Date: __________________

Dear: ________________________________

Your appointment has been scheduled with Dr. ________________________________

Your appointment has been scheduled for ____________________________ at __________ AM  __________ PM

at the following office location:

100 Physicians Drive, Greer SC  29650  113 Doctors Drive, Greenville, SC  29605

Our office location directions are enclosed and available on our website. Take a moment to confirm the location of your appointment as we may be unable to accommodate your visit if you arrive at the incorrect location for your scheduled appointment.

We would like to thank you for choosing Southern Eye Associates, P.A. for your eye care. Our new patient information packet is designed to collect your information ahead of time to expedite the length of time in our office. These forms will require signatures so please read them carefully. **You may choose to return the enclosed forms by mail, secure email or simply bring the completed forms to your appointment.**

Please arrive twenty minutes prior to your scheduled appointment and bring the following information with you:

1. The completed enclosed forms (if not mailed to us in advance)
2. Your MOST current insurance card(s) – **Tell us if you will use medical or vision insurance at check-in**
3. Any required physician, insurance or employer referral authorizations—these are your responsibility
4. All current medications in their original bottles and containers
5. **Your eyes may be dilated during the exam and may be sensitive to light** – this may hinder ability to drive

In addition to quality eye care, Southern Eye provides full optical centers in which we offer the latest in frame designs, a wide range of lens options and sunglasses, including Oakley, Maui Jim and Costa Del Mar. We offer complete contact lens service with contact lens fitting and products at competitive prices.

We are looking forward to meeting you in the near future. If you have any questions pertaining to your upcoming visit please do not hesitate to give us a call at (864) 269-3333. For more information regarding Southern Eye, please visit our website at [www.southern-eye.com](http://www.southern-eye.com).

Sincerely yours,

The Physicians and Staff of Southern Eye Associates, P.A.
Thank you for choosing our practice for your eye care needs. We are committed to providing the best possible care. The following information is provided to avoid any confusion regarding payment for our professional services. Your signature on the patient registration form indicates you have read and agree with the Patient Responsibility Payment Policy. Please present current insurance cards and photo ID at the time of your visit.

**Payment Policy:**

- We accept cash, check, debit card, Visa, Master Card, Discover and American Express.
- Co-pays, deductibles and non-covered services, such as, Refractions are due upon check-out. Your insurance company requires us to collect your co-pays and deductibles at the time of service. Please note that Medicare and most Medicare Advantage plans do not pay for Refractions and Contact Lens Evaluations (please refer to your Medicare Handbook).
- If you do not have in-network insurance or are uninsured we can offer you a convenient payment arrangement through our billing department prior to your appointment. NOTE: Co-pays are not eligible for this arrangement.
- For High-Deductible policies (including HSA’s), payment will be collected at the time of service.
- Additional Forms: Driver’s License forms, copies of medical records (separate authorization required), disability or other forms are available at an additional cost ($10 - $45) and are payable at the time of pick up.
- If the patient is a minor (18 years old and younger), the parent or guardian is responsible for payment of the account in accordance with the policies outlined above. If parents are divorced, the adult who brings the child to the appointment is responsible for applicable fees.
- For returned checks, a $25.00 collection fee will be applied to your account.
- There is a $20.00 no-show fee for failing to notify our office you will not be able to keep your appointment.

**Insurance:**

We will file your insurance as a courtesy. It is your responsibility to be educated on your benefit policy, to notify this office of any changes to your insurance coverage and to pay any amount that is determined to be your responsibility. Insurance claims have to be paid timely, therefore if the insurance balance is unpaid after 30 days you will be responsible and you can seek reimbursement directly from your insurance carrier.

**Medical Insurance and Vision Plans:**

You are responsible for knowing if your Medical Insurance offers Vision Coverage and to notify us if you will be using your Medical Health Plan or your Vision Plan at the time of Check-In. We are contracted with a number of different Vision Plans but your preferred Doctor may not participate with your Vision Insurance. You are ultimately responsible for payment if your private insurance company denies payment for a routine eye exam. We cannot change diagnoses or types of insurance after your claim has been filed. It is your responsibility to know your benefits, to notify this office of any changes to your insurance coverage, and to pay any amount that is determined to be your responsibility. You must provide the office with the correct insurance card before services are rendered. Please verify this information prior to scheduling your appointment.

