# Shelley Eye Center
# Welcome to Our Office

***Invest in your vision. We do.***

Shelley Eye Center is pleased to assist you with your ocular health and vision care needs. It is an honor and a privilege that you have chosen us as your eye health and vision care provider. We provide thorough, competent, highly skilled care and offer only the highest quality products.

***PLEASE FILL OUT COMPLETELY*** Date________________________

PATIENT: ___________________________________________________ DOB ____/____/_______ AGE __________
MAILING ADDRESS _________________________________CITY __________________STATE_______ ZIP _________
Home #________________ Work # ________________ Cell #________________ Email ____________________________
SS# ___________________________ Sex ☐ M ☐ F Married _____ Single _____ Divorced _____ Other __________

**RESPONSIBLE PARTY -** Who is responsible for the account?
NAME _______________________________________________DOB ____/____/_______ SS# ______________________
ADDRESS_________________________________________CITY ___________________STATE_______ ZIP ________

**INSURANCE INFORMATION -- Please provide the insurance card(s) to receptionist**
Insured's Name_____________________________________ DOB ____/____/_______ SS# ________________________
Insured's Employer ___________________________________________________________________________________
Medical Ins. Co. _____________________________________ ID#:____________________________________________
Supplemental Insurance______________________________ ID#:____________________________________________
Vision Plan _____________________________________ Relationship to Member ___ Self ___Spouse ___Child___Other

## REASON FOR VISITING OUR OFFICE TODAY (please check all that apply):

- ❑ Annual Ocular Health Exam
- ❑ Contact Lens Exam
- ❑ Blurred Near and/or Distance Vision
- ❑ Foreign Body (something in the eye)
- ❑ Trouble Seeing at Night
- ❑ Headaches
- ❑ Eyes ___burn/itch ___ feel tired ___ feel dry
- ❑ Flashes of Light
- ❑ Floaters (black specks & spots)
- ❑ Eye Strain

Do you wear contact lenses? Y N
How long have you worn contacts? ___________
**Type of Contacts**
Soft Daily Disposable Gas Perm Other
Brand of Contacts ________________________
How long do you wear your contacts? ______hrs
Do you have a backup pair of glasses?: Y N
How often do you wear your glasses? _______hrs
Do you regularly wear sunglasses?: Y N

**Date of Last Eye Exam** ____________________

**Referral source:**

Dr. _______________________ Internet Insurance Friend/Family Other: ______________

**List ALL medication that you are currently taking (including vitamins, supplements, and birth control):**

______________________________________________________________________________________________

______________________________________________________________________________________________

**List ALL major injuries, surgeries, illnesses, diseases:**

______________________________________________________________________________________________

______________________________________________________________________________________________

**Do you or any of your immediate blood relatives have any of the following conditions?** (Check all that apply)

| | Y | N | Relationship to Patient | | Y | N | Relationship to Patient |
|---|---|---|---|---|---|---|---|
| Glaucoma | | | | Blindness | | | |
| Macular degeneration | | | | Cataracts | | | |
| High Blood Pressure | | | | Digestive disease | | | |
| Circulatory Problems | | | | Stroke | | | |
| Respiratory Disease | | | | Tuberculosis | | | |
| Heart Disease | | | | Blood Disease | | | |
| Kidney Disease | | | | Thyroid Problems | | | |
| Liver Disease | | | | Diabetes | | | |
| Cancer | | | | Arthritis, Rheumatism | | | |

**Do YOU have any of the following conditions?** (Check all that apply)

| | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|
| Cortisone/Prednisone Treatment | | | Dementia / Senility / Alzheimer's | | | Headaches | | | |
| Venereal Disease | | | Allergies to Medication | | | Jaw Pain | | | |
| HIV/AIDS | | | Chemotherapy | | | Tobacco Use: | Never | Former | Current |
| Drug / Alcohol Use / Abuse | | | Back Problems | | | Alcohol Use: | None | Social | Moderate Excess |

**LIFESTYLE QUESTIONNAIRE**

1. Which of the following visual demands do you encounter on a regular basis?
   ○ Artificial Lighting ○ Computer Work ○ Close Up Work ○ Reading ○ Potential Eye Hazards

2. Which of the following activities or hobbies do you participate in? (Circle All that Apply)

| | | | | |
|---|---|---|---|---|
| Auto Repair | Golf | Sewing | Bookkeeping | Bowling |
| Computer | Drawing | Swimming | Gardening | Woodworking |
| Welding | Home Repair | Painting | Crafting | Biking |
| Driving | Racquetball | Reading | Snow Sports | Tennis |
| Hunting/Shooting | Jogging/Running | Musical Instrument | Piloting/Flying | Boating/Water Sports/ Fishing |

3. Do your eyes seem to be bothered by glare from any of the following situations?

| | | | | | |
|---|---|---|---|---|---|
| Car headlights | Y N | Florescent lights | Y N | Traffic Lights | Y N |
| Computer Monitor | Y N | Night Driving | Y N | Sunshine | Y N |

Please answer the following questions to assist our Opticians in determining your eyewear needs.

