

# **Coastal Skin & Eye Institute**

## **New Patient Packet**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Mobile #: \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please circle the best phone number for you. May we text you for:

\_\_\_ health and appointment notifications

\_\_\_ discounts/specials

Emergency Contact/ Phone #: \_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_

Occupation & Workplace: \_\_\_\_\_

Pharmacy Name & Address: \_\_\_\_\_

I authorize Coastal Skin & Eye Institute, to submit a medical claim to my medical insurance carrier or its intermediaries for all covered services or products provided by the practice. I understand that I am responsible for any deductible, coinsurance, copayment or non covered services. I understand that it is the policy of the practice to collect at the time of service. I understand that the practice is able to refer my account to collections if I do not make payment. I understand that it is my responsibility to update my insurance file whenever I change insurance carriers. I understand that failing to provide current information will make me immediately responsible for balances otherwise paid by my medical carrier. I understand that if I join an HMO, I will inform the practice prior to scheduling any case, such that the staff can identify my eligibility for care with this practice. I have completed the above information and certify that it is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or the above information.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

## Medical History

### Past Medical History (please circle all that apply):

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD (Acid Reflex)	Pacemaker
Atrial Fibrillation	Hearing Loss	Prostate Cancer
Benign Prostatic Hyperplasia	Hepatitis	Radiation Treatment
Bone Marrow Transplant	Hypertension	Seizures
Breast Cancer	HIV / AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD (Emphysema)	Hyperthyroidism	
Coronary Artery Disease	Hypothyroidism	

**Other:** \_\_\_\_\_

**Auto Immune:** Check if applicable and specify: \_\_\_\_\_

### Past Surgical History

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### Skin Disease History (please circle all that apply):

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever & Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Do you wear sunscreen? If yes, what SPF?	Yes	No
	_____	_____
Do you tan in a tanning salon?	Yes	No
Do you have a family history of Melanoma? If yes, which relatives? Any other family history?	Yes	No
	_____	_____
	_____	_____

**Ocular History (please circle all that apply):**

Amblyopia	Dry Eyes	
Cataracts (Right, Left)	Glaucoma (Right,Left)	
Corneal Dystrophy (Right, Left)	Lasik	
Diabetic Retinopathy (Right, Left)	PRK	
Double Vision	RK	

Other: \_\_\_\_\_

**Medications and Supplements**

Medication Name	Mg/ Mcg
<b>Drug Allergies:</b>	



**Notice of privacy practices as required by the privacy regulation created because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to review a Notice of Information Practices that gives a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions that the organization has already taken action in reliance thereon.

The Privacy Rule gives the right to access an individual's health records to a personal representative of the individual. If you would like a representative to have access to your health records, please indicate so below.

Name of Representative: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* Patient must sign here even if they do not wish to give access to any representatives.**

**Payment Policy**

CSEI will send a medical claim to your insurance company based on the insurance information that you have provided to us. We will require you to provide our office with complete insurance or workman comp information including the name of the carrier/claim mailing address, the insured's person name, member/subscriber ID (which may be the SSN), group number, and employer information for each visit.

This is not a guarantee of any insurance benefit. All patients bear responsibility for their insurance benefits. If your insurance company does not pay your claim, you will be expected to pay the total balance owed.

All (including self pay) patients have financial responsibility for all services that were rendered and our office accepts payment in the form of cash, check, and all major credit cards.

**Signature of Patient or Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Coastal Skin & Eye Institute**  
**Additional Billing Information**

**Eye Refractions and Medical Insurance**

Refractions are considered routine eye examinations for prescriptions for eyeglasses or contact lenses. Although eye refractions are an integral part of a comprehensive eye examination, they are specifically excluded from coverage by Medicare and most Medical Insurance Plans (PPO's). Please see the CMS publication, "Your Medicare Benefits."

Coastal Skin & Eye Institute charges for this portion of the eye examination. Our charge is \$50.

Medicare and other medical insurance plans do cover the portion of the eye examination devoted to the determination of eye disease and the treatment of that disease. Medical plans also cover diagnostic testing to aid the doctor in diagnosing eye disease and monitoring its progress. If you have diagnostic testing performed, charges for these services will be billed to your medical insurance carrier. You will be responsible for any co-payments, co-insurance, and deductibles associated with your specific insurance plans.

We have made an attempt to contact your carrier(s) prior to the arrival for your appointment to maximize your benefit coverage and to determine your financial responsibilities. Please understand that whatever we report to you is only an estimate. We are not your insurance carrier, and can only discuss your coverage and benefits from the information they report to us.

**Eye Refractions and VSP Vision Care**

If you have VSP Vision Care insurance in addition to medical insurance, we would be happy to accept your plan's benefits as payment for the refraction portion of your comprehensive eye examination. You may combine the benefits of both insurance plans. If your vision and medical insurance plans have separate co-payment charges, we will accept the vision plan co-payment amount. Vision insurance rarely covers diagnostic testing to diagnose eye disease or monitor its progress. If you need those services, their charges will be applied to your medical insