



WELCOME

Thank you for choosing Charleston Cornea & Refractive Surgery for your cataract evaluation. We look forward to seeing you during your visit and are excited to help you regain your vision. Cataract surgery has evolved over the last 20 years to be one of the safest and most reliable methods to restore your vision. The purpose of this letter is to let you know that you will need to make some decisions about the technology we offer and the type of intraocular lens implant that you would like us to insert in your eye(s). This is an important decision since you will be looking through these lenses for the rest of your life. We want you to choose the implant that will help you regain the lifestyle to which you have become accustomed, and to do what you love to do most with clear vision. Please feel free to discuss these implant options with family or friends.

Here is a brief overview of your lens implant options:

- A **“monofocal” (single focus) lens implant** provides clarity of focus at one distance only. This is usually chosen to be your distance vision, reducing the need for distance glasses. You will still need glasses (like bifocals) for intermediate and near vision activities such as reading or using the computer. If you have astigmatism and don't choose to have that corrected you will need glasses for both distance and near. This monofocal lens has no additional costs and is covered by your insurance.
- A **“multifocal” lens implant** or an **“extended depth of focus” (EDOF) lens implant** (Tecnis Multifocal or Symphony) provides distance, intermediate, and near vision. 85-90% of people that choose this lens are independent of their glasses and contacts for most daily activities.
- A **“toric” lens implant** is designed to reduce or eliminate corneal astigmatism; therefore, the toric implant provides significantly improved distance vision, which reduces the need for corrective lenses for distance, but reading glasses (drug store type) are still required.

We have enclosed additional information about your lens replacement options. Please review these prior to your appointment. Be prepared to ask questions, discuss options, and make a decision based on my recommendation, that best fits your lifestyle.

Please be aware that insurance doesn't cover the premium lens options. The out-of-pocket expenses can seem expensive at first but when you consider how much you use your eyes each day and potential savings on glasses or contacts, the investment pays off many times over. The exact costs will be discussed with you by our surgery counselor during your exam.

Thank you for trusting us with your vision. We care about you and will do everything possible to help you see clearly once again. 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



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



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

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.

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

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 Retinopathy: _____
Diabetes: _____ Stroke: _____ Retinal Detachment: _____
Other: _____

SOCIAL HISTORY

Employment Status:

- | | | | |
|--|--|--|------------------------------------|
| <input type="radio"/> Employed (full time) | <input type="radio"/> Employed (part time) | <input type="radio"/> Self Employed | <input type="radio"/> Retired |
| <input type="radio"/> Student (full time) | <input type="radio"/> Student (part time) | <input type="radio"/> Active Duty Military | <input type="radio"/> Not Employed |

Marital Status:

- Married Widowed Separated 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



Patient Name: _____

Chart #: _____ Eye Being Evaluated: Left Right

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?

1. Reading small print, such as labels on medicine bottles, telephone books, or food labels? Yes No
2. Reading a newspaper or book? Yes No
3. Reading a large-print book, or large-print newspaper, or large numbers on a telephone? Yes No
4. Recognizing people when they are close to you? Yes No
5. Seeing steps, stairs, or curbs? Yes No
6. Reading traffic signs, street signs, or store signs? Yes No
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry? Yes No
8. Writing checks or filling out forms? Yes No
9. Playing games such as bingo, dominos, or card games? Yes No
10. Taking part in sports like bowling, handball, tennis, or golf? Yes No
11. Cooking? Yes No
12. Watching television? Yes No

SYMPTOMS

Have you been bothered by:

1. Poor night vision? Yes No
2. Seeing rings or halos around lights? Yes No
3. Glare cause by headlights or bright sunlight? Yes No
4. Hazy and/or blurry vision? Yes No
5. Seeing well in poor or dim light? Yes No
6. Poor color vision? Yes No
7. Double vision? Yes No

DRIVING

1. Have you ever driven a car?
 Yes (continue) No (stop)
2. Do you currently drive a car?
 Yes (continue) No (skip to #5)
3. How much difficulty do you have driving during the day because of your vision?
 No difficulty A little difficulty A moderate amount of difficulty A great deal of difficulty
4. How much difficulty do you have driving at night because of your vision?
 No difficulty A little difficulty A moderate amount of difficulty A great deal of difficulty
5. When did you stop driving?
 Less than 6 months ago 6-12 months ago More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, and if the only way to help you see better is cataract surgery, do you feel vision problem is bad enough to consider cataract surgery now?

Yes No

Patient/Guardian Signature

Date

Witness

Date



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? _____



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



**Charleston Cornea
& Refractive Surgery**

**(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 insurance claims or other requests as permitted or required by law.*



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