New Patient Information

Name_____ SSN# _____ - _____ - _____

Date of Birth _____ Male / Female _____ Marital Status _____

Mailing Address _____ Email _____

City _____ State_____ Zip_____ Home Phone _____

Employer _____ Work Phone _____ Cell Phone _____

How did you hear about our office? _____

Emergency contact_____ Relationship_____ Phone_____

Primary Insurance Carrier _____

Secondary Insurance Carrier _____

Is this plan through an employer? No/ Yes Employer_____ Self/Spouse/Parent

Name of Individual on Insurance Plan _____ DOB ____/____/_____

To obtain insurance benefits and authorization, we are often asked for the subscriber's social security number. Please provide the SSN of the individual listed above: SSN # _____-_____-_____

I hereby authorized release of any information necessary to process this claim and request that payments of benefits be made either to myself or to the party who accepts assignment. I understand that I am financially responsible for all charges not paid by my insurance company. A copy of this authorization will remain on file for all future visits.

Signature_____ Date_____

If your visit is related to a work injury, please complete the following information

Employer_____ Employer Phone_____

Employer Address _____

Supervisor/Contact Person_____

FINANCIAL POLICY

At Triangle Visions Optometry, it is our goal to provide you with the best eye care services available. Please take a minute to carefully review our financial policy.

Copays are expected at time of service. For your convenience we accept cash, personal checks, Visa, Mastercard, and Discover. There is a $25.00 charge for returned checks.

Refractions are not covered by Medicare and some insurance carriers. If you receive a refraction as part of your exam, you will be asked to pay the refraction fee of $40.00 when you check out.

Your physician may recommend diagnostic testing. Diagnostic testing is a very important tool which aids your physician in the diagnosis and treatment of many ocular problems. Your insurance company may not cover the costs of diagnostic testing. If you have any questions about the costs of diagnostic testing, please ask the technician before tests are performed. If your insurance plan does not cover the diagnostic testing, the patient is responsible for the costs.

We participate in many insurance plans. It is your responsibility to check with your insurance company to be sure we participate with your plan. Please bring with you your current insurance card(s) and valid identification such as a state issued driver's license. We regret that we cannot honor any insurance plans not submitted at the time of your appointment.

Any balance not paid by your insurance company is the responsibility of the patient and you will be billed after we receive payment from your insurance company. Patient balances are expected to be paid within 30 days after billed. Balances not paid within 120 days will be forwarded for collections. We are happy to provide payment arrangements for those patients needing to setup a payment plan. If you need a payment plan, please ask to speak with our administrator to help make arrangements for you.

I have read and understand the above financial policy and agree to pay all charges incurred with my examination and treatment.

_____ _____

Patient Name (Please Print) Date

_____

Patient Signature

TRIANGLE VISIONS OPTOMETRY
A member of VISION SOURCE

Routine Eye Exams, Medical Eye Exams, and Refractions

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit, so you will know how billing will be handled. Ultimately, it is your responsibility to know what your own medical or vision plan covers. We hope this information will help you to understand how your visit is submitted to your insurance for today's visit and future visits. Benefits may vary based upon the reason for your visit. Your description of your eye condition will help us to determine whether your visit is defined as "Routine" or "Medical". Your symptoms and eye examination will determine how your visit is coded and billed to your insurance.

Routine Eye Examinations: A "routine eye exam" takes place when you come for an eye examination without any medical eye problem, and there are no symptoms except for visual changes that can be corrected by eyeglasses or contact lenses. The doctor screens the eyes for disease and finds no medical problems. Glasses and contact lens prescriptions may be updated. These examinations are often covered by discount vision plans such as VSP, Eyemed, Superior Vision, etc…

Medical Eye Examinations: Your visit will be coded as a "medical eye examination" whenever you are being evaluated or treated for a medical condition or symptom that you bring up, eye problems you tell our staff about, or a condition that the doctor finds during the examination. Examples that will necessitate your visit being submitted to your medical insurance include headache, diabetes, eye irritation, dry eyes, allergies, floaters, glaucoma, cataract, eye muscle imbalance, "lazy eye", macular degeneration, and others.

Refraction: A refraction is the part of the office visit that determines the eyeglass prescription. This involves the comparison question "which choice is clearer, choice one or choice two?" as different lens combinations are presented to the patient. Medicare does not consider a refraction to be a "medically necessary" service, and therefore Medicare will not pay for this part of the examination. Many medical insurance plans, as well as Medicare replacement plans will not pay for this service either. Typically, patients are only billed for a refraction when they only have medical insurance to file, as discount vision plans are typically the only plans that cover the refraction. Per our Financial Policy, we discount the refraction charge to $40.00 when the refraction is done in combination with an examination.

Frequently Asked Questions

Q: Are routine exams covered by Medicare?

A: By law, Medicare does not pay for routine vision exams or refractions. Medical conditions must be present for the exam to be filed. Medicare typically covers 80% of the billed amount after deductible. The remaining 20% is either paid by the patient or by a Medicare Supplemental Policy. Patients without a supplement will be asked to pay 20% of the Medicare allowable at checkout. This is in addition to the refraction charge of $40.00.

Q: If a patient has both medical insurance and a vision plan, which gets billed?

A: This depends on the reason for the visit: examinations for medical care, evaluation of an eye complaint, or to follow an existing medical condition are billed to the patient's medical insurance. Examinations for the purpose of checking vision to update eyeglasses or contact lenses are billed to the patient's vision plan, if the doctor participates in that plan.

PLEASE NOTE WE ACCEPT MEDICARE. WE DO NOT ACCEPT MEDICAID.

_____ _____

Print Patient Name Patient Signature Date

TRIANGLE VISIONS OPTOMETRY
A member of VISION SOURCE

Medical History

Name_____ **Date of Birth**_____ **Date**_____

Primary Care Physician _____ **Phone** _____

Please list any past surgeries, injuries, or hospitalizations _____

_____

Please list any eye surgery or eye injury that you have had_____

_____

Drug Allergies: _____

Allergy	**yes**	**no**
environmental allergies	_____	
Cardiovascular	**yes**	**no**
high blood pressure	_____	
heart disease	_____	
heart attack	_____	
stroke	_____	
Constitutional	**yes**	**no**
fever	_____	
weight loss	_____	
fatigue	_____	
Endocrine	**yes**	**no**
diabetes	_____	
thyroid	_____	
Gastrointestinal	**yes**	**no**
colitis	_____	
diverticulitis	_____	
ulcers	_____	
liver/hepatitis	_____	
Genitourinary	**yes**	**no**
kidney problems	_____	
bladder problems	_____	
prostate problems		
Head/ENT/Dental	**yes**	**no**
hearing loss	_____	
sinus problems	_____	
recent dental work	_____	
Lifestyle Questions	**yes**	**no**
smoke	_____	
consume alcohol	_____	

Hematologic/Lymph	**yes**	**no**
anemia	_____	
bleed/bruise easily	_____	
Immunologic	**yes**	**no**
HIV/AIDS	_____	
Integumentary (Skin)	**yes**	**no**
rash	_____	
severe acne	_____	
Musculoskeletal	**yes**	**no**
arthritis	_____	
joint pain	_____	
Neurological	**yes**	**no**
seizures	_____	
Alzheimers/dementia	_____	
tingling in fingers or toes	_____	
Psychiatric	**yes**	**no**
depression	_____	
anxiety	_____	
Respiratory	**yes**	**no**
asthma	_____	
tuberculosis	_____	
sarcoidosis	_____	

Current Medications: _____

_____

_____

_____

_____

_____

_____

Family History (Immediate Family only)

Diabetes	Y N	Strabismus (eye turn)	Y N	Cataracts	Y N
Glaucoma	Y N	Retinal Detachments	Y N	Macular Degeneration	Y N

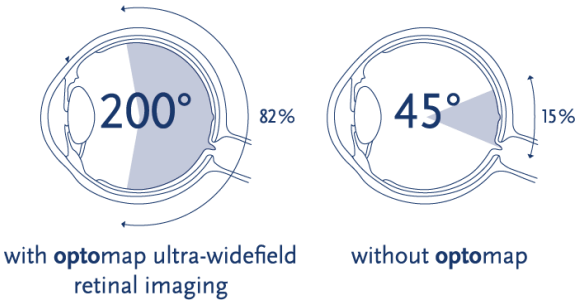
OPTOMAP RETINAL IMAGING

At Triangle Visions Optometry, it is our goal to provide you with the best eye care services available. Please take a minute to carefully review this information on retinal imaging.

Retinal imaging is a non-invasive procedure used for the early detection or retinal problems and diseases such as those associated with glaucoma, macular degeneration, diabetes, and optic nerve disorders.

Our doctors use Optomap retinal imaging to document patients' retinal conditions and provide excellent baseline data that can be used to follow the progression of ocular health over time.

This test is highly recommended for all of our patients, especially those with a history of diabetes, high blood pressure, headaches, floaters or flashing lights, high cholesterol, and retinal problems such as detachment or tears.



Many patients choose Optomap imaging instead of dilation as the Optomap provides 200 degree ultra-widefield imaging without the use of eyedrops or dilation drops.

Charges for this procedure are normally billed at ninety-five dollars through medical insurance. As a new patient, on your initial visit, we would like to offer this service to you for **$39.00**.

Please take a minute to let us know your preference below.

_____ YES, I would like to have digital retinal photography.

_____ NO, I am choosing NOT to have this test performed. I further agree NOT to hold Triangle Visions Optometry or any of its doctors responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained through this retinal imaging.

_____ _____

Patient Signature Date

TRIANGLE VISIONS OPTOMETRY
A member of VISION SOURCE

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CONTACT LENS EVALUATION AND EXAM FEES

Q: Why is there a contact lens evaluation fee in addition to the standard eye exam fee?
A: Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. The FDA closely regulates contact lens prescriptions and requires them to be renewed annually per Federal Law. Contact lenses are medical devices and even though they may feel fine, there are health risks that must be taken seriously. In order to renew your contact lens prescription today, your doctor will perform the following additional tests:

- Slit lamp microscope examination of the contact lens on the eye to check the lens fit.
- Slit lamp microscope examination of the cornea, conjunctiva and eyelid tissues, to check the eye health and to look for adverse effects from contact lens wear.
- Contact lens refraction to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions)
- Review new lens designs and materials that may improve comfort and/or health.

These additional charges may apply to your visit today. Insurance typically does NOT cover these fees. However, we will apply any insurance or discounts that may apply.

Contact Lens Exam Evaluation	Established Wearer	New Wearer
Spherical Lens	**$70.00**	**$145.00**
Toric Lens	**$70.00**	**$145.00**
Multifocal or Monovision Lens	**$100.00**	**$190.00**
RGP (Rigid Gas Permeable) Lens	**$190.00**	**$250.00**
Specialty Lens	**starting at $250.00**	

_____
Patient Name Date

_____
Patient Signature

_____
Technician Signature Date

REQUEST FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____Date of Birth: _____

Patient Address: _____

INFORMATION TO BE DISCLOSED:
□ Record of last exam including spectacle prescription and contact lens prescription
□ Entire record

PRACTICE FROM WHICH INFORMATION IS REQUESTED:

Name of Practice: _____

Practice Address: _____

Phone Number: _____ **Fax:** _____

RECIPIENT:
Name and address of person or class of persons to whom the Practice may disclose my health information:

Amy V. Harper, O.D.
Kimberly Orr, O.D.
Triangle Visions Optometry
853 Old Winston Rd. Ste 113
Kernersville, NC 27284
Tel: (336) 993-3930 Fax: (336) 993-3979

TERM: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills the request. By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization.

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization of applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to the Practice's Office Manager at the address listed above. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information.

_____ _____
Signature of Patient or Legally Authorized Representative Date

Effective Date of notice: 01/29/2018

Notice Of Privacy Practices

Clark Optometric, Inc, d/b/a Triangle Visions Optometry
598 Airport Blvd, Suite 700, Morrisville, NC 27560
919-230-4167
Fax: 919-678-3814

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medication and faxing or calling them to be filled; showing you low vision aids, referring you to another doctor or clinic for eye care of low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without and special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special permission.

USE AND DISCLOSURES FOR OTHER REASON WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

When a state or federal law mandates that certain health information be reported for a specific purpose;
For public health purposes, such as contagious disease reporting, investigation or surveillance; and notice to and from the federal Food and Drug Administration regarding drugs or medical devices;
Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or agencies; Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral director to aid in burial; or to organizations that handle organ or tissue donations;
Uses or disclosures for health related research;
Uses or disclosures to prevent a serious threat to health or safety;
Uses or disclosures for specialized governmental functions, such as for the protection of the resident or high ranking officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
Disclosures of de-identified information;
Disclosures relating to worker's compensation programs;
Disclosures of a "limited data set" for research, public health, or health care operations; Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
Disclosures to 'business associates' who perform health care operations for us and who commit to respect the privacy of your health information.
Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, and/or call you. It may be necessary to leave a reminder message on your answering machine, voicemail, or with someone who answers your phone.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosure of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization form, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocation must be in writing and must be sent or brought to the office.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

Ask us to restrict our uses and disclosure for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor restrictions that you want. To ask for a restriction, send a written request to the office. Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office.

Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have e copy of your health information within 30 days of asking us (or sixty if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instruction about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access of photocopies if we send you a written notice of the extension. If you want to preview or get photocopies of your health information, send a written request to the office.

Ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with our health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office.

Get a list of the disclosures that we have made of your health information with the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purpose of treatment, payment or health care operations; disclosure with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for the in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office.

Get additional paper copies of this Notice of Privacy Practice upon request. It does not matter whether you got one electronically or paper form already. If you want additionally paper copies, send a written request to the office.

OUR NOTICE OF PRIVACY PRACTICE

By law, we must abide by the terms of this Privacy Practice until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think we have not properly respected the privacy information, you are free to complain to our Privacy Officer (Michael Marino, OD), and office General Manager, or the US Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office.

This privacy statement represents the policies of the owners, the contracted doctors, and all the staff of Clark Optometric, Inc, d/b/a Triangle Visions Optometry.