Print

New Patient Information

Personal Information (Please Print)

Name _____ Date _____
Date of Birth _____ Male / Female (Circle one) Age _____
Social Security # _____ Email address _____
Address _____
Street City State Zip

Phone: Home (____) _____ Work (____) _____
Occupation: _____ Employer: _____
Address: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Spouse Name _____ Employer: _____
Address _____ Phone (____) _____

Complete if under 18 years or a student

Name of Father _____ Employer _____
Address _____ Phone (____) _____
Name of Mother _____ Employer _____
Address _____ Phone (____) _____
Referred by: ☐ Friend / Relative _____ ☐ Doctor _____
☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other _____

Insurance Information

☐ Medicare# _____ ☐ Medicaid# _____
☐ Workers Compensation (job injury) to whom is bill to be sent? _____
☐ Other Medical Insurance _____
Group# _____ ID# _____
Name / Address 2nd Insurance _____
Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is? _____
Name _____ Relationship _____ DOB _____
Who to notify in emergency (nearest relative or friend)? _____
Name _____ Relationship _____
Address _____
Phone: Home (____) _____ Work Phone (____) _____

Financial Assignment and Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for a payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-payment, co-insurance, or any other balance not paid for by your insurance upon each visit.**
2. Refractions (the measurements taken for spectacle prescriptions) are not covered by Medicare and most insurance plans unless you have routine vision coverage. The cost for a refraction is $25.00. **It is your responsibility to pay the $25.00 refraction fee at the time service is rendered.**
3. I request that payment of authorized Medicare and / or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____

Northshore Eye Associates, LLC.
Patient History Form

Patient Name_____ Date _____
Birth Date_____ Referred by _____

Review of Systems **Do you currently have any of the following problems?**					
					If yes, please explain.
Please list medications you are taking, including eye drops.					
Do you have any allergies to any medication?	Yes		No		
Constitutional (Fever, Weight Loss, Other)	Yes		No		
Eyes (Glaucoma, Cataract, Lazy Eye, Retina Problems, Other – please Specify)	Yes		No		
Ear / Nose / Mouth / Throat (Hearing Loss, Sinus Problems, Sore Throat)	Yes		No		
Cardiovascular (Heart Problems, Chest Pain, Irregular Heart Beat)	Yes		No		
Respiratory (Asthma, Shortness of Breath, Wheezing, Coughing)	Yes		No		
Gastrointestinal (Heartburn, Abd. Pain, Diarrhea, Vomiting)	Yes		No		
Genitourinary (Urinary Problems, Blood in Urine)	Yes		No		
Integumentary (Skin Rashes, Excessive Dryness)	Yes		No		
Musculoskeletal (Muscle Aches, Joint Pain, Swollen Joints)	Yes		No		
Neurological (Numbness, Weakness, Headaches, Paralysis)	Yes		No		
Hematologic / Lymphatic (Blood Disorders, Leukemia)	Yes		No		
Allergic / Immunologic (Hay Fever, Allergies)	Yes		No		
Endocrine (Thyroid Problems)	Yes		No		
Psychiatric (Depression, Anxiety)	Yes		No		

Family and Social History: Do any medical or eye diseases run in your family. If YES, please note relationship to patient.

___ Glaucoma
___ Diabetes
___ High Blood Pressure
___ Macular Degeneration
___ Other

Do you smoke? If YES, how much? Yes ☐ No ☐
How much: _____
Drink alcohol? If YES, how much? Yes ☐ No ☐
How Much: _____

Comments: _____

Physician's Signature: _____ Date: _____

NORTHSHORE EYE ASSOCIATES, LLC
HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for the other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We are required by law to maintain the privacy of your protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this Notice of Privacy Practices currently in effect, but we may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised coy be sent to you in the mail or asking for one at the time of your next appointment.

Any uses or disclosures other than those expressly permitted by this Notice of Privacy Practices will be made only with the written authorization of the individual.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice. Following are examples of the types of uses and disclosures of your protected health information that your physician's 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 will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use of disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

Treatment Alternatives: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you or to remind you of your appointment.

Fundraising Communications: You will be made aware of any fundraising activities supported by our office and have the right to opt out of such fundraising communications with each solicitation. You will be sent a pre-printed, pre-paid postcard to mail back to the office as a way to opt out (if you so choose) of your involvement with these fundraising activities. Your treatment will not be affected in any way by your choice to participate or opt out of any fundraising activities.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Business Associates: We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: we may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA- regulated products or

activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims or a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Director, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information I reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for the law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made *only with your written authorization*, unless otherwise permitted or required by law as described below. The following uses and disclosures will be made only with authorization from the individual:

1. Most uses and disclosures of psychotherapy notes.

2**. Uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications.** Disclosures of your protected health information that are considered marketing and therefore require patient authorization include communications about health related products or services (whether as part of treatment or health care operations) if the covered entity receives "financial remuneration" in exchange for making the communication

from or on behalf of the third party whose product or service is being described. Financial remuneration is defined to include payments in exchange for making marketing communications and does not include non-financial benefits, such as in kind benefits provided to the entity in exchange for a communication about a product or service. The following are expressly excluded from the definition of marketing 1) refill reminders or other communications about a drug or biologic currently prescribed to an individual 2) face to face communications if remuneration is received from a third party, or a promotional gift of nominal value is provided by the covered entity 3) telephone communications for marketing are not face to face 4) communications promoting health in general that do not promote a product or service from a particular provider and 5) communications about government and government sponsored programs.

3. Disclosures that constitute a sale of protected health information. This includes covered entities or business associates receiving direct or indirect remuneration in exchange for the disclosure of protected health information, unless the covered entity first obtains patient authorization, or if an exception applies. Exceptions include the following: 1) any disclosure permitted by the Privacy Rule if the remuneration is limited to the reasonable cost of preparation and transmittal of the protected health information, to include labor, materials, supplies for generating, storing, retrieving, and transmitting protected health information and capital overhead costs, and profits from the disclosure are not permitted 2) disclosures for public health, treatment of the individual and payment, the sale, transfer, merger or consolidation of all of part of a covered entity and related due diligence, if the recipient will become a covered entity, services rendered by a business associate under a business agreement at the request of the covered entity, disclosures to provide individuals with access to their protected health information or an accounting of disclosures, and other disclosures required by law, even though there may be a transfer of compensation as a result of these types of disclosures (e.g. copying fee for records). Further, the following activities are not considered a "sale" of protected health information 1) payments from grants, contracts or other arrangements to perform programs or activities such as research studies or 2) the exchange of protected health information through health information exchange that is paid fees assessed on participants. Disclosures of protected health information that constitute a "sale" includes when the covered entity or business associate is being compensated primarily to supply data it maintains in its role as a covered entity or business associate. The prohibition on the sale of protected health information applies to the receipt of remuneration not only from a third party that receives the protected health information, but also from another party on behalf of the recipient of the protected health information. Patient authorizations for the sale of protected health information must specifically state that the covered entity is receiving remuneration by the recipient.

4. Other uses and disclosures not described in this Notice of Privacy Practices.

You may revoke authorization for any of uses and/or disclosures in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstance, you may have a right to have this decision reviewed.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request, unless an individual has paid for services out-of-pocket, in full, and the individual requests that the healthcare provider not disclose protected health information related solely to those services to a health plan. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by providing it in writing to our Privacy Officer. In your request, you must tell us (1) what information you want restricted (2) whether you want to restrict our use, disclosure or both (3) to whom you want the restriction to apply and (4) an expiration date. **We are not required to agree to any requested restriction.**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodations by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members of friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a

limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

IF A SECURITY BREACH OCCURS INVOLVING YOUR PROTECTED HEALTH INFORMATION, YOU WILL BE CONTACTLY IMMEDIATELY BY OUR PRIVACY OFFICER.

The protected health information of a deceased individual will be kept and protected for a term of 50 years following that individual's death.

Other Applicable Laws

This Notice of Privacy Practices is provided to you as a requirement of HIPAA. There are other federal and state privacy laws that may apply and limit our ability to use and disclose your protected health information beyond what we are allowed to do under HIPAA. Below is a list of the categories of protected health information that are subject to these more restrictive laws and a summary of those laws. These laws have been taken into consideration in developing our policies of how we will use and disclose your protected health information.

Alcohol and Drug Abuse: We are allowed to use and disclose alcohol and drug abuse information without your permission under certain limited circumstances, and/or disclose only to specific recipients.

