PALMER EYE CENTER
Board certified Opthalmic Surgeons

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(850) 877-7337 Office **(850) 877-8675 Fax**

Thank you for choosing Palmer Eye Center! We look forward to providing you with the best ophthalmic care. Below is a list of items you need to bring with you to your appointment:

1. **Palmer Eye Center paperwork** (enclosed). Please complete your paperwork prior to your visit. *This will speed up your check-in process!* If you do not complete your paperwork prior to your appointment, please arrive 30 minutes early.

2. **Palmer Eye Center Appointments** Most clinical exams are an hour visit and usually include dilation. ***Surgical evaluations are at least two-hour visits.***

3. **Photo I.D. and Insurance-** Please bring your Photo I.D., and insurance cards to appointment.

We strive to keep our patients on time. If you must reschedule, please call the office within 24 hours of cancellation at (850) 877~ 7337. If you fail to reschedule, there will be a $25.00 "no-show" fee charged.

Sincerely,
Palmer Eye Center

******Patients for CATARACT and LASIK evaluation appointments******

CATARACT PATIENTS: No contact lenses **2 weeks** ahead of your evaluation

LASIK PATIENTS: No contact lenses **1 week** ahead of your evaluation

Appointment Date: _____

Appointment Time: _____

CONSENT FOR DILATING EYE DROPS INFORMATION REGARDING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. While dilated you may experience glare, difficulty focusing and contrast. It is not possible for your ophthalmologist to predict how much your vision will be affected. However, we advise not to operate any motorized vehic1e or machinery as well as getting assistance with electric wheelchairs due to the risk of falling and/or injury. Because operating any motorized vehicle may be difficult after an examination, it's best if you make arrangements not to drive yourself.

Adverse reactions occur rarely, however dilating drops can provoke acute angle-closure glaucoma. allergic reactions, increased blood pressure, irregular heart rates, dizziness, and increased sweating. This is extremely rare and treatable with immediate medical attention. If your child is dilated and you notice any agitation or unusual response contact us or the emergency room immediately. Additionally, we recommend sun glasses, which we can provide to you.

I hereby authorize Dr. Matthews, Dr. Whitfield and/or such assistants as may be designated to administer dilating eye drops. I understand the eye drops are necessary to diagnose my condition.

CONSENT FOR REFRACTION INFORMATION REGARDING REFRACTION

Refraction is an essential part of a complete eye exam. It is the process of determining the eye's refractive error, or the need for corrective glasses and/or lenses. Refraction is sometimes necessary depending on the patient's diagnosis and/or visual complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, refraction is necessary to determine if this is due to a need for corrective lenses or due to a medical problem. A refraction will be done when it is necessary, to determine the cause for a decrease in your vision or simply to provide you with a means to achieve your best corrected vision. **PUPILLARY DISTANCE CANNOT BE MEASURED.**

Our mission is to ensure you have the very best possible vision. For this reason, you have come to us for an eye exam. At the start of your eye exam, our technician will measure your visual acuity on the eye chart and review the quality and status of your glasses. If your vision is not 20/20, the technician will begin the process of refraction. The refraction is for review and use in our clinical setting. We do not complete refractions for the sole purpose of producing a glasses/lens prescription. If you need a prescription for glasses/lenses we recommend you seek the services of an optometrist.

For patients anticipating cataract surgery, refraction is also required by insurance companies to provide documentation for the medical necessity for eye surgery. We must demonstrate that your vision cannot be simply improved with a glasses prescription. However, most insurance plans, including Medicare, DO NOT cover the refraction. This is true even after you have had eye surgery.

Federal law requires that we bill for refractions. There will be a $40.00 charge for refractions. Although refractions are typically a non-covered benefit all refractions are billed to your private insurance company and a refund issued to your account, should your insurer cover the charge.

_____

Patient (or person authorized to sign for patient) Date

PALMER EYE CENTER PAYMENT AUTHORIZATION POLICY

Patients with full Insurance coverage

I certify that I have full coverage (i.e. - Medicare & supplemental insurance) for today's office visit. I agree to pay for any charges that may be considered non-covered such as a refraction.

Signature of Patient _____

Patients with Insurance co-pay or deductibles

I understand that payment is due on the date services are rendered. I agree to take full responsibility for any co pay or charges that are applied to my deductible. I further understand that any unpaid charges will be charged to me after first being billed to my insurance carrier.

Signature of Patient _____

Insurance Carrier _____

Patients without Insurance coverage

I certify that I have no insurance coverage and understand that payment is due on the date services are rendered. I agree to take full responsibility for today's charges.

Signature of Patient _____

CANCELLATION POLICY

It is our priority to provide quality eye care to you and all of our patients, for us to do this it's essential for patients to keep appointments or give us sufficient notice if you are unable to do so. Patients will be reminded prior to their examination, and given the opportunity to reschedule to another date. Failure to reschedule or cancel your appointment without 24 hours notice to our office will result in a $25.00 "no-show" fee. Your appointment time has a 15-minute maximum grace period. If you are more than 15 minutes late, your appointment time will be closed and you will be assessed the $25.00 no-show fee.

Name (print): _____ Date: _____

Signature _____ :

PALMER EYE CENTER FINANCIAL POLICY

We are dedicated to providing our patients with the highest quality ophthalmic care and to running our clinic efficiently. Please assist us in achieving these goals by complying with our financial policy. Payment is due at the time the service is provided. It is your responsibility to verify insurance and determine the status of coverage (co-pay and deductible) prior to your visit.

REQUIREMENTS	Photo identification with current address, current original insurance card (including Medicare, BCBS, etc.)
FORMS OF PAYMENT	Cash, check, major credit card.
CO-PAYS & DEDUCTIBLES	All Medicare, and other insurance plan co-pays and deductibles are payable upon Check in. It is your responsibility to know your portion payable at the time of service.
MEDICARE	We accept assignment and will file all Medicare claims. At the time of service you are responsible for 20% of the Medicare allowable fee, plus the deductible and any service charge not covered by Medicare (such as a refraction).
PRIVATE INS. & MANAGED CARE	If you participate in a plan that we accept we will be happy to file your insurance claims for you. Otherwise, payment in full is your responsibility. Please note that you are ultimately responsible for payment if your private insurance company denies payment.
SELF-PAY	Payment is expected at Check-In prior to being seen by the doctor. You may call our office for an estimate of our fees. Any refund or balance due will be calculated at the Check-Out. If you are not prepared to cover your exam, then we would ask you to reschedule your appointment to a time when you are prepared to cover the costs associate with your exam.
DRIVERS FORM	We will be happy to complete a Driver's Form for you for a charge of $20.00 per form and they will be ready in 2-3 business days.
OTHER FORMS	For any additional insurance forms or dictated letters from our doctors, the fee is $30.00 per form and they will be ready in 2-3 business days. A request for medical records is a $1.00 per page & $2.00 per page for color.
REFUNDS	Credit balanced under $50.00 will remain as a credit to be applied to your next visit unless a refund is requested.

I have read and accept the terms of Palmer Eye Center, LLC. financial policy. I agree to pay for services rendered by Palmer Eye Center, LLC. that are not covered or paid by my insurance company.

Name (print): _____ Date: _____

Signature: _____

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Single ☐Married ☐Divorced ☐Widowed

NAME: SOCIAL SECURITY#: DOB:

EMAIL:

STREET ADDRESS:

STATE: ZIP:

CITY: CELL: WORK PHONE:

HOME PHONE:

**Please provide 2 contact numbers If possible.*

EMERGENCY CONTACT: CELL: WORK PHONE:

Employer's Name: Occupation:

Employer's Address: City: State: Zip:

Spouse's Name: Spouse's Employer.

RESPONSIBLE PARTY INFORMATION:

If the patient is a child, Name of Guarantor:

Street Address (if different from above):

City: State: Zip:

How were you referred to our office:

REASON FOR VISIT: *please circle*

Cataract Evaluation Lasik Evaluation Routine -No Particular Problems Referred by Physician

Dry Eye Exam Glaucoma Exam Diabetic Eye Exam

Possible Medical or Surgical Problem Other, please explain:

CIRCLE IF YOU HAVE THE FOLLOWING PROBLEMS:

Blurry/Fuzzy Vision Tearing or Burning Redness

Discharge Dry Eye Problems with Glasses

Floaters/Cobwebs Flashing

Itching

Other, please explain:

PAST EYE HISTORY: please circle

Eye Injury Infections Retinal Problem Glaucoma

Diabetic Eye Disease Cataracts Muscle Imbalance Blurry Vision

Double Vision Halos

Other, please explain:

PAST EYE SURGERIES _____

FAMILY HISTORY: *please circle* (Mother-M, Father-F, Sibling-S, Grandparent-G)

Blindness M F S G Glaucoma M F S G Cancer M F S G Lupus M F S G

Heart disease M F S G Arthritis M F S G Kidney disease M F S G Thyroid disease M F S G

High blood pressure M F S G Diabetes M F S G Stroke M F S G

Other, please explain:

YOUR MEDICAL HISTORY: *please circle*

H1V or AIDS	Tuberculosis	Blood transfusion	Skin Disorder
Thyroid trouble	Cancer	Alcohol Dependence	Diabetes
Lupus	Arthritis	Headaches	Hay Fever
Sinus Infection	Drug Dependence	High Blood Pressure	Smoker

Other, please specify:

ARE YOU:

Pregnant Possible Pregnant Not Pregnant Unknown Using Contraceptives

Do you wear Contacts: Yes No

Do you wear glasses: Yes No If yes, how long have you had the current prescription?