4. Do you currently wear glasses? Y N Single Vision Progressive(no-line) Bi-Focal Other ________________
5. Will you be purchasing new glasses today? Y N
6. What do you like most about your current eyewear (style, color, fit, brand, etc.)? ___________________________________
   ______________________________________________________________________________________________________
7. What don't you like about your current eyewear (weight, thickness, dryness, glare, etc. _____________________________
   ______________________________________________________________________________________________________

**How will you settle your account today?** Check Cash Visa MasterCard CareCredit

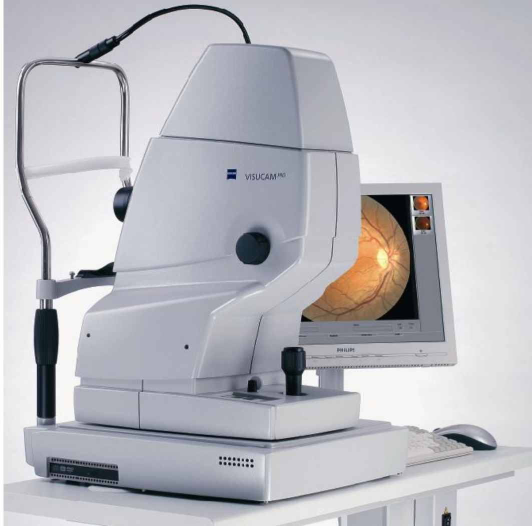
The above information is accurate to my knowledge. I personally guarantee payment for all services rendered. I authorize the release of any medical information to my insurance company in order to process claims related to my care.

Patient/Guardian Signature ______________________________________________________________________________

# The MREye™ Digital Screening System:
# Powerful Tools to detect Eye Disease and Prevent Blindness

Shelley Eye Center developed the exclusive **MREye™ Digital Screening System** to more accurately detect eye disease before symptoms occur. By combining two proven technologies into one powerful tool, your eye health can be more accurately evaluated than was previously available. Compare your family doctor listening to your heart and lungs to an MRI, as you would a routine eye exam to the **MREye™ Digital Screening**.

The **MREye™ Digital Screening** is in addition to our regular examination fees and is not covered by insurance.



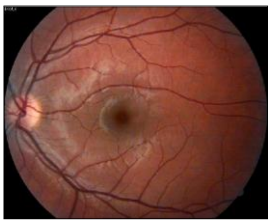
**Digital Fundus Screening**

**Cirrus HD OCT – RETINAL IMAGING**

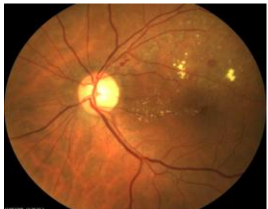
## ***Why should I have a Digital Fundus Exam?***

Diseases such as Glaucoma and Macular Degeneration develop slowly over time and can lead to partial or total loss of vision. Digital Fundus exams allow our doctors to track changes over time as we can now compare your retinal findings from baseline and annually thereafter.

Recommended: **All patients**



*Normal Eye*

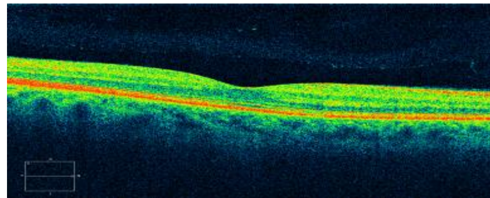


*Diseased Eye*

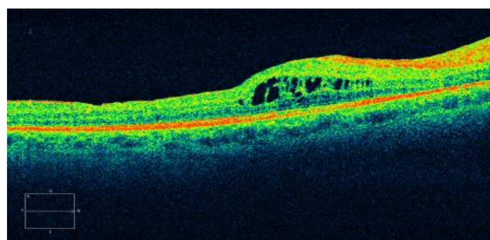
## ***Why should I have an OCT Exam?***

Diseases such as Glaucoma, Macular Degeneration, and Diabetic Retinopathy tend to progress without symptoms in early stages. Age is the primary factor. That is why it is vital to be tested for these conditions early with Cirrus HD OCT.