HIV/AIDS: Restrictions apply to the use and/or retention of HIV/AIDS information

Mental Health: We are allowed to use and disclose mental information without your permission under certain limited circumstances, and/or disclose only to specific recipients

Minors: Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such state laws

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Northshore Eye Assocaites of your complaint. We will not retaliate against you for filing a complaint.

Northshore Eye Associates
Acknowledgement of
Receipt of Privacy Practices

I have been presented with a copy of Northshore Eye Associates, LLC's Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

_____

Internal Use Only:

If patient or patient's representatives refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Hammond Office
17170 S I-12 Service Rd.
Hammond, LA 70403
Phone: 985-542-3336
Fax: 985-542-0733

Mandeville Office
1011 N. Causeway Blvd., Suite 1
Mandeville, LA 70471
Phone: 985-727-0008
Fax: 985-727-0718

Northshore Eye Associates, LLC
Patient Consent to Release Medical Information

Patient Name:_____
Date of Birth: _____

Do we have permission to release:

All information (this includes appointments, medications, current medical statues, billing, and all other information about yourself)	☐ Yes	☐ No
Appointments:	☐ Yes	☐ No
Medication	☐ Yes	☐ No
Billing	☐ Yes	☐ No

I give my permission to share this information with the person(s) listed below:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____

_____ _____
Patient Signature Date

_____
Witness

If not signed by the patient, please indicate name and relationship to patient:

_____ _____
Name Relationship

Hammond Office
17170 S. I-12 Service Rd.
Hammond, LA 70403
Phone: (985) 375-1111
Fax: (985) 542-0733

Mandeville Office
1011 N. Causeway Blvd., Suite 1
Mandeville, LA 70471
Phone: (985) 727-0008
Fax: (985) 727-0178

Northshore Eye Associates, LLC
Information Regarding Dilating 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. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Griener and / or such assistants as may be designated by him / her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____
Patient (or person authorized to sign for patient) Date

_____ _____
Witness Date

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Hammond, LA 70403
Phone: (985) 375-1111
Fax: (985) 542-0733

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1011 N. Causeway Blvd., Suite 1
Mandeville, LA 70471
Phone: (985) 727-0008
Fax: (985) 727-0178

Northshore Eye Associates
Medical vs. Vision Insurance

Do you have vision/optical coverage? ☐Yes ☐No

One of the most challenging billing issues in an ophthalmology office is whether we should bill the medical or vision plan.

An ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides comprehensive, medical eye exams. However, ophthalmologists also provide routine vision exams for people with no eye disorders.

For Patients with Vision Coverage

Vision insurance is intended to provide you with a baseline eye evaluation. Some medical insurance plans will also have routine vision coverage. If your medical insurance policy does cover routine vision care, we will bill your examination to your medical insurance.

If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc.), you are being provided with medical care and we will bill your medical insurance for visits related to medical complaints and problems. **Your vision insurance does not provide coverage for medical care.**

For patients with no Vision/Optical Coverage

If you are being seen for a routine eye evaluation and do not have vision/optical coverage, your medical insurance will not pay for an eye examination. Medical insurance coverage is intended to cover medical examinations. Also, please be aware that many medical insurance plans no longer consider an eye examination with a diagnosis of blurred vision or headache as a medical examination. They are considering this a routine vision exam and **will not pay** for the visit.

If you have medical problems (corneal disorders, diabetes, a lazy eye, cataracts, glaucoma suspect, double vision, etc.), your visit is considered a medical examination and can be billed to your medical plan(s).

Our billing department will determine the appropriate plan to bill after your examination.

_____ _____

Signature Date

Hammond Office
17170 S I-12 Service Rd.
Hammond, LA 70403
Phone: 985-542-3336
Fax: 985-542-0733

Mandeville Office
1011 N. Causeway Blvd., Suite 1
Mandeville, LA 70471
Phone: 985-727-0008
Fax: 985-727-0718

Northshore Eye Associates, LLC
Refraction Service and Fee

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contacts lenses.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination since it is not a covered service.

If you have a separate **vision plan** that covers routine or annual eye examinations and / or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for a refraction is $25.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement
I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, co-insurance, or deductible I may have separate from and not included in the refraction fee.