INSURANCE INFORMATION:

PRIMARY:

Insurance Company:_____ Member ID:_____

Group Number:_____ Plan Type: PPO HMO OTHER:_____

Insurance Co Phone:_____

Insurance Claims Address:_____

SECONDARY:

Insurance Company:_____ Member ID:_____

Group Number:_____ Plan Type: PPO HMO OTHER:_____

Insurance Co Phone:_____

Insurance Claims Address:_____

****PLEASE BRING A COPY OF YOUR MOST RECENT INSURANCE CARDS TO YOUR VISIT. IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY OUR OFFICE OF ANY INSURANCE CHANGES.****

Patient Acknowledgment of Having Received & Read or Been Read the Notice of Health Information Practices (HIPAA)

- I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices Palmer Eye Center.
- l understand that Palmer Eye Center is committed to treating and using protected health information about me responsibly.
- I understand my rights as it relates to my records at Palmer Eye Center and understand how information about me may be used and disclosed.
- I understand that my health record is the physical and legal property of Palmer Eye Center but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.
- I understand that Palmer Eye Center is required to maintain the privacy of my health information. Palmer Eye Center will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by Palmer Eye Center staff and physicians; billing to myself or a third-party payer; in addition, business associates of Palmer Eye Center may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.
- Palmer Eye Center may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.
- Palmer Eye Center may contact me via mail and email.
- I have read and understand the Health Information Practices of Palmer Eye Center.

Patient Name: _____ Signature:_____

Date: _____

List the names we can fully discuss your medical condition with:

Name: _____Relationship: _____

Name: _____ Relationship: _____

PALMER EYE CENTER
Board certified Opthalmic Surgeons

Pre-Surgical Cataract Patient Questionnaire

This page is only required for cataract evaluation patients / appointments.

PATIENT NAME_____ DOB_____

Visual Functioning

1. Do you have difficulty, even With glasses, with the following activities?	☐Yes	☐No
2. Reading small print, such as labels on medicine bottles, food labels, books or newspapers?	☐Yes	☐No
3. Seeing steps, stairs, or curbs?	☐Yes	☐No
4. Reading traffic signs, street signs, or store signs?	☐Yes	☐No
5. Doing fine handwork like sewing, knitting, crocheting. or carpentry?	☐Yes	☐No
6. Watching television?	☐Yes	☐No
7. Do you feel your vision is bad enough to consider cataract surgery now?	☐Yes	☐No

Symptoms

Have you been bothered by:

1. Poor night vision?	☐Yes	☐No
2. Seeing rings, glare, or halos around lights?	☐Yes	☐No
3. Hazy and/or blurry vision?	☐Yes	☐No
4. Seeing well in poor or dim light?	☐Yes	☐No
5. Poor color vision?	☐Yes	☐No

PLEASE FILL OUT COMPLETELY

PHARMACY PREFERENCE: _____ LOCATION _____

PHONE NUMBER _____

MEDICATION ALLERGIES

_____

_____

_____

_____

_____

In the past 5 years, list any surgeries with the date of occurrence _____

_____

_____

_____

MEDICATION LIST

_____

_____

_____

_____

_____

_____

_____

_____

Patient Printed Name:_____

Patient Signature: _____ Date: _____

PATIENT MOBILITY INFORMATION

To provide the appropriate level of care, a number of tests may be required as part of your eye exam. This will require the patient to position their body and head in an upright posture for the equipment to work properly. The patient must be capable of doing this under their own power. In addition, patients who use a wheelchair, scooter, or other similar personal mobility device must be able to be transferred from those devices into exam chairs with only minimal assistance to maintain stability. Palmer Eye Center employees cannot lift patients from wheelchairs or other mobility devices for the purposes of completing the exam.

1) Does the patient have the ability to position their body / head in an upright position under their own power? If no, please explain:

_____

_____

2) If the patient uses a wheelchair or similar personal mobility device, are they able to transfer themselves from the wheelchair into an exam chair under their own power or with only minimal assistance as needed to maintain stability? If no, please explain:

_____

_____

3) Does the patient require any special accommodation to communicate clearly with healthcare staff? i.e. sign language, interpreter if language is other than English, or other:

_____

_____

4) Is there any other information you would like to disclose about patient mobility or other need which would impact the successful completion of a comprehensive eye exam or surgery consultation?

_____

_____

Patient Printed Name:_____

Patient Signature: _____ Date: _____

PALMER EYE CENTER

Board Certified-Fellowship Trained Eye Physician & Surgeon

Phone: (850)877-7337 * Fax (850)877-8675

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Late arrival, cancellation, and no-show policy

Our office has a 15 minute grace period from the time of your scheduled appointment before you are considered a “no-show”. If you arrive after your 15 minute grace period has ended, you will be rescheduled to the next available appointment date and time. All no-shows will be assessed a $25.00 missed appointment fee. This is a strict office policy we enforce to keep clinical visits on a timely schedule.

If you need to cancel your appointment, please do so at least 24-hours in advance. Excepting emergencies, day-of cancellations will be subject to the same $25.00 fee as a missed appointment.

Call to cancel or reschedule an appointment:

850-877-7337