

BOWDEN

EYE & ASSOCIATES

Eyes • Aesthetics • Hearing

Welcome to our practice. We are pleased that you have chosen us to provide you with your eye care needs. We would like you to know about our office policy on Billing. The more you know, the more we can be of service to you. If you have any questions please feel free to speak with anyone in our Billing Department at any time. Once again, Welcome to our practice!

Due to the increasing cost of providing medical care we ask that our patients pay their co pay, deductible, or coinsurance as they check out of our office. We understand that situations occur when you may not be able to pay the entire portion. In this case we ask that you speak with our Billing Department prior to your office visit. Failure to pay this at the time services are rendered will result in a \$25 billing charge.

Patients on HMOs:

Our staff will strive to make sure that every patient on an HMO plan has a referral for their visit, however it is the patient's responsibility. Our office can not always get that referral from the Primary Care Doctor on the day of the visit. Most Primary Care Doctors will not issue this office a referral if the patient has not been in their office within a certain period of time. Patients that are seen in our office on an HMO policy are required to bring a referral with them to every visit. These will be copied and place in your record. Please feel free to call our office before your appointment to make sure we have a referral on file. Failure to bring a referral will result in insurance non-payment; therefore the patient will be responsible for all charges on that visit. We cannot bill your insurance for visits without authorization.

If we suspect that your insurance company may not cover a service we will ask that you sign a form in advance acknowledging that you have been advised and accept financial responsibilities. In addition we ask that cosmetic surgery, refractive surgery such as LASIK, and elective procedures be paid prior to services being performed.

Our office will bill all covered services to a Primary and Secondary Insurance. We do not bill to more than two insurance carriers. We will give insurance carriers a maximum of 60 days to pay the claim. Failure for them to process the claims in a timely manner will result in it being turned over to the patient's responsibility. We encourage you, the patient, to be involved and make sure your insurance is paying in a timely manner.

After 120 days if a patient responsibility balance is still on the account without payment arrangements, it will be forwarded to our collection agency. The patient will be responsible for any collection charges that accrue. Continued access to our practice will be terminated if billing policies are ignored.

If financial obligations arise, please contact our Billing Department immediately. Monthly payment plans can be set up with payments as low as \$100.00 a month.

I transfer all rights and benefits contained in the policy to Bowden Eye and Associates, including the right to act as the authorized representative during an appeal and right to file suit; including the right to obtain disclosure of the summary, plan description, or policy.

Patient's Signature

Date

Office Use Only



PATIENT CONSENT FORM

Effective Date: March 15, 2003

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance with your prior consent. Bowden Eye and Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed for treatment, payment, or healthcare operations.
- Bowden Eye and Associates has a Notice of Privacy Practices and that the patient has opportunity to review this Notice.
- Bowden Eye and Associates reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict uses of their information but Bowden Eye and Associates does not have to agree to those restrictions.
- The patient may revoke this consent in writing at anytime and all future disclosures will then cease.
- Bowden Eye and Associates may condition treatment upon execution of this consent.

Patient Signature for Receipt of Notice: _____

Printed Name: _____

Relationship if other than patient: _____

Office Staff Initials: _____



CONFIDENTIAL PATIENT INFORMATION

Date: _____
Patient's Name (First, M.I., Last): _____
Sex: M F Marital Status: S M W D
Date of Birth: _____ Age : _____
Street Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Home Phone Number: _____ Cell/Alternate: _____
Email Address: _____ May we occasionally email you? Y N
Social Security#: _____ Driver's License Number: _____
School Name, if student: _____
If Child, Mother's Name: _____
Father's Name: _____
Name of closest friend or relative that does not live with you: _____
His/Her address: _____ His/Her Phone #: _____
How did you hear about our office?
Radio TV Jaguar Stadium Family/Friend Internet Phone Book
Other, please explain: _____
Who is your Primary Care Physician? _____ Phone #: _____

Primary Insurance: _____ Secondary Insurance: _____
Policy #: _____ Policy #: _____
Policy Holder's Name: _____ Policy Holder's Name: _____

LEGAL GUARDIAN, SPOUSE, PARENT OR POWER OF ATTORNEY INFORMATION

For Power of Attorney please submit notarized signatures
Name: _____ Relationship to Patient: _____
Address: _____ Home#: _____
SSN: _____ Driver's License#: _____

The patient or responsible party agrees to the Physician's reasonable and customary fee for medical services. The receptionist will accept cash, check, credit card for routine visits as you leave. If financial problems arise, please make special arrangements with the billing department or be subject to all costs of collections including, but not limited to, attorney fees, court costs and finance charges. I authorize Bowden Eye and Associates to release any information acquired in the course of my exam or treatment to other physicians, etc for health reasons and consent to the use of photographs for the purpose of documentation, publication in medical journals or presentations during medical meetings.

