OptoMap Screening Retinal Exam

Dr Davis, Dr Frazier and Dr Hinkle believe that the **Optomap Screening retinal exam** is an essential part of your comprehensive eye exam and recommend it for all patients once per year.

Diseases such as **Macular Degeneration, Glaucoma, Retinal tears and detachments**, as well as other health problems such as diabetes and high blood pressure can be detected with a thorough exam of the retina.

An Optomap Retinal Exam provides:

- A scan to confirm a healthy eye, or to detect the presence of a disease.
- An overview or map of the retina, giving your doctor a more detailed view can be achieved by other means.
- A permanent record for your medical file, enabling your doctor to make important comparisons if potential problems show themselves at a future examination.

The Optomap Screening Retinal Exam is fast, easy and comfortable.

PLEASE NOTE: The Optomap Screening Retinal Exam is a non-covered service with your health plan, meaning that you would be responsible for the charges. Our fee for the Optomap Screening Retinal Exam is $44.00

_____ Yes - I want to take advantage of this advanced technology.

_____ No- I decline the Optomap screening against medical advice.

Patient signature: _____ Date: _____

(307)-856-9451

24 Hour Cancellation & "No Show" Fee Policy

Riverton Vision Center, P.C. reserves the right to charge a fee of $50.00 for all missed appointments which would be considered a " No Show" and appointments which are not canceled within a 24- hour advance notice (without a compelling reason). Arriving more than 10 minutes late after your appointment time will be considered a "No Show" and may result in your appointment being rescheduled to a different day. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No shows" in any 12 month period may result in termination from our practice.

We are committed to ensuring that all patients have access to the care they need. Thank you for working with us to meet this standard.

By signing below you acknowledge that you have received this notice and understand this policy.

*Signature:*_____

*Printed Name:*_____ *Date:*_____

WELCOME TO RIVERTON VISION CENTER, P.C.

Patient Health History

First Name _____ Last Name_____ Height____ Weight____
Preferred Language_____ Race/Ethnicity_____
Do you use tobacco products? Yes/No Packs per day? _____ How many years? _____
Do you drink alcohol? Yes/No How often? _____

Please circle Yes Or No if you have ever been diagnosed or treated for a disease of the following systems. If yes, please list the specific condition(s).

Yes/No Eye Conditions (Cataract,Glaucoma,Trauma,etc.) _____
Yes/No Cardiovascular (High blood pressure, Heart disease, etc.) _____
Yes/No Endocrine (Diabetes, Thyroid, etc.) _____
Yes/No Genitourinary (Kidneys, Ovaries, etc.) _____
Yes/No Ears/Nose/Throat _____
Yes/No Blood (HIV, Sickle Cell, etc.) _____
Yes/No Gastrointestinal (Ulcers, Crohn's, etc.) _____
Yes/No Skin (Rash, eczema, etc.)_____
Yes/No Muscle/Bone (Arthritis, fibromyalgia, etc.) _____
Yes/No Neurological (Parkinson's, Seizures, etc.)_____
Yes/No Psychiatric (Depression, ADHD, etc.) _____
Yes/No Lungs (Asthma, COPD, etc.) _____
Yes/No Any Hayfever, Food or Seasonal Allergies?_____
Are you currently pregnant or nursing? Yes/No _____
Other _____

Please List:

Medications	Reason	Dosage

Please List Eye Drops or Eye Vitamins _____
Allergies to Medications? Yes/No if yes, please list _____
Have you had any surgeries? Yes/No if yes, please list _____

Other Past Medical History_____

Is there a family history of the following? (parents, siblings, grandparents) If yes please list.

Yes/No Diabetes _____ Yes/No Glaucoma _____
Yes/No Heart Disease_____ Yes/No Cataracts_____
Yes/No Cancer _____ Yes/No Macular Degeneration_____

Reviewed by Doctor: _____ Date:_____

WELCOME TO RIVERTON VISION CENTER, P.C.