Recommended: **40 and above**



*Normal Eye*



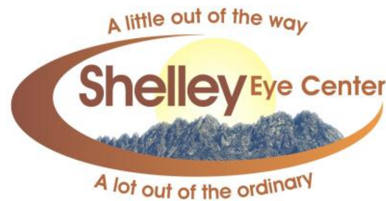
*Diseased Eye*

The **MREye™ Digital Screening** is not a covered benefit of major medical insurance or vision plans. However further testing that is determined to be necessary after an **MREye™ Digital Screening** evaluation may be covered by your medical insurance. Our fee for the **MREye™ Digital Screening** is $85.00. Photos can be provided via email within 48 hours at your request.

Yes, I request the **MREye™ Digital Screening** evaluation: _____ Please initial

Please email my eye photos to: ______________________@__________________________________

No, I decline the **MREye™ Digital Screening** evaluation: _____ Please initial




**IT IS IMPERATIVE THAT YOU READ OUR BILLING POLICIES IN FULL:**

**THIS PRACTICE FOLLOWS STANDARD BILLING PRACTICES AND GUIDELINES AS DEFINED BY THE CENTERS FOR MEDICARE SERVICES**

I understand and agree that I am financially responsible for any and all charges for services rendered or not paid by my insurance(s). This includes any medical service or visit, preventative exam/physical, lab or diagnostic testing, and any other screening ordered by the doctor or doctor's staff.

I understand that Shelley Eye Center does **not** accept Medicaid, whether it is my primary or my secondary insurance, and that I am solely and wholly responsible for any and all fees.

I understand that it is my responsibility and not the responsibility of the doctor or staff, to know if my insurance will pay for such medical services, preventative exam/physical, lab or diagnostic testing, and any other screening ordered by the doctor or doctor's staff.

I understand that while my insurance may confirm benefits, confirmation of benefits does not mean that the insurance company will pay the doctor, and that I am responsible for **any** unpaid balance.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the service I receive and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may result in claims being denied or higher out of pocket expenses to me.

I understand that the office will file my insurance but if for any reason the insurance has not made payment within 45 days, the balance becomes my responsibility. Any money received from the insurance company after the 45 days will then be reimbursed to me. It is my responsibility to let the office staff know of any insurance changes so that claims can be filed correctly. If insurance is not active at time of service, I will be charged the balance in full.

Most Medicare Secondary plans receive the secondary claim directly from Medicare, it is your responsibility to inform the front desk and to provide them with your secondary insurance card. The only secondary plan we directly submit to is VSP. If for any reason you have two commercial insurances, we will only bill the primary. If we do not obtain the proper secondary insurance information from you, this office will not bill the secondary. It will then be your responsibility to file the claim and request payment.

As per page 1.8 of the VSP Manual, VSP is considered SECONDARY to any and all medical insurances, including but not limited to Medicare, BCBS, Lovelace, Cigna, Aetna, Tricare, Presbyterian, Lovelace, Health Smart, Principal, etc. As such if you have diabetes, cataracts, macular degeneration, use medications that have potential ocular side effects, glaucoma, or any other medically related eye condition, your medical insurance is PRIMARY, while your vision plan is SECONDARY. Under no circumstances does VSP cover any form of exam requiring medical treatment of the eye or a prescription for medication.

If you are a Medicare recipient and provide us your Medicare card, and your insurance is declined because you opted into a Medicare HMO or PPO plan, you will be financially responsible for the entire bill. We will not re-file a claim on your behalf. It is your responsibility to provide us with the proper insurance card at the time of service.

There are many different types of insurance plans offered now. Many insurance policies have high deductibles in order to have lower premiums. As such we have made changes to account for these plans:

1. **MEDICAL INSURANCE vs VISION CARE PLANS**
   a. **Medical Insurance**: When a medical condition or diagnosis is present such as cataracts, glaucoma, high blood pressure, diabetes, or any other condition related to the health of the eye, it is necessary for the doctor to provide you with a comprehensive ocular health exam. In this case, we will file a claim to your major medical insurance carrier. Most carriers will pay a portion of some diagnostic tests needed to determine, diagnose, and treat medical conditions related to your ocular health.
      i. **You will be dilated if**:
         1. You have been referred by another practitioner:
         2. You have a systemic condition that directly affects the eyes (Diabetes, Lupus, rheumatoid arthritis, etc),
         3. You take medications that directly affect the eyes (spironolactone, Plaquenil, hydroxychloroquine, prednisone, etc)
         4. You have been previously diagnosed with an ocular health condition
   b. **Vision Care Plans**: Vision coverage through most vision plans is designed to determine the prescription for glasses or contact lenses ONLY. This CATEGORICALLY EXCLUDES a detailed examination of the health of the eye or any diagnostic tests needed to determine medical conditions. ***If you are diabetic, your exam will be billed to your medical insurance without exception.***

2. **Co-payments and Deductibles:** Co-payments will be collected at the time of service. If you have not met your deductible, we will collect the entire cost of the visit. Because each insurance has different allowable amounts per type of office visit, we will estimate what your insurance will allow and collect that amount. If we overestimate, we will apply that amount toward your next visit, or write you a refund check after all insurance has cleared. If we underestimate, you will be billed for the balance. We accept checks, cash, Visa and MasterCard. There is a $35.00 charge for all returned checks.
   a. Professional fees, Co-pays and co-shares are NOT refundable

3. **Refractions:** Refraction is a procedure incorporated into an ocular exam used to determine your best possible vision, and if applicable your eyeglass prescription. It is considered to be a “non-covered” service by Medicare, secondary supplemental insurances and most major medical commercial insurance companies. You are asked to pay the refraction fee at the time of service whether or not a new prescription is written.

4. **Insurance:** in order to avoid being responsible for payment in full, you are required to present a current insurance card at each visit. If you do not present a card, you will be charged for the services and any diagnostic tests.

5. **Missed Appointments**: Please notify us as soon as possible if you need to cancel an appointment since someone else may need the time that we reserved for you. A $25 charge will be billed to your account for any and all missed appointments. We will attempt to notify you of your appointment, but ultimately it is your responsibility to call us to cancel if you are unable to keep your appointment. After 2 missed appointments, you can be dismissed from the practice.

6. **Phone calls:** We are glad to answer brief questions for you over the phone. However, when phone advice becomes extended, it often takes the place of an office visit. There will be a charge of $25 - $78 for extended phone advice with a doctor during normal office hours.

7. **Forms and Letters:** We are happy to fill out vision reports and work/school excuse forms at the time of the visit. It saves us time to fill out these forms as the visit is being completed and the chart is open. Please give these forms to the technician at the beginning of the visit. There will be a $20.00 charge for forms filled out at other times, due and payable when the forms are dropped off.

8. **Medical Records:** The charge for record transfer or medical record copies is $25.00. There is a $10.00 charge to print year-end financial summaries. We issue receipts at each visit to help you avoid this charge.

The doctors and staff of Shelley Eye Center sincerely appreciate your compliance with these policies. We strive to provide excellent, cost-effective eye care in an ever-changing health care environment. We are happy to discuss any questions you have about these policies.

I certify that I, and/or my dependent(s), have medical insurance coverage and/or vision coverage as stated herein. I assign directly to Dr. Brent E. Shelley & Associates, all insurance benefits, if any, for all services rendered. I authorize the use of my signature on all claims submitted to the insurance company(ies) I have listed above. Dr. Brent E. Shelley & Associates may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits and as allowed by the federal HIPPA law.

- I may request a copy of the Shelley Eye Center Notice of Privacy Practices although it is displayed in the office and available online at www.shelleyeyecenter.com,
- I am financially responsible for ***all*** charges incurred today,
- I am financially responsible for any charges that my insurance or vision plan ***does not*** pay, including, but not limited to, any deductibles, co-pays, and/or services not covered by my insurance or vision plan,
- If I have any questions regarding payment or non-payment, I MUST contact the insurance company directly,
- It is my responsibility to know what my medical insurance and vision plan coverage is,
- Professional fees (exam, testing and contact lens fitting fees) and optical materials are ***NOT*** REFUNDABLE (absolutely NO exceptions),
- The information I have provided is accurate to the best of my knowledge.

**ALL MEDICAL SERVICE FEES, GLASSES FEES and CONTACT LENS EXAM FEES ARE DUE UPON COMPLETION OF SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.**

**We gladly offer interest free financing through WWW.CARECREDIT.COM**

**By signing below I affirm that I have read, received, and understand the policies of Shelley Eye Center.**

______________________________________________
Printed Patient Name (and guardian name if applicable)

______________________________________________
Signature (guardian signature if applicable)            Date

**OUR OFFICE DOES NOT MAKE THE RULES**

**THEY ARE DETERMINED BY YOUR SPECIFIC MEDICAL INSURANCE OR VISION PLAN**