Patient Signature Date



SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name: _____ DOB: _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Bowden Eye and Associates for services furnished to me. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Bowden Eye and Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Bowden Eye and Associates, if possible or otherwise to me.

3. RELEASE OF INFORMATION: Bowden Eye and Associates may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to for reimbursement for services rendered, and (2) any health care provider for continued patient care. Bowden Eye and Associates may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.

4. OTHER INSURANCE: I understand that Bowden Eye and Associates maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Bowden Eye and Associates has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individual obligated to pay the full charges of all services rendered to me by Bowden Eye and Associates if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Bowden Eye and Associates contracts with health care service plans (i.e.,HMOs, PPOs) state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Bowden Eye Associates to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Bowden Eye and Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Bowden Eye and Associates for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Bowden Eye and Associates. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Bowden Eye and Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

7. DIVORCED PARENTS: We do not second party bill. The parent bringing the child to our facility will be responsible for required co-payments, deductibles etc. at the time of service.

8. PRIVACY PLAN: I agree that I have been given the opportunity to read and receive a copy of the Bowden Eye and Associates privacy plan.

NOTICE OF PRIVACY PRACTICES.

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.

Patient Signature Date

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HOW DID YOU FIND US?

As we continue to provide the best service possible to our patients, we ask that you please answer a few questions. Once completed, please give to the receptionist. We appreciate your time and assistance.

How did you hear about Bowden Eye and Associates?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Website | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Referring Physician | <input type="checkbox"/> Sign | _____ |
| <input type="checkbox"/> Jaguar Stadium | <input type="checkbox"/> Word of mouth | _____ |

Would you like to receive special coupons and information taking place at Bowden Eye and Associates or the Aesthetic Center and Hearing Center? (Your email address would not be used for any other reason).

- YES NO

If yes, please list your email address. _____

Thank you for choosing Bowden Eye and Associates.
We highly value you as our patient.

REFRACTION POLICY

Upon your visits at Bowden Eye and Associates, it may be necessary to perform a refraction test. While Medicare and some major insurance carriers do not cover this test, it is necessary to determine your visual acuity.

FAQ

1. What is a Refraction, and why are you charged for it?

You may know the test as a determinant for your need of glasses, this is so but it can also detect vision loss. Some of the time vision loss is slow and progressive and the patient may not even notice, that is why a physician will check the patient's vision by refracting them. The test can also uncover other problems a patient may be unaware of. This test is integral to determining a patient's eye health.

2. Why is this charge separate from the exam?

Medicare has deemed that a refraction is not a medical service and therefore not a covered service. Medicare does acknowledge that this is separate to the rest of the eye exam and therefore there is a separate fee for this service. Most insurance companies have followed Medicare's lead and do not cover the refraction, because they consider the test to be "vision care" and unrelated to the office visit. However, this is the only way to detect some types of vision loss.

3. Do we have to charge for the refraction?

The answer is yes, especially for Medicare patients. The Office of the Inspector General has deemed that not charging for a provided service is an "inducement" to the patient and therefore illegal. The Federal Government therefore insists that if an exam, procedure or test is performed, it must be charged for. They do this because they are worried some physicians may try to lure patients in by offering them an incentive such as a reduced fee, and want it to be a fair playing field for all physicians who accept Medicare. We are obligated by the government to charge for all of our services.

Please be aware that when we call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plans benefits when your healthcare insurance company received and processes the claim.

ACKNOWLEDGMENT

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 the refraction and agree to pay for the refraction at the time of service. Any co-payments due are separate from and not included in the \$49 fee for the refraction.

Patient Signature / Legal Guardian for a minor

Date

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EYE / MEDICAL HISTORY

Name: _____ Date: _____

How did you first hear about Bowden Eye and Associates? (Circle one)

TV Print Ad Provider Handbook Radio Billboard Family/Friend Jaguar Stadium

Did a doctor suggest that you come to our office? YES NO

If yes, please indicate their name _____

Which of the following special services are you interested in learning about?

- | | |
|--|--|
| <input type="checkbox"/> Corrective eye surgery
(Excimer Laser; PRK, LASIK, LASEK) | <input type="checkbox"/> Sun-wear with UV coating |
| <input type="checkbox"/> Custom Cataract Surgery | <input type="checkbox"/> Specialty glasses (transition lenses,
no line bifocals, trifocals) |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eyelid or Brow Lift |
| <input type="checkbox"/> INTACS for Keratoconus fillers | <input type="checkbox"/> Eyelash growth |
| <input type="checkbox"/> CK for Near Vision | <input type="checkbox"/> Botox, Juvederm, or other |
| <input type="checkbox"/> Contact Lenses (bifocals, UV protection,
colored, toric for astigmatism) | |

Please check the box if the condition applies to you, and explain when necessary.

- | | |
|--|---|
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Other Headaches? If yes, please describe _____ |
| <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Difficulty driving due to vision _____ |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Glare from car lights or sunlight _____ |
| <input type="checkbox"/> Eye mattering | <input type="checkbox"/> Double vision? _____ |
| <input type="checkbox"/> Film over eyes | <input type="checkbox"/> Vision blackout? _____ |
| <input type="checkbox"/> Road signs blurry | <input type="checkbox"/> Flashes of light, floaters or spots in vision? If yes, please describe _____ |
| <input type="checkbox"/> Small print is blurry | <input type="checkbox"/> Do you wear glasses? If yes, which kind ___ prescription ___ reading glasses |
| <input type="checkbox"/> Dry or scratchy eyes | <input type="checkbox"/> Have you ever tried contact lenses? If yes, when? _____ What kind? _____ |
| <input type="checkbox"/> Eyes swelling or itch | <input type="checkbox"/> Do you have a known eye disease? If yes, what type? _____ |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Have you ever had eye surgery? If yes, when? _____ What type? _____ |
| <input type="checkbox"/> Droopy Eyelids | |

Please check the box if you are experiencing any symptoms in these areas or if you have ever been diagnosed with the condition:

- Chronic fever, unexpected weight gain/loss, fatigue? If yes, when? _____
- Ear, nose, throat problems? (e.g. hearing loss, sinus, sore throat) _____
- Heart problems? (e.g. murmur, CHF, stroke, heart attack, irregular heart beat) _____
- High blood pressure? If yes, is it ___ controlled? ___ uncontrolled? _____
- Respiratory problems? (e.g. asthma, emphysema, TB, shortness of breath) If so, when? _____
- Urinary problems? (e.g. pain or discomfort, kidney stones, dialysis, kidney disease) _____
- Diabetes or other endocrine problems? _____
- Blood or lymphatic disease? (e.g. free bladder, bleeding disorders, leukemia, etc.) _____

Continued on Back

Have you ever been told that you have:

Gastrointestinal problems? (stomach ulcer, abdominal pain, etc) If yes, when? _____

Allergic or immunologic problems? _____

Cancer? If yes, what type skin pituitary lung colon breast stomach other: _____

Musculoskeletal problems? (e.g. joint pain) Arthritis? If so where, knees hand wrist elbow back

Skin conditions? Please describe: _____

Neurological Problems? (e.g. numbness, weakness, tingling, headache) _____

Psychological problems? (e.g. depression, anxiety) _____

PAST HISTORY:

Do you have any other medical conditions that you have NOT listed in the categories above? _____

Have you had any surgery in the past 10 years? YES NO If yes, when? _____

What type of surgery? _____

Are you currently taking any medications? YES NO

If yes, please list below with dosages: _____

Do you have any known drug allergies? YES NO If so, what drug _____

Do you use a wheelchair, walker or cane? YES NO

Have you ever had any general anesthesia? YES NO

Have you ever had an HIV (AIDS) test? YES NO

If so, was it Positive or Negative

Why was it done? _____

Do you have any hepatitis of any form? YES NO If so, what type? _____

Have you had any type of blood transfusion since 1980? YES NO Why? _____

Are you taking aspirin, Coumadin, or any other blood thinner? YES NO

If yes, please describe: _____

Have you been diagnosed or treated for alcoholism or drug abuse? YES NO

If yes, please describe: _____

Have you been diagnosed or treated for a mental/ emotional condition? YES NO

Please describe: _____

SOCIAL HISTORY:

Do you smoke? YES NO If so, how much? _____ How long? _____

Do you drink? YES NO If so, how much? _____ How long? _____

FAMILY HISTORY:

Does /Did anyone in your immediate family have any of the following:

Glaucoma? YES NO Father Mother Brother Sister Grandparent

Blindness? YES NO Father Mother Brother Sister Grandparent

Diabetes? YES NO Father Mother Brother Sister Grandparent

Heart Disease? YES NO Father Mother Brother Sister Grandparent

High Blood Pressure? YES NO Father Mother Brother Sister Grandparent

Physician's Signature: _____

Date: _____