Patient's Name: _____ _____ _____ Today's Date:_____
(First) (M.) (Last)

Date of Birth: _____ SSN: _____ Male/Female

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

Occupation/Grade: _____ Employer/School: _____

Home Phone: (___)_____Work Phone: (___)_____ Cell Phone: (___)_____

Email Address:_____

Marital Status (check one): __Single __ Married __Divorced __ Widowed

Spouse's Name:_____ If minor: Parent's Name:_____

Family member responsible for account:_____

Relationship to patient: _____ Occupation: _____

Employer: _____ Work Phone: (___)_____ SSN: _____

Examination fees are due upon completion of services. Fees not paid by insurance and any incurred collection fees are the responsibility of the patient.

Preferred method of payment (check one): ___Cash ___Check ___ Credit Card

Do you have a Vision Plan? __ Yes __ No

Do you have a Medical Plan? __ Yes __ No

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP)
2. Medical Insurance (such as BCBS, and Medicare)

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problems or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Insurance Company: _____ Policy Number: _____

Insurance Authorization and Release/Acknowledgement of Receipt of Notice of Privacy Policies: I request that payment of authorized insurance benefits for any services furnished to me be made on my behalf to Dr. Ballard, Dr. Hinkle, or Dr. Frazier. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge that I have been given a copy of this office's notice of privacy policies.

Signature: _____ Date: _____

Riverton Vision Center Financial Policy

Payment

Full payment is due at the time of service. Eyeglasses, contact lenses, and other materials are to be paid in full at the time of purchase. We accept cash, check, Visa, MasterCard or Discover. We also offer Care Credit as a payment option.

About your insurance/vision plan

There are two types of plans that might help pay for your eye care services and/or optical products. You might have both types and Riverton Vision Center accepts many plans in both categories: 1). Vision Plans (such as VSP) and 2.) Medical Insurance (such as Blue Cross/ Blue Shield, Medicare, Medicaid, and others).

-Vision plans only cover routine vision wellness exams,eyeglasses, and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management, or treatment of eye health problems).

- Medical insurance must be used for medical eye care.
- If you have both types of plans it may be necessary for us to bill some services to one plan and some services or materials to the other.
- Please provide your insurance card to our staff member to make a copy. We need to have your medical insurance or Medicare card on file for future billing of your insurance. If your deductible and/or co-insurance has not been met it is your responsibility to pay the balance due. We will notify you and get your approval before we bill any insurance plan.
- All co-pays, Optomap imaging fees, refraction fees, fees for contacts and contact lens fitting fees, and any amount above the allowed vision plan benefits on frames and lenses are due at the time of service.

-If it is determined that you or the beneficiary were not eligible for services and/or materials through your medical insurance and/or vision plan on the date of service or date of purchase of materials, you will be responsible for payment in full for the charges for the services and/or materials purchased.

Minor Patients (under 18 years old)

The parent or guardian accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card or insurance plan or payment for services and any co-pays are made by cash or check. The parent or guardian should call ahead and authorize treatment, such as Optos imaging and or/ dilation.

Professional Fee Refund Policy

Professional fees, such as exam fees or contact lens fitting fees, represent payments for services that were rendered (even if not successful) and are not refundable.

Eyeglass and Contact Lens Return Policy

Eyeglass lenses are custom made devices and are not refundable, but we will be happy to correct any problems that you may experience. See our separate sheet on Doctor's Rx changes for more information and our policy on frame returns. Contact lenses may only be returned if the packaging is not opened or written upon and the contacts are not expired.

Delinquent Accounts

-There will be a 1.5% monthly service charge on accounts 30 days past due. Accounts not paid in full within 120 days may be sent to an outside collection agency.

-There will be a $35 service fee charge for any returned check. Cash, credit car or money order will then be required for payment.

-By signing below, I acknowledge that I have received and understand the policy above.

Patient signature:_____ **Date:**_____

Patient name:_____