_____ _____
Patient Signature (Parent for Minor) Date

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Fax: (985) 542-0733

Mandeville Office
1011 N. Causeway Blvd., Suite 1
Mandeville, LA 70471
Phone: (985) 727-0008
Fax: (985) 727-0178

Northshore Eye Associates, LLC.
Medications

Name: _____ D.O.B. _____

Please list all current medications that you are taking.

Medication	Dosage	Frequency	By Mouth, Ear or Other

Please list all allergies and reactions you are experiencing.

Allergies	Reaction

Please list all over the counter medications you are taking.

OTC Meds

Northshore Eye Associates
Patient Financial Policy

Northshore Eye Associates is committed to providing high-quality healthcare services to our patients. To ensure transparency and clear communication regarding financial responsibilities, we have established this Patient Financial Policy. Please read and understand this policy before receiving services at our clinic. If you have any questions or need clarification, our staff is here to assist you.

Insurance Coverage:

1. **Insurance Information:** It is the patient's responsibility to provide accurate and up-to-date insurance information, including primary and secondary insurance plans, at the time of registration. Failure to do so may result in denial of insurance claims due to timely filing. **You will be responsible for payment for any denied claims related to inaccurate information**.
2. **Co-payments and Deductibles:** Patients are responsible for paying all co-payments, deductibles, and any other amounts not covered by their insurance plan at the **time of service**.
3. **Insurance Claims:** Northshore Eye Associates will submit claims to the patient's insurance carrier as a courtesy. Your policy and benefits are an agreement between you and your insurance company, so ultimately you are responsible for all charges.
4. **Choosing not to use your insurance:** If you choose not to use your insurance company, you will be responsible for full payment at the time of service. Northshore Eye Associates will not submit any claim at a later date for the date of service(s) in question and you will be responsible to file the claim(s) to your insurance company.
5. **Out-of-Network Providers:** Patients are responsible for understanding their insurance network status and any additional costs associated with seeing out-of-network providers.

Self-Pay Patients:

1. **Payment at Time of Service:** Patients without insurance coverage (self-pay) are required to pay for services in full at the time of the visit, unless prior arrangements have been made.
2. **Payment Plans:** If you are unable to pay in full, please speak with our billing department to discuss possible payment plan options.

Billing and Payments:

1. **Billing Statements:** Patients will receive billing statements for any outstanding balances after insurance claims have been processed. These statements will include a detailed breakdown of charges.
2. **Payment Due Date:** Payment for services not covered by insurance is due within 30 days of receiving the statement.
3. **Accepted Payment Methods:** We accept cash, checks, credit cards, and online payments through our secure portal.
4. **Collections:** Unpaid balances may be referred to a collection agency after 90 days of non-payment, and the patient will be responsible for any associated collection fees.
5. **Financial Assistance:** If you believe you may qualify for financial assistance or have difficulty paying your bill, please contact our billing department to discuss options.

continued

Missed Appointments and Cancellations:

1. **Missed Appointments:** Patients are responsible for notifying Northshore Eye Associates at least 24 hours in advance to cancel or reschedule appointments. Failure to do so may result in a missed appointment fee.
2. **Missed Appointment Fee:** A fee of $25 may be charged for missed appointments without proper notification.

Patient Responsibilities:

1. **Verification:** Patients are responsible for verifying their insurance coverage and understanding their benefits and financial responsibilities.
2. **Communication:** Patients are **required** to communicate any changes in their personal information, insurance coverage, or financial situation promptly.
3. **Compliance:** Patients are expected to comply with this financial policy and make timely payments.

By seeking medical services at Northshore Eye Associates, you agree to comply with the terms outlined in this Patient Financial Policy. We are committed to providing excellent care and are here to assist you with any questions or concerns related to your financial responsibilities.
Please sign below to acknowledge that you have read, understood, and agree to adhere to this policy.

Patient Signature: _____ Date: _____

Directions to our Mandeville Facility

1011 N. Causeway Blvd., Suite 1 | Mandeville, LA 70471 | (985) 727-0008

Exit off I-12 to Exit 63A (Covington/Mandeville) on to Causeway Blvd. (190). Continue south down Causeway Blvd and move into the left lane after the Hwy 22 overpass until you reach the red light. Immediately after the red light, Perlis Shopping Center will be first then the Brookside Office Park. Turn in to Brookside Office Park and our office is located at Suite 1.

We look forward to your visit!