this information at every visit.
- For your protection, we require personal identification. Bring your driver's license or picture ID on every visit to the front office check in system.
- Our registration form is available on our website.

CANCELLATION/NO SHOW

- Confirmation calls go out 3 days in advance. We require a 24 hour notice if you wish to cancel or reschedule your appointment.
- A $50.00 fee will be charged if you miss an appointment without notifying us, or rescheduling with less than 24 hour notice.

COLLECTION FEES

- **After attempts have been made to collect any outstanding balances, your account will be turned over to a collection agency.** A collection fee will be added to your balance on a percentage basis, as our collection agency charges us to turn your account over. Please call our office to discuss your balance and possible payment plan before allowing your account to be turned over.

INSURANCE CARDS & INSURANCE FILING

As a courtesy to all our patients, we will file insurance claims to your primary and secondary insurance carrier. You must bring your current insurance card to every visit to file insurance claims on your behalf. It is your responsibility to inform us in a timely manner of any changes to your billing information.

- If an insurance company denies payment for incomplete or incorrect information provided by you or for non-covered services, you will be expected to pay for services in full.
- If we do not participate in your insurance plan, be aware your benefits may be reduced.
- Medicare and most insurance companies DO NOT cover standard care of eye refraction, (eyeglass prescriptions), contact lens fitting or contact lens modification.
- Charleston Cornea's refraction fee is $65.00 and contact lens fit fee is $130.00
- We do not file school or automobile insurance.

INSURANCE AUTHORIZATION

- If your insurance requires an authorization for office visits or procedures, it is your responsibility to make sure we have authorization prior to the visit or service.
- If you want to be seen without an authorization, you will be considered a self-paying patient, and you will be required to pay in full for all services at the time you are seen.

PAYMENT

- We accept Cash, Check, Money Order, Visa, MasterCard, Discover, American Express and Care Credit. Patients are expected to pay for all estimated co-pays, outstanding deductibles, and coinsurance AT THE TIME OF SERVICE as required by your insurance company.
- Patients will also receive a monthly statement for any unpaid services by patient or insurance. Returned check fee is $25.00.
- Medical record fee of $25.00 in advance for completion of disability forms.

SELF-PAY/UNINSURED

- It is impossible to determine what the cost of the care will be prior to the date of service.
- We require a minimum payment of $100.00 up front before seeing one of our doctors for new self-pay patients.
- Additional payment may be required after services rendered.
- Patient will be billed for any balance not paid at checkout. Payment is due upon receipt of statement.

MINOR PATIENTS

- Patients under the age of 18 must be accompanied by a parent or guardian.
- The parent who consents for treatment will be the responsible party on the account and is responsible for all charges regardless of divorce or separation decree.
- We request patients age 18 or older covered under their parents insurance to sign an authorization allowing Charleston Cornea & Refractive Surgery, P.A. to contact parents regarding insurance and billing issues.

EXTENDED PAYMENT PLANS & FINANCIAL ASSISTANCE

- Please call our billing office to discuss any extended payment plan options, which may be available to you under hardship circumstances.

TERMINATION/DISCHARGE FROM PRACTICE

The following scenarios may jeopardize the patient/physician relationship in which Charleston Cornea & Refractive Surgery, P.A. will terminate and discharge the patient from the practice. The patient will be sent a letter of discharge for:

- Noncompliance/Abusive Patients
- Excessive no shows
- Financial –failure to meet financial obligations

Please direct any questions concerning the above policy to our business office at (843) 856-5275. By signing below, I acknowledge that I have read and understand the financial policy set forth by Charleston Cornea & Refractive Surgery, P.A.

Name of Patient/Responsible Party ______________________ Date ______________

(843) 856.5275
CharlestonCornea.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ______________________________ Phone #: ______________

Address: ____

City: ______________________ State: __________ Zip: ______________

DOB: ______________ SS#: ______________ Account #: ______________

I hereby authorize the following person(s) to have access to my medical records:

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

By signing this authorization, I authorize and permit the above designated person or person to obtain my protected health information (PHI) as requested. This authorization permits Charleston Cornea & Refractive Surgery to release your protected health information to the above person or persons without any further authorization from you. YOU may revoke this authorization in writing and sent to Charleston Cornea & Refractive Surgery, 574 Lone Tree Road Mt. Pleasant, SC 29464.

By authorizing others to view or have access to my PHI, your PHI may no longer be protected by federal privacy law.

To authorize release of information to designated person/persons:

______________________________ ______________

Patient/Guardian Signature Date

______________________________ ______________

Office Witness Signature Date

❍ **I DO NOT AUTHORIZE ANYONE TO ACCESS TO MY MEDICAL RECORDS***
(please be advised that this includes spouses and/or family members)

______________________________ ______________

Patient/Guardian Signature Date

**This does not apply to filing for insuarance claims or other requests as permitted or required by law.*

(843) 856.5275
CharlestonCornea.com

NOTICE OF PRIVACY POLICIES & PRACTICES

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

At Charleston Cornea & Refractive Surgery, PA, we are committed to treating and using protected healthcare information about you responsibly. It also describes your rights as they relate to your protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit Charleston Cornea & Refractive Surgery, PA, a record of your visit is documented. This record contains information about your examination, your diagnosis, test results, treatment provided, and other pertinent healthcare data. Understanding what is in your record and how this information is used helps to ensure its accuracy. It helps you to determine what entities should have access to your information when making a decision to authorize the disclosure of this information to other individuals.

HOW WE MAY USE & DISCLOSE YOUR HEALTH INFORMATION

Your protected healthcare information may be used and disclosed by the physician, our staff, or others outside of our practice for:

- Providing treatment
- Healthcare operations
- Communication with family members
- Processing information for payment
- Appointment correspondence
- Business Associates

You may submit a written revocation of your authorization of use or disclosure of your protected healthcare information, if you mind. Your protected healthcare information may be used and disclosed, without your written consent, authorization or opportunity to object under these circumstances:

- Law enforcement
- Criminal Investigations
- Healthcare Oversight Agency
- Information required by Food & Drug Administration
- Organ Donor Agencies
- Legal Proceedings
- Public Health
- Military & National Security Coroners & Funeral Directors
- Research/Training/Teaching

OUR RESPONSIBILITIES

Charleston Cornea & Refractive Surgery, PA is required to:

- Maintain the privacy of your protected health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to the information we collect
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of healthcare information

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in Federal and State laws and regulations. Upon request, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected healthcare information that we maintain.

YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARDS

- You have the right to inspect and copy your protected health information.
- You have the right to request a restriction of your protected health information.
- You have the right to receive confidential communication from us by alternate means or at an alternate location.
- You have the right to an accounting of how and to whom your protected healthcare information has been disclosed.
- You have the right to amend or submit corrections to your protected healthcare information.
- You have the right to receive a printed copy of this notice.

TO FILE A COMPLAINT

If you believe that your privacy rights have been violated, please contact our Privacy Officer, Teresa McKenzie at (843) 856-5275, or 574 Lone Tree Drive, Mount Pleasant, SC 29464 to file a complaint.

You may also file a complaint with the Office for Civil Rights, US Department of Health and Human Services, 200 Independence Ave. S W Room 509F HHH Building, Washington DC 20201.

There will be no retaliation for filing a complaint.

This notice was published and becomes effective April 14, 2003