Knoxville Pediatric Ophthalmology

Patient Information

Date: _____

Name: _____

Birth Date: _____

Soc. Sec.#: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Place of Employment: _____

Occupation: _____

Employer's Address: _____

Spouse's Name: _____

Birth Date: _____

Soc. Sec. #: _____

Address: _____

_____

Work Phone: _____

Cell Phone: _____

Place of Employment: _____

Occupation: _____

Employer's Address: _____

Insurance Coverage

Primary Coverage

Ins. Company Name: _____

I.D. #: _____

Group #: _____

Insured Name: _____

Insured's Address: _____

Secondary Coverage

Ins. Company Name: _____

I.D. #: _____

Group #: _____

Insured Name: _____

Insured's Address: _____

Emergency Information

Name of nearest relative not living with patient

Name: _____ Phone: _____ Relationship to patient: _____

Financial Information

How do you plan to pay for today's charges: Check _____ Visa _____ M/Card _____ Cash _____

Payment is expected at the time of service unless arrangements have been made in advance with our Financial Manager.

Are other members of our immediate family seen here: Yes ____ No _____

If so, please list their names: _____

Referred to our office by: _____

Address: _____

Family physician: _____

Address: _____

Do you want a letter sent to your doctor containing our findings and recommendations? Yes _____ No _____

Knoxville Pediatric Ophthalmology
2100 Clinch Avenue, Koppel Plaza Ste. 400 Knoxville, TN 37916
Phone: (865) 521-7998 Fax: (865) 521-7405

Consent for Refraction

- Refraction is the part of the exam that determines whether or not correction is needed to improve the patient's eyesight or eye alignment
- It is performed during every New Patient exam and periodically as needed, usually once per year.
- Refraction is required in order to write an eyeglass or contact lens prescription. Note that in some cases, the refraction shows that corrective lenses are not needed, or that the current lenses do not need to be changed.
- The refraction is a critical portion of the eye exam, and without doing a refraction, the ophthalmologist will be unable to determine whether problems such as eye misalignment, double vision, headaches, blurred vision, eyestrain, or failed vision screening can be helped with corrective lenses, or with a change in current corrective lenses.
- Refraction is **NOT** a covered service by most insurance plans including Medicare. These plans consider refraction a "vision service" and not a "medical service." **Our fee for refraction is $50.00 and, unless your plan automatically covers the refraction, this fee is collected at the time of service in addition to any co-payment required by your plan.** If your plan unexpectedly covers the refraction, we will reimburse you.

I have read the above information and understand that my insurance plan may not cover the cost of a refraction. I agree to pay the refraction fee of $50, along with any required co-pay, deductible or co-insurance required by my plan, at the time of service.

Initials_____

Consent for Dilating Eye Drops

- Dilating drops are used to dilate or enlarge the pupils of the eyes to allow the ophthalmologist to get a better view of the inside of your child's eyes.
- Dilating drops frequently blur vision for a length of time, which varies from person to person, and may make bright lights bothersome. It is not possible to predict how much your child's vision will be affected.
- The pupils will remain large for several hours, and may take several days to return to a completely normal size. The pupils may return to normal asymmetrically, creating unequal appearing pupils. This is normal and is not dangerous.
- Adverse reaction, such as acute angle-closure glaucoma or allergic reaction, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I have read the information above and consent for my child to receive dilating eye drops. The eye drops are **necessary** to diagnose my child's condition.

Initials_____

Consent for Photography

- Photographs are taken to document certain ocular conditions.
- These medical photos may be shared with other medical professionals, as deemed appropriate by the treating physician.
- Personal information such as name, age, address or medical record number will not be displayed with the photos.

I have read the information above and consent to photography.

Initials_____

_____ _____

Patient Name D.O.B Parent/Guardian signature
Date

_____

Printed Name/Relationship to patient Date

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Financial Policy

PAYMENT is expected at the time of your visit. We accept cash, check, or major credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service. For patients with insurance, payments collected are an estimate based on the benefits provided to us from your insurance company. Once claims have processed, if there is any remaining balance, you will receive a bill in the mail.

POLICY ON NON-COVERED SERVICES: This office offers access to many innovative services and procedures some of them are deemed as "not covered" by insurance. In some cases, you will be given an ABN (Advanced Beneficiary Notice) for these types of services/procedures before they are provided/performed. You will be responsible for payment in full at the time of service.
a. Refractions - A refractive examination is not a covered service by most insurance companies, including Medicare. If you receive a refraction, you will be charged $50.00 which is payable at the time of the visit.

b. Contact Lens Fitting – In order to receive a contact lens prescription, a contact lens fitting must be performed. There will be a separate charge for the fitting, which may or may not be covered by insurance. Based on your benefits, you will be required to pay $100.00 for your fitting in full before receiving your contact lens prescription.

RETURNED CHECKS will incur a $35.00 service charge.

FORMS FEES:

a. Medical Record Copies – Medical record copy requests made by the patient for their personal use, for an insurance company, an attorney, etc., will incur a copying fee, as directed by the state statute and are as follows, following the completion of a release of medical records form: $25.00 for the first 20 pages $.15 per page for additional pages over 20 $25.00 for Billing Records. There is no charge for records being released to another physician. If the chart must be retrieved from storage the cost will be $35.00.

b. Forms Completion – Forms may be dropped off and we will call when they are ready to be picked up, or we will send to appropriate designee. The fee for form completion is $20.00.

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Knoxville Pediatric Ophthalmology for charges not covered by the assignment of insurance benefits and all non-covered charges.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Knoxville Pediatric Ophthalmology to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Knoxville Pediatric Ophthalmology all payments otherwise payable to me for Knoxville Pediatric Ophthalmology services.

RELEASE OF INFORMATION: I hereby authorize and direct Knoxville Pediatric Ophthalmology to release (verbally or in writing) confidential medical information to any person, entity, government agencies, insurance carriers, or others who are financially liable to Knoxville Pediatric Ophthalmology for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.

SELF PAY PATIENTS WHO ARE NOT INSURED: Self-pay patients will be identified when they make the initial contact with the office and will be defined as a patient who • has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school, or AFLAC • does not claim third party liability for the patient's health care treatment • is not eligible for worker's compensation coverage; and • has no other responsible party covering the expenses associated with the care received from our clinics Self-pay patients will be required to pay a $225.00 deposit for their visit at time of check in. Any additional charges incurred will be collected at check out. All charges are due on the date of service.

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BILLING AND COLLECTION FEES: Knoxville Pediatric Ophthalmology will submit a claim for payment to your insurance company. In the event your insurance carrier/company denies the services provided, you will be responsible for the payment in full. We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay an additional $25.00 fee to cover the fees imposed to Knoxville Pediatric Ophthalmology by the collection agency in order to collect the outstanding balance.

DIVORCED PARENTS OF PATIENTS: By signing below, the adult who signs in a minor child to our practice on the day of service accepts full responsibility for payment. It is not our policy to send bills or records to the other parent/guardian for issue of payment or communication. We will communicate about treatment and payment with the parent present at the time of visit. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

NO SHOW POLICY: We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than a 24-hour notice. Patients who do not show up nor provide more than a 24-hour notice are considered a NO SHOW. Patients who No-Show three (3) or more times, may be dismissed from the practice.

DISCLAIMER: Knoxville Pediatric Ophthalmology does not consider an individual seeking treatment to be a patient until a preliminary assessment is completed and the individual has been notified that he or she has been accepted as a patient; simply making an appointment does not automatically initiate doctor-patient relationship.

If it has been three (3) years or more since you were last seen you will be seen and charged as a new patient exam.

I have read and understand the practice's office and financial policies and I agree to be bound by its terms for as long as I am a patient here at, Knoxville Pediatric Ophthalmology. I also understand and agree that such terms may be amended

Patients and/or parent/guardian are responsible for all required referrals.

We do not file AmeriChoice/ United Healthcare Community plan TennCare insurance and do not accept payment from them for services rendered or any retroactive enrollment in AmeriChoice/ United Healthcare Community plan.

_____

Signature of Patient/Guarantor/Guardian Date

I give permission for the following individuals to bring my child in for medical care.

_____

_____

_____

Medical History

Please fill out completely

Knoxville Pediatric Ophthalmology, PLLC

PATIENT NAME: _____ DATE OF BIRTH: _____

Who is accompanying the patient today?: □ mother □ father □ grandparent □ guardian □ other _____
Social History: □ Student excellent/average/below average □ Smokers in the home □ Lives with parents/grandparents/foster care/ adopted

Family Ocular/Medical History: Which of the patient's **relatives** have had any of the following? (In blank space write in relationship)

Yes	No		Yes	No	
□	□	Blindness _____	□	□	Cataracts in childhood _____
□	□	Amblyopia (lazy eye) _____	□	□	Glaucoma in childhood _____
□	□	Patching Treatment _____	□	□	Other serious eye disease _____
□	□	Strabismus (crossed eye) _____	□	□	Complications from anesthesia _____
□	□	Eye Muscle Surgery _____	□	□	Genetic disease (in family) _____
□	□	Glasses before age 6 _____	□	□	Other serious illness _____
□	□	Are both parents alive and in good health? _____			

Patient Medical History (medical history and review of symptoms)

Yes	No	
□	□	Allergy/Immune (autoimmune disease, seasonal allergy) _____
□	□	Cardiovascular (heart problems, chest pain shortness of breath, irregular heartbeat, abnormal blood pressure) _____
□	□	Constitutional (fever, weight loss, fatigue, poor appetite, chills, unexplained weight loss) _____
□	□	Endocrine (excess thirst, excess urination) _____
□	□	Gastrointestinal (abnormal pain, nausea, diarrhea) _____
□	□	Genitourinary (pain on urination, blood in urine, bladder problem) _____
□	□	Hematology/Oncology (anemia, cancer) _____
□	□	Ears, Nose, Throat (hearing loss, sore throat, runny nose) _____
□	□	Skin (rash, change in mole, skin sore, skin cancer) _____
□	□	Musculoskeletal (muscle aches, joint pain, difficulty lying flat, back) _____
□	□	Neurologic (weakness, headache, dizziness, seizure) _____
□	□	Psychiatric (ADHD, bipolar, depression) _____

Allergies to medications? (please list): _____
List previous surgery, hospitalization, major illnesses, or injuries (other than eye problems): _____
List any medications the patient is taking (including eye drops):_____
History of Eye Problem: Has the patient had any of the following and at what age (other than today)? (WRITE IN AGE IN BLANK SPACE)

Yes	No		Age	Yes	No		Age
□	□	Last Eye Exam (do not include today)	_____	□	□	Eye Injury	_____
□	□	Glasses	_____	□	□	Eye Surgery	_____
□	□	Patching	_____	□	□	Other Eye problems	_____

Recent Symptoms

Yes	No		How Long?	Yes	No		How Long?
□	□	Crossed/wandering eye	_____	□	□	Frequent Headaches	_____
□	□	Excessive squinting	_____	□	□	Tired eyes when reading	_____
□	□	Frequent tearing or discharge	_____	□	□	Weakness or numbness	_____
□	□	Blurred Vision	_____	□	□	Clumsiness or bumping into things	_____
□	□	Light sensitivity	_____	□	□	Can't make normal eye contact	_____
				□	□	Change in performance in school	_____
				□	□	Other symptoms not mentioned above	_____

Birth History

Yes	No	(If "YES" what was the problem)
□	□	Pregnancy problems _____
□	□	Forceps delivery problems _____
□	□	Cesarean section _____

Birth Weight: _____

Yes	No	(If "YES" what was the problem?)
□	□	Delivery more than 2-weeks □ early or □ late
□	□	Baby kept in hospital due to illness. What illness? _____
□	□	Delayed development _____

Forms completed by: _____ Date: _____
Relationship: _____

Pharmacy Name and Number: _____

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Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip:_____
Previous Name: _____
Patient Phone: _____

Release Records To:

Provider Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone: _____ Fax: _____

Release Records From:

Provider Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone: _____ Fax: _____

Printed Name of Parent/Legal Representative: _____
Signature of Patient/Legal Representative: _____
Relationship to Patient: _____ Date: _____

Information Requested:

Date(s) from: _____ to _____ or Specific Date: _____

- € History & Physical
- € Discharge Summaries
- € Operative/ procedure notes
- € Consultations
- € Other (specify):

- € Radiology reports
- € Cardiac reports
- € Pathology reports
- € Lab results

- € Emergency services
- € Legal Medical Record

- € Obstetrics (labor & delivery)
- € Office/ clinic notes
- € Respiratory reports
- € Circle one: FMLA, Power of Attorney, Pre-Admission Screening & Resident Review