**Federal Health Exchange Plans:** Southern Eye Associates is NOT contracted with every Federal Health Exchange Insurance Plan. It is your responsibility to maintain your insurance premiums. Southern Eye Associates will release all claims that are denied by your insurance company due to unpaid premiums to the patient for payment. Refunds will be issued for all claims that are paid by the insurance company once the premium is current.

**Medicare:** Your current copy of the Medicare card or your Medicare Advantage card is required. Deductibles, co-pays and non-covered fees will be your responsibility. Some Medicare Advantage plans require you to go a contracted provider. It is your responsibility to know what doctors are in contract. Otherwise, you will be responsible for the payment is full at the time of service.

**Medicaid:** Southern Eye Associates is NOT contracted with every Medicaid plan. If your Medicaid requires an authorization through a family physician, you must have established a relationship with them so an authorization may be obtained. Due to the changing nature of Medicaid plans, it is your responsibility to inform our office prior to your scheduled appointment if your Medicaid plan has changed. A current copy of the Medicaid card is required prior to treatment at every visit or the patient will be rescheduled.
Patient Registration Form

Patient Information

Legal Name: ___________________________ SS#: ___________________________ 

Last Name: ___________________________ First Name: ___________________________ MI: ___________________________

Address: ___________________________ City: ___________________________ State: ___________________________ Zip: ___________________________

Tel Home: ___________________________ Cell: ___________________________ Email: ___________________________

Birth date (Mo/Day/Yr): ___________________________ Age: _____ Sex: □ M □ F Marital Status: S M W D

Is patient employed: □ Yes □ No □ Fulltime □ Part-time Is patient a student: □ Yes □ No

Is your visit related to a work accident or worker’s compensation claim? □ No □ Yes (if yes, please complete additional form)

Is your visit related to an injury or trauma? □ No □ Yes (if yes, please complete additional form)

How did you hear about us? ___________________________ Referring Physician? ___________________________

Preferred Language: English Spanish French German Other: ___________________________

RACE: Black or African American/ American Indian or Alaskan Native/ Asian/ White/ Native Hawaiian/Pacific Islander Other: ___________________________

Ethnicity: Hispanic or Non-Hispanic

Preferred Method of Contact (circle): Email Text US Postal Service

Emergency contact: ___________________________ Relationship: _______ Home: _______ Cell: _______

Referring physician: ___________________________ Tel: ___________________________

Family physician: ___________________________ Tel: ___________________________

Billing & Insurance Information - Please bring current insurance cards and a photo ID to your visit.

Who is responsible for the payment of your visit? □ Self □ Other ___________________________

If other: please list relationship and contact number: Relationship: ___________________________ Tel: ___________________________

Do you have a Vision Plan (vision insurance) that you will be filing for your visit today? □ Yes □ No

Vision Plan Name: ___________________________ Policy Holder Social Security #: ___________________________

ID/Policy Number: ___________________________ Policy Holder DOB: ___________________________

Relationship to Patient: ___________________________ Employee ID: ___________________________

Employer: ___________________________

Are you filing your Medical Insurance for your visit today? □ Yes □ No

Primary Policy: ___________________________ ID/Policy Number: ___________________________

Policy Holder Name: ___________________________ Policy Holder Social Security #: ___________________________

Policy Holder DOB: ___________________________

Relationship to Patient: ___________________________

Secondary Policy: ___________________________ ID/Policy Number: ___________________________

Policy Holder Name: ___________________________ Policy Holder Social Security #: ___________________________

Policy Holder DOB: ___________________________

Relationship to Patient: ___________________________
If your secondary insurance is MEDICARE, please select one of the following reasons why it is not your primary insurance:

- □ I am of working age and/or my spouse has insurance with a group health plan
- □ Disabled under age 65 w/large group health plan  □ Worker’s Compensation  □ Veterans Administration
- □ Public Health Service or other Federal Agency  □ End Stage Renal Disease  □ Black Lung
- □ No Fault Insurance including auto is primary

Billing & Insurance Information Continued

1. Are you currently residing at a Skilled Nursing Facility? □ Yes □ No Name: ______________________________
2. Are you currently enrolled in a Hospice Program? □ Yes □ No
3. If filing TRICARE, please list the following information:
   
   Sponsors Name: ______________________________
   Sponsors DOB: ______________________________
   Sponsors SS#: ______________________________

You agree to the following:

