CHATTANOOGA EYE INSTITUTE, P.C.

Charles A. Kirby, M.D., F.A.C.S. / R. Evan Levy, M.D.

NAME ____ SEX M F
(Last) (First) (M.I.)

ADDRESS ______________________________ PHONE ____________

CITY ______________ STATE ______ ZIP ______ EMAIL ____________

DATE OF BIRTH ______________ SOCIAL SECURITY # ______________

EMPLOYER/OCCUPATION ____________________ WORK# ____________

MARTIAL STATUS S M W D NAME OF SPOUSE ______________

SPOUSE DATE OF BIRTH ______________ SOCIAL SECURITY #______________

SPOUSE EMPLOYMENT __________________ WORK# ______________

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PARENTS OF GUARDIANS OF THOSE PATIENTS UNDER 18 YEARS OF AGE

FATHER'S NAME______________ DOB ________ADDRESS ______________

EMPLOYMENT ______________ SS# ______________PHONE#____________

MOTHER'S NAME ______________ DOB ________ ADDRESS ____________

EMPLOYMENT ______________ SS# ____________ PHONE #____________

>>>

PRIMARY CARE PHYSICIAN ____________________ PHONE # ____________

NAME OF REFERRING PHYSICIAN __________________ PHONE # ____________

NAME OF EMERGENCY CONTACT __________________ PHONE # ____________

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I request that payment of insurance, including Medicare, supplement insurance and all other insurances, be made to Chattanooga Eye Institute, P.C. for services furnished to me by Chattanooga Eye Institute, P.C.

I authorize the release of medical or other information of the above listed insurance provider(s). I/We agree to pay any collection or attorney fee owed, in addition to court costs, if charges are not paid according to established policy and legal action is necessary to affect collection. I/We certify that I/we have read all of the above and the information given is true.

PATIENT/GUARANTOR SIGNATURE ________________________ DATE __________

HOW DID YOU HEAR ABOUT US? ______________________________

Chattanooga Eye Institute
HIPAA Compliance Patient Consent Form

Patient's Full Name	Patient's Social Security Number
Address	Patient's Date of Birth
City, State, Zip Code	Patient's Telephone Number

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. *Please allow 15 business days for processing.*

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO
May we phone, email or sent a text for marketing purposes?	YES	NO

Email: _____

If YES, please name the two (2) family/friend members allowed:

_____

_____

This consent was signed by: _____
(Please Print Name)

Signature: _____ Date: _____

Witness: _____ Date: _____

NAME_____

HISTORY REVIEWED: PHYSICIAN'S SIGNATURE_____ DATE_____

Do you currently have any problems in the following areas? If yes, provide information in the COMMENT SECTION.

	YES	NO		YES	NO
Skin	____	____	Bones/Joints/Muscles	____	____
Head	____	____	Neurologic	____	____
Neck	____	____	Blood Disorder	____	____
Lungs / Breathing	____	____	Allergies/Immunologic	____	____
Heart / Blood pressure	____	____	Psychiatric	____	____
Stomach / Intestines	____	____	Hayfever / Sinus	____	____
Genitals / Kidneys	____	____	Throat / mouth	____	____
Bladder	____	____	Fever / weight loss	____	____
Diabetes Mellitus	____	____			

COMMENTS:_____

EYES

DATE OF LAST EXAM_____ DOCTOR_____

ARE YOU HAVING ANY PROBLEMS WITH YOUR EYES: IF YES, EXPLAIN UNDER COMMENTS.

	YES	NO		YES	NO
Loss of Vision	____	____	Itching/burning	____	____
Blurred/Distorted	____	____	Excess tearing	____	____
Double Vision	____	____	Glare/light sensitivity	____	____
Dryness/gritty feeling or infection/discharge	____	____	Pain/soreness	____	____
Redness	____	____	Lazy Eye	____	____
			Contact lens/glasses	____	____
			Tired Eyes	____	____

COMMENTS;_____

PAST MEDICAL HISTORY

LIST ANY MEDICATIONS YOU TAKE:

LIST ALL MAJOR ILLNESSES / INJURIES:

LIST ALL SURGERIES YOU HAVE HAD IN THE PAST:

LIST ALL HOSPITALIZATIONS WITH EXPLANATIONS OF WHAT THEY WERE FOR:

ARE YOU ALLEGIC TO ANY MEDICATION? YES NO

IF YES – LIST MEDICATIONS:

IF YOU ARE A MINOR, HAVE YOU HAD REQUIRED IMMUNIZATIONS? YES NO

FAMILY HISTORY- Does your family have a history of: Blindness – YES NO Heart Disease – YES NO

Glaucoma – YES NO Diabetes - YES NO Sjogrens Disease - YES NO

Retina Disease - YES NO High Blood Pressure - YES NO Other_____

Do you use alcohol / tobacco or any medications not listed above?_____

Education Level (Please Check) _____ High School _____College _____Post Graduate Degree

CHATTANOOGA EYE INSTITUTE, P.C.

CHARLES A. KIRBY, M.D., F.A.C.S.
R. Evan Levy, M.D.
5715 CORNELISON ROAD, BUILDING 6600
CHATTANOOGA, TENNESSEE 37411

NON-COVERED SERVICES RELEASE FORM '

Eye exams are generally covered under Medicare, Medicare Alternative Plans, and all Commercial Insurance plans. However, they do not pay for the refraction portion of the exam. You will be responsible for that cost.

Medicare also does not pay for broken or lost glasses/lens, sunglasses, or any other type of glasses except after cataract surgery. Following cataract surgery Medicare, Medicare Alternative Plans, and all Commercial Insurance plans will pay for standard lens and frames. Deluxe features are not covered. You may pay for those yourself if you so desire to have any deluxe features.

WAVIER FORM

I understand that if I have no secured appropriate authorizations and otherwise complied with the terms of my health benefit plan, there may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive, and that I will be financially responsible for the services not covered.

Patient's Signature _____

Date _____ Witness Signature _____

Chattanooga Eye Institute, P.C.

CHARLES A. KIRBY, M.D., F.A.C.S. R. Evan Levy, M.D.

5715 Cornelison Road Building 6600 Chattanooga, Tennessee 37411

ABOUT YOUR INSURANCE

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:

Vision care plans (such as VSP and EyeMed)

Medical insurance (such as Blue Cross/Blue Shield 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 problem 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.

I have read and agree with these policies.

_____ _____

Patient signature (or parent/guardian signature if patient is a minor) Date

Please provide your insurance cards to our staff.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Refraction	Non Covered Service	$42

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Refraction** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: