CAROLINA GLAUCOMA PA

Welcome to Carolina Glaucoma, We look forward to having you as a patient and assisting you in every way we can with your glaucoma needs. Here are some things to remember to make your first visit a successful one

1. You have received a New Patient Packet either through the mail or provided by your Primary Eye Care Doctor. Please make sure this is completed in its entirety **prior to your arrival.** If your packet is not completed you may be asked to reschedule your appointment.
2. We offer a 15 minute grace period on all appointment times. Please contact the office at 910-341-0011 if you feel you are going to be late or need help with directions. Please be advised that arriving later than 15 minutes past your appointment time may result in rescheduling of your appointment.
3. If you are being referred for a surgery or laser evaluation please know that your procedure will not be performed at your first visit. This will be a consult only.
4. You may be dilated for any new patient appointment as deemed appropriate by Dr. Price. If you feel uncomfortable driving while dilated you may wish to bring a driver.
5. Please note that this is the first time we will be meeting you and therefore your appointment may take some time. Please plan to be here for 1-2 hours on your first visit.

We look forward to meeting you soon!

CAROLINA GLAUCOMA PA

Mary Elizabeth Price, M.D., F.A.C.S.
1907 SOUTH 17TH STREET, SUITE 3
WILMINGTON, NC 28401
910.341.0011 (TEL)
910.341.0012 (FAX)

PATIENT INFORMATION

Last:	First:	MI:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:		State:	Zip:	
Home Phone (Do not leave messages ❑)	Work Phone (Do not leave messages ❑)		Cell Phone (Do not leave messages ❑)		
Social Security Number: - -	Email Address:				
Marital Status: ❑ S ❑ M ❑ W ❑ D	Do you drive? ❑ Y ❑ N		Preferred Contact Method: ❑ Phone ❑ Email ❑ Letter ❑ Patient Portal		
Race (check one): ❑ White ❑ African American ❑ Asian ❑ Native American ❑ Other	Ethnicity (check one): ❑ Hispanic/Latino ❑ Non-Hispanic/Latino		Preferred Language (if not English): ❑ Spanish ❑ Other: _____		
Employer:			Primary Doctor		
Name of Spouse (if applicable)	Phone Number:		Emergency Contact Name:	Phone Number:	
Who referred you to this office?			Preferred Pharmacy and Location?		

*PRIMARY INSURANCE SUBSCRIBER (check if same as individual responsible for payment ❑)

Last:	First:	MI:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:		State:	Zip:	
Home Phone (Do not leave messages ❑)	Work Phone (Do not leave messages ❑)		Cell Phone (Do not leave messages ❑)		
Social Security Number: - -	Email Address:				
Insurance Company	Group Number		Subscriber Number/ID		

We need this information in order to file this claim with your insurance company.

Patient Name_____ **Date of Birth**_____

MEDICAL HISTORY

Y/N		Y/ N	
❑ ❑	Anxiety	❑ ❑	Hepatitis (A, B or C)
❑ ❑	Arthritis	❑ ❑	High Blood Pressure / Hypertension
❑ ❑	Asthma	❑ ❑	HIV/AIDS
❑ ❑	Atrial Fibrillation	❑ ❑	Hypercholesterolemia
❑ ❑	Bone Marrow Transplant	❑ ❑	Hyperthyroidism/Hypothyroidism
❑ ❑	Breast Cancer	❑ ❑	Leukemia
❑ ❑	Colon Cancer	❑ ❑	Lung Cancer
❑ ❑	COPD	❑ ❑	Lymphoma
❑ ❑	Coronary Artery Disease	❑ ❑	Prostate Cancer
❑ ❑	Depression	❑ ❑	Radiation
❑ ❑	Diabetes	❑ ❑	Seizures
❑ ❑	End Stage Renal Disease	❑ ❑	Stroke
❑ ❑	GERD	❑ ❑	Other

Please describe any issues listed above:

_____

_____

SURGICAL HISTORY

Y/N		Y/N	
❑ ❑	Appendix	❑ ❑	Ovaries
❑ ❑	Bladder	❑ ❑	Pancreas
❑ ❑	Breast	❑ ❑	Prostate
❑ ❑	Colon	❑ ❑	Rectum
❑ ❑	Gallbladder	❑ ❑	Skin
❑ ❑	Heart	❑ ❑	Spleen
❑ ❑	Joints	❑ ❑	Testicles
❑ ❑	Kidney	❑ ❑	Uterus
❑ ❑	Liver	❑ ❑	Others

Please describe any issues listed above:

_____

OCULAR HISTORY

Y/ N		Y/N	
❑ ❑	Macular Degeneration	❑ ❑	Narrow Angles
❑ ❑	Blepharitis (eyelid skin irritation)	❑ ❑	Ophthalmic Migraines
❑ ❑	Cataract	❑ ❑	Retinal tear/detachment
❑ ❑	Contact Lenses	❑ ❑	PVD/Floaters
❑ ❑	Corneal Dystrophy	❑ ❑	Diabetic Retinopathy
❑ ❑	Dry-eye	❑ ❑	Glasses
❑ ❑	Glaucoma	❑ ❑	Other

Please describe any issues listed above:

_____

_____

_____

OCULAR SURGERY

Y/ N		Y/N	
❑ ❑	Intravitreal Injections	❑ ❑	Strabismus (Muscle)Surgery
❑ ❑	LASIK	❑ ❑	Retinal Laser
❑ ❑	LPI (Glaucoma laser treatment)	❑ ❑	Retinal Surgery
❑ ❑	Glaucoma Surgery	❑ ❑	Cataract Surgery
❑ ❑	PRK	❑ ❑	YAG Capsulotomy Laser
❑ ❑	Ptosis Repair/Droopy Eyelid(s)	❑	Other
❑ ❑	Punctal Plugs		

Please describe any issues listed above:

_____

_____

_____

_____

PLEASE LIST ALL ALLERGIES AND/OR ALLERGIC REACTIONS YOU HAVE TO ANY MEDICATIONS

(INCLUDE ALLERGIES SUCH AS LATEX AND ADHESIVES)

MEDICATIONS AND/OR SUBSTANCE	REACTION

SOCIAL HISTORY

(Check all that apply and provide details below)

Y/ N		Y/N	
❑ ❑	Current Smoker	❑ ❑	Daytime driving
❑ ❑	Former Smoker	❑ ❑	Nighttime driving
❑ ❑	Alcohol use	❑ ❑	Do you work? Occupation:

Please describe any issues listed above:

FAMILY HISTORY

	(Mother, Father, Brother, Sister, Grandparent,)
Cancer	
Diabetes	
Glaucoma	
Heart Disease	

PLEASE LIST <u>ALL</u> MEDICATIONS YOU CURRENTLY TAKE

This is very important so that we do not prescribe you any medications that will cause harmful reactions from the medications that other doctors have prescribed to you.

MEDICATIONS TAKEN	MILLIGRAM	HOW OFTEN

PATIENT ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE
(PLEASE INITIAL)

_____I acknowledge that I have received or have been offered a copy of Carolina Glaucoma, PA Notice of Privacy Package, effective August 1, 2016.

_____I acknowledge my rights and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Carolina Glaucoma, PA may refuse to accommodate my request if it is not reasonable.

Please indicate the ***telephone number*** you would like our office to use for appointment reminders or other office communications (including but not limited to billing matters and test results) (_____)_____-_____

Is there a family member or friend that you would allow us to leave messages with or release billing or medical information to?

Name:_____

Phone #:(_____)_____-_____

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WILMINGTON, NC 28401
910.341.0011 (TEL)
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MEDICAL RELEASE AUTHORIZATION

(EXPIRES UPON ONE TIME RELEASE)

Patient Name:		Date of Birth	
Street Address	City	State	Zip

I authorize the practice below to release my health information:

Please forward/release my health information to:
1907 South 17th Street Ste. 3 Wilmington, NC 28401, Fax: 910-341-0012

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED

Patient Information:

I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document I can do this by written notification to Carolina Glaucoma, P.A.

Signature ***Date***

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

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE

CONSENT FOR TREATMENT:

The undersigned consents to any examination, laboratory procedure, or other medical treatment or service rendered to the patient under the general and special instructions of Mary Elizabeth Price, M.D. The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of the patient's rights and responsibilities.

RELEASE OF INFORMATION:

The undersigned hereby authorizes this medical office to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of this medical office's charges or having the responsibility for reviewing such charges, including but not limited to this medical office or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned must be transferred to another provider/facility. The undersigned acknowledges and consents that medical records, laboratory results, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST FOR PAYMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION FOR MEDICARE / MEDICAID PATIENTS:

The undersigned requests payment of authorized Medicaid/Medicare benefits, if any, for any services furnished to the patient by Carolina Glaucoma, PA, including physician services, and hereby assigns such benefits otherwise payable directly to the patient, to Carolina Glaucoma, PA, or the physician(s) furnishing such services. The undersigned authorizes Carolina Glaucoma, PA or such physicians to submit a claim for such services to Medicare/ Medicaid. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare/Medicaid, or its agent, claims processor, or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS:

In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorizes Carolina Glaucoma, PA, or physicians to submit a claim for such services, and benefits are hereby assigned to this medical office for application on the patient's bill. It is agreed that Carolina Glaucoma, PA may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information given by or on behalf of the patient in applying for payment from all third party payors is correct.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that the patient and guarantor are financially responsible to Carolina Glaucoma, PA for charges for medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient's insurance plan or Medicare/Medicaid. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized as the patient's general agent to execute the above and accept its terms.

I HAVE READ, OR I HAVE HAD EACH OF THE ABOVE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

_____ _____

Signature of Patient or Personal Representative ***Date***

PAYMENT POLICY

Thank you for choosing Carolina Glaucoma, PA as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of you contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. There will be an additional charge of $20.00 if we have to bill your co-pay.

Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay these in full at the time of your visit.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit you claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we refer your account to a collection agency and you or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Please be aware that should your account be referred to a collection agency, the percentage charged by the collection agency to our practice will be added to the total amount of your bill.

Missed appointments. There is a $25 no-show/late cancellation fee. All appointments must be canceled no later than twenty-four (24) hours prior to your appointment (or by 3 PM on Friday for a Monday appointment), to avoid charges for a no-show or late cancellation. Insurance will not cover charges for a no-show/late cancellation fees. We reserve the right to reschedule your appointment if you are more than 15 minutes late.

Copies of Medical Records and Insurance/Disability Forms. Our office will gladly make copies of medical records for you. The fee for this service is based on the number of pages copied. If you need our office to complete any disability forms or forms for your insurance company or other parties, we will be glad to do so for a fee of $15.00, payable in advance.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

_____ _____

Signature of Patient or Personal Representative ***Date***