- I certify that the information I provide is correct to the best of my ability
- I understand that I am subject to be charged a $20 (twenty dollars) no show fee for failing to contact Southern Eye Associates in advance to notify them that I am not able to keep my appointment. I understand that this charge will be added to my next visit, and/or can be paid over the phone by contacting the billing department at (864) 335-0667
- I understand that any unpaid balances from previous visits will be collected at check-out

PATIENT PORTAL

We are pleased to offer you the ability to review your medical records and communicate with our office via our secure patient portal. You will receive your secure log in and password information at the end of your appointment at the checkout counter. This information is private and uniquely yours—please keep it in a safe place. Unfortunately, if you lose your secure password we are not permitted to give the information out over the phone. You will need to come to our main office at 113 Doctors Dr. Greenville, SC 29605 to retrieve the password.

If you need assistance navigating the patient portal or would like help logging in for the first time please let one of our staff members know as it will be our pleasure to assist you.

Patient Acknowledgement of Privacy Practices and Patient Payment Policy

I hereby authorize the providers at Southern Eye Associates to examine, diagnose and treat the above named patient for whom I am legally authorized to give consent including myself.

By signing this form, I acknowledge receipt of the Notice of Provider Privacy Practices of Southern Eye Associates, which outlines how they may use and disclose my protected health information. I understand that a copy of the Notice of Provider Privacy Practices of Southern Eye Associates is also available at the check-in/reception desk. I understand that their Notice of Provider Privacy Practices is subject to change and that I may obtain a copy of the revised notice or ask any questions by contacting Southern Eye Associates at (864) 269-3333. I hereby authorize Southern Eye Associates to release my health information for purposes of treatment, payment (authorized to file Medicare and all other insurance plans) and healthcare operations as described in Southern Eye Associates’ Notice of Provider Privacy Practices.

I have read, understand and agree to the Patient Responsibility Payment Policy. I understand that any charges not covered by my insurance company are my responsibility, including costs associated with Refractions and Contact Lens Exams. I understand and authorize with my signature that my insurance benefits be paid directly to Southern Eye Associates, P.A.

Name (print): __________________________________ Date: _______________

Patient / Guardian / Guarantor Signature: __________________________
Authorization to Release Medical Information

Patient Name: __________________________ Date of Birth: ___________ Account # ___________

Social Security Number: ______________________ Phone Number: ______________________

Complete Address: ___________________________________________ Phone Number: ___________

Address City State Zip

I hereby authorize the following person(s) to have access to my medical records:

Name: __________________________________ Relationship: ____________________ Phone: ____________

Name: __________________________________ Relationship: ____________________ Phone: ____________

Name: __________________________________ Relationship: ____________________ Phone: ____________

By signing this authorization, I authorize and permit the above designated person or person to obtain my
protected health information (PHI) as requested. This authorization permits Southern Eye Associates to
release your protected health information to the above person or persons without any further authorization
from you. YOU may revoke this authorization in writing and sent to Southern Eye Associates, 113 Doctors
Drive, Greenville, SC 29605.

By authorizing others to view or have access to my PHI, your PHI may no longer be protected by federal
privacy law.

To authorize release of information to designated person/persons:

__________________________________________________________

Patient Signature & Date Office Witness & Date

☐ I DO NOT AUTHORIZE ANYONE TO *access to my medical records: (please be advised
that this includes spouses and/or family members)

__________________________________________________________

Signature Date

*This does not apply to filing for insurance claims or other requests as permitted or required by law.
MEDICAL QUESTIONNAIRE

Patient Name: ___________________________ Account# ___________________ Date Completed: ____________________

Reason for Visit (Please be specific): ___________________________________________________________

Routine Visit? □ Yes □ No

Is this a Worker’s Compensation Visit? □ YES □ NO

Is this visit related to an injury or trauma? □ YES □ NO

(*) Have you been treated in our office for this condition before? □ YES □ NO

MEDICAL, EYE AND FAMILY HISTORY

Please check if you have any of the following. If YES, how long or what type?

