FINANCIAL POLICY

Thank you for choosing **Metrolina Eye Associates (MEA)** for your healthcare needs. This policy is designed to provide you with a clear and concise understanding of your financial responsibilities with regards to any service rendered. It is the policy of MEA that payment in full is due at the time of service unless special arrangements have been made in advance. This includes co-payments and/or deductibles that are required by your insurance company.

Filing Insurance

I understand MEA will file claims on my behalf to insurance companies that MEA is contracted with. If MEA is not contracted with my insurance company, I agree to pay for services in full the date services are performed. MEA will be happy to assist me in filing my claim with my insurance company. I understand that MEA will bill me for any remaining portion of my balance, if any, once all insurance claims have been made and payments have been received. I understand that I am financially responsible for services deemed to be not medically necessary or for services not covered by my insurance plan. I am also financially responsible for any Deductible, Coinsurance or Co-payments that result from any claims that are filed. ****Copayments are due at the time services are rendered.** ****

Refractions: A **refraction** is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for our providers as they assess your eyes. It is NOT a covered service by most medical insurance companies. **Our refraction fee is collected upon check-out from your visit.** If your insurance company pays for your refraction, we will reimburse you accordingly.

Self- Pay (no insurance/non-participating plans)

I understand that should I not have insurance coverage for the services rendered, or if the insurance information I provide to MEA be inaccurate, or should coverage not be in effect at the time of service, I will be responsible for payment in full for services rendered at the time of service. I understand that I will be required to make pre-payment for services prior to being seen by the provider, and at check-out, I will be responsible for any fees over this pre-payment amount. I understand that if the services rendered cost less than the prepayment amount I will be refunded the difference via separate check.

Returned Checks

I understand that MEA will charge me $35.00 for any returned check or insufficient funds denial. I understand that payment in full (amount of total charge + $35.00 fee) is due ten (10) calendar days after MEA contacts me regarding the returned/insufficient check. Payment in full as a result of returned/insufficient checks may be paid in cash, money order or credit card only. MEA will not accept a check to cover payment for a returned check.

Account Balances

I understand after my insurance has paid and/or processed my visit, there may be a balance remaining. MEA will mail a statement showing the patient responsibility. I understand that I must pay any outstanding balance due within the time frame shown on the statement. I understand that any outstanding balance must be paid upon arrival for my next appointment prior to additional services being rendered, unless I have been approved for a payment plan by MEA. I understand that failure to pay any outstanding account balance may result in my account being forwarded to other agencies for collections and to credit reporting agencies.

I certify that I have read the above conditions of treatment. I understand and agree to their content.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____

Printed Name of Patient.

Description of Personal Representative's Authority (attach necessary documentation)

METROLINA EYE ASSOCIATES PLLC
A Clear Vision of Excellence
www.metrolinaeye.com

MEDICAL vs. ROUTINE VISION PLANS

Routine vision plans such as VSP, Community Eye Care, Superior Vision, Eyemed, Opticare and others provide coverage for a basic screening eye exam to ensure the health of your eyes and for checking for the need for glasses and contacts. Benefits vary according to the specific plan, but routine vision plans DO NOT cover a medical diagnosis.

If during the course of your examination it is discovered that you have a medical issue such as eye allergies, redness, burning, itching, dryness, infection, glaucoma, cataracts, diabetes, headaches, or any other eye related medical issue or complaint we will not be able to treat you under your routine policy. We treat these medical problems under your medical insurance, which generally has a higher co-pay or deductible.

We know that your time is valuable, and we would like to take care of **all** of your eye care during one visit. However, sometimes this is not possible. Some medical issues interfere with our ability to properly fit you for glasses or contacts until the issue is resolved. In this case we will gladly schedule you for a routine exam as soon as possible. If you have a medical condition that does not allow for a new eyeglass prescription, we will gladly do that while you are here.

Note: Your specific vision plan or medical insurance may not cover an eyeglass fit (refraction) when performed during a medical visit. In this case, you will be responsible for the cost of the refraction in addition to your medical co-pays. Any amount that you are responsible for is due at the time of service.

We strive to deliver the best care for your particular issues whether they are routine or medical.

By signing this statement, you agree that you have read and understand the difference in coverage for your routine vision plan and medical insurance.

_____ _____
Signature Date

_____
Printed Name

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ___/____/_____

Primary Care Physician: _____Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city)

_____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Allergies: Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy □ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted)
□ Amblyopia (Lazy eye) □ Diabetic Retinopathy □ Iritis □ Optic Neuritis
□ Aphakia □ Dry Eyes □ Keratoconus □ Retinal Detachment
□ Astigmatism □ Glaucoma □ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery □ Foreign Body Removal □ Punctal Plugs □ Trabeculectomy
□ Blepharoplasty □ Retinal Laser Surgery □ RK (Glaucoma surgery)
□ Cataract Surgery □ LASIK □ Strabismus Surgery (eye muscle) □ Vitrectomy
□ Corneal Transplant □ PRK
Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy □ Herpes □ Hypothyroidism □ Sjogrens
□ AIDS □ HIV Positive □ Lupus □ Graves Disease
□ Diabetes □ Hypertension □ Multiple Sclerosis □ Hyperthyroidism
□ Rheumatoid Arthritis
Other_____

Current Eye Medications: (Please list)

_____

_____

Systemic Illnesses:

□ No history of illnesses □ Congestive Heart Failure □ Hepatitis □ Lung Disease
□ Anemia □ COPD □ High Blood Pressure □ Lupus
□ Arthritis □ Diabetes □ High Cholesterol □ Migraine
□ Arrhythmia □ Eczema □ HIV □ Polymyalgia
□ Asthma □ Fibromyalgia □ Kidney Disease □ Psychiatric Disorder
□ Bleeding Disorder □ Headache □ Kidney Stones □ Skin Cancer
□ Cancer □ Hearing Loss □ Liver Disease □ Stroke
□ Thyroid Disease
Other_____

General Surgeries / Operations: (Please list)

_____

_____

Please continue on the back side of this page →

Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C Infection
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphilis
□ Toxoplasmosis
□ Wound

Other_____

Family History:

□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Blood / Lymph nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Drug Use: □ Yes □ No If yes what and how often?_____

Signature _____ Date _____