<table>
<thead>
<tr>
<th>Do you have:</th>
<th>How Long:</th>
<th>Do you have:</th>
<th>How long:</th>
<th>Do you have</th>
<th>How long:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blurred Vision</td>
<td></td>
<td>Dryness</td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
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<tr>
<td>Redness</td>
<td></td>
<td>Soreness/Irritation</td>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Burning/Pain</td>
<td></td>
<td>Burning</td>
<td>Asthma</td>
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<td></td>
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<tr>
<td>Itching</td>
<td></td>
<td>Eye Fatigue</td>
<td>Emphysema</td>
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<td></td>
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<tr>
<td>Excess Tearing/Watering</td>
<td></td>
<td>Macular Degeneration</td>
<td>Heart Disease</td>
<td></td>
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<tr>
<td>Tired Eyes</td>
<td></td>
<td>Cataracts</td>
<td>Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Constant Lens Discomfort</td>
<td></td>
<td>Retinal Detachment</td>
<td>Other Problems</td>
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<tr>
<td>Feeling of sand/grit</td>
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<td>Lazy Eye</td>
<td>Glaucoma</td>
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<tr>
<td>Light Sensitivity</td>
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<td>Other Eye Problems</td>
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</table>

Does anyone in your IMMEDIATE family have any of the above problems or diseases?
If so, who and what is their relationship to you?

Have you had eye Surgery | When did you have the surgery and by whom?
--------------------------|--------------------------------------------------
Cataract Surgery          |                                                  |
Glaucoma                   |                                                  |
Refractive (LASIK)         |                                                  |
Other (list type)          |                                                  |

Do you currently wear eyeglasses? □ YES □ NO

Do you currently wear contact lenses? □ YES □ NO

What is the current brand of contact lenses you are wearing? ____________________________

When was your last eye examination? ____________________________ By whom? ____________________________

When was your last prescription change? ____________________________

Name of your family physician: ____________________________

SOCIAL HISTORY

Do you use alcohol? Yes No If yes, how much? ____________________________

Do you use tobacco? Yes No If yes, how much? ____________________________
Your Hobbies: ____________________________  Your Occupation: ____________________________

Marital Status:  Single  Married  Widowed  Separated  Divorced

SYSTEMIC REVIEW OF SYSTEMS

Please check any that apply to you:

- Weight loss or Weight Gain Problems
- Shortness of breath
- Easily bleeding
- Painful joints
- Diabetes
- Mental Health
- Chest pain
- Allergies
- Loss of smell
- Numbness / Headaches
- Painful joints
- Skin rashes
- Thyroid problems
- Double Vision
- Intestinal problems
- Frequent Urination

LIST ALLERGIES TO ANY MEDICATIONS AND YOUR REACTION
(list additional allergies to medications and reactions on the bottom of this page)

Medication: ____________________________  Reaction: ____________________________

Medication: ____________________________  Reaction: ____________________________

Medication: ____________________________  Reaction: ____________________________

Medication: ____________________________  Reaction: ____________________________

CURRENT MEDICATIONS (Including Aspirin, Blood Thinners and Eye Medications)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Times Per Day</th>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Times Per Day</th>
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*NOTE: Please bring your current medications in their current prescription bottle to your initial appointment*
NOTICE OF PRIVACY PRACTICES

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.

Under the HIPAA privacy regulations, we are required by federal law to maintain the privacy of your protected health information (“PHI”). PHI is information about you that may identify you and that relates to your past, present, or future physical or mental health condition and related healthcare services. Federal law also requires us to provide you with notice of our legal duties and privacy practices with respect to PHI, and we are required to abide by the terms of the notice currently in effect. We reserve the right to change our notice of privacy policies and this change will effect all PHI that we maintain. Before we make a material change in our policies, we will change our notice and post the new notice in the waiting area, and on our website. You may request a copy of the notice at anytime.

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you. Your PHI may also be used and disclosed to pay your healthcare bills and to support the operation of our office. The following is a list of examples of the types of uses that our office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you medical care when you visit our office. This includes the coordination or management of your healthcare – for instance, we can disclose your PHI to third parties for treatment, such as, a specialist we may refer you to. We may disclose your PHI when we contact you about appointment reminders, no-show appointments, or treatment alternatives. We may disclose your PHI information to your family or friends that are in the examination room with you. We may also disclose your PHI with your family or friends who are assisting you with appointments, surgical procedures, diagnostic testing or your care. We may also disclose your PHI to optical or contact lens vendors or companies for the processing of your eyeglass or contact lens order. We may disclose your PHI to, but are not limited to, healthcare facilities, and laboratories for the continuing of your healthcare.

**Payment:** We may disclose your PHI for payment purposes. For example, PHI may be disclosed to your insurance provider so we may be reimbursed for services rendered to you. If someone else is responsible for your payment, we may contact that person. We may disclose PHI to an outside collection agency as deemed necessary. Or, we may need to disclose your PHI to your health plan when obtaining pre-approval for diagnostics, surgical procedures or hospital stays.

**Healthcare Operations:** We may disclose or use your PHI to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical professionals, licensing, and conducting or arranging other business activities. For instance, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician or we may call you by name from the lobby or other area in the building. For example, medical record storage may provide some related services for business operations and will have a written contract that requires them to protect your PHI in the course of performing their job.

In addition, the practice may use or disclose your PHI in accordance with the specific requirements of HIPAA regulations without us needing to obtain an authorization or giving you an opportunity to agree or object if any of the following instances occur:
- **Required by law.** For example, we must provide your PHI to the Secretary of the Department of Health and Human Services if the Secretary so requests.
- **Required for public health purposes.** For example, we may disclose PHI for the maintenance of vital records such as the number of births and deaths.
- **Required disclosures about victims of abuse, neglect, or domestic violence.** For example, we may disclose PHI for the reporting of spousal, adult or child abuse.
- **Required by a health oversight agency for oversight activities.** For example, we may disclose PHI to government health oversight agencies for such purposes as investigations, inspections, audits, surveys, and licensure.
- **Required in the course of any judicial or administrative proceeding.** For example, we may disclose PHI in response to a court or administration order if you are involved in a lawsuit or similar proceeding.
- **Required for law enforcement purposes.** For example, we may disclose PHI for the purpose of identifying a fugitive from justice.
- **Required by a coroner or medical examiner.** For example, we may disclose PHI to a medical examiner to identify a deceased individual or to identify the cause of death.
- **Required for organ or tissue donation purposes.** For example, we may disclose PHI to an organ donation bank to facilitate the donation if you are an organ donor.
- **Required for research purposes.** For example, we may disclose PHI to a medical university to aid their research activities.
- **Required to prevent or lessen a serious and imminent threat to the health or safety of the person or the public.** For example, we may disclose PHI to prevent the spread of a communicable disease.
- **Required for military purposes.** For example, we may disclose the PHI of individuals who are in the armed forces for activities deemed necessary by appropriate military command authorities to ensure the proper execution of the military mission.
- **Required for national security purposes.** For example, we may disclose a patient’s PHI to the appropriate government agencies for counter-intelligence purposes.
- **Required for penal purposes.** For example, we may disclose a patient’s PHI to a correctional facility if the patient is an inmate in the facility.
• Required for workers’ compensation programs. For example, we may disclose a patient’s PHI for workers’ compensation and other similar programs.

You have the following rights regarding your PHI.

Confidential Communications. You have the right to request that you receive communications of PHI by alternative means or at alternative locations. For example, you may request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. You do not need to give a reason for your request, and we must accommodate reasonable requests.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. In addition, you have the right to request that we restrict disclosure of your PHI to certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you. We may terminate the restriction by informing you of the termination, except that such termination is only effective with respect to PHI created or received after we have informed you of the restriction termination.

Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, except for psychotherapy notes, information compiled in anticipation of litigation, or that we are otherwise forbidden by law to disclose. You must submit your request in writing to the office designated at the bottom of this notice. We may charge a fee for the costs of copying, mailing, labor, and supplies associated with the request. We may deny your request in certain cases; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews.

Amendment. If you believe the information we have about you is incorrect or incomplete, you may ask that we modify or add to the information. To do so, please submit your request in writing to the office designated at the bottom of this notice. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request for amendment in the following cases: (1) the current information is accurate and complete; (2) it is not part of the medical information we keep; (3) it is not part of what you would be allowed to view and copy; and (4) it was not created by us. If we deny the request, you have the right to file a statement of disagreement. We may then prepare a rebuttal and we will give you a copy of the rebuttal.

Accounting of Disclosures. You have the right to receive an accounting of disclosures of PHI made by us in the six years prior to the date on which the accounting is requested. We are not required to include in the list we provide you the following types of disclosures: (1) to carry out treatment, payment, and healthcare operations; (2) to you; (3) for our directory; (4) for national security or intelligence purposes; (5) to correction institutions or law enforcement officials; or (6) that occurred prior to April 14, 2003. Your request must be in writing and be sent to the office designated at the bottom of this notice. The first accounting you request within a 12-month period will be free. Additional accountings may involve a charge, and you may cancel or adjust your request before any fees are incurred.

Right to Provide an Authorization. We will obtain your written authorization for uses and disclosures that are not identified in this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the purposes described in the authorization.

Paper Copy of Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy, simply inform the office designated on the bottom of this notice.

Filing Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the office designated at the bottom of this notice. All complaints must be in writing and we will not penalize you for filing a complaint.

The Effective Date for this notice is April 14, 2003.

Contact information regarding this notice or the privacy policies described above:

Attn: Privacy Officer
Southern Eye Associates, P.A.
113 Doctors Drive
Greenville, SC 29605

Southern Eye Associates, P.A. is committed to maintaining the privacy of your protected health information. If you feel that we are upholding the privacy regulations as established by HIPAA, you do not need to do anything further with this notice.
Southern Eye Associates, P.A.
CONTACT LENS FITTING, EVALUATION & MANAGEMENT POLICY

Welcome to the Contact Lens Department of Southern Eye Associates! This form has been designed to help you understand our policies and procedures. Your Physician will evaluate the health of your eyes and the fit of your contacts to determine the optimal prescription. The price depends on the type of contact lens that your doctor decides is best for you, doctor/staff time involved and expertise necessary. A contact lens prescription will not be provided if a fitting was not completed and/or any follow up visits were not kept.

EVALUATIONS, FITTINGS & TRIALS

- The contact lens evaluation is not part of the standard eye exam, it is an elective service
- Contact lens exams are required on a yearly basis, and all contact lens patients will be charged a yearly contact lens evaluation fee and/or prescription update
- Trial lenses cannot be dispensed if the prescription is expired
- Corneal Topography is considered mapping of the cornea and is a specialized test, necessary for certain types of contact lenses. If the doctor believes this procedure necessary there will be a fee, which will need to be paid at the time of your co-pay. It has been determined that your insurance may not cover this procedure, however we will file the service to your insurance and issue the proper refund if your carrier covers the procedure.

Level I: Contact Lens Evaluation and Management $69.00

- Applies to: Established Patients, New Contact Lens Fittings, and New Patients wearing the following lenses: Spherical, Toric, and Gas Permeable
- Evaluates your current contact lens fit and prescription on an annual basis for compatibility, and renews your contact lens prescription for 1 year in accordance with the FDA and SC State laws
- Service includes: complete analysis of contact lens requirements, previous history, lens type, wearing schedule, physiological requirements, tear film/corneal health analysis, contact lens follow up visits for the first 90-days, and diagnostic trial lenses.
- New Contact Lens Wearers will receive proper instruction on insertion and removal, handling, care, and Starter Solution Kit

Level II Contact Lens Evaluation and Management $89.00

- Applies to: New and Established Multifocal, Bifocal, or Monovision contact lens wearers
- Includes all services provided in the Level I Evaluation
- Renews your contact lens prescription for 1 year in accordance with the FDA and SC State laws

Level III Specialty Contact Lens Fitting $199.00

- Applies to: Post-surgical, corneal rehabilitation, and Keratoconus Lens Fittings
- Includes all services provided in the Level I and Level II Evaluation
- If additional visits are necessary past the initial 90-days to ensure a proper fit due to the complicated nature of these lenses, your visits will be charged on a per office visit basis

ORDERING POLICY

Order through SEA to receive the following following additional benefits:

1. Convenient home delivery (s&h may apply)
2. Discounts and Rebates off of year supply orders **
3. 20% off your spectacle orders (if not billed to insurance)

*NOTE: All contact lens orders must be picked up within 30 days or they will be returned

** Discounts and Rebates are subject to availability

If you choose to order through another source please be advised of our policy:

1. Additional trials cannot be supplied to you
2. All visits for follow up care will be charged
3. No reimbursement or credit will be given for unused lenses in the case of a needed power or parameter adjustment

☐ YES, I want a contact lens evaluation and agree to pay the above mentioned fees

☐ NO, I do NOT want a contact lens evaluation and will not receive a contact lens fitting and/or prescription for Contact lenses. If I change my mind I understand I will need to update my records by completing a new form

Signature ___________________________ Date: _______________ Chart #_________________
Scanned into EMR: ____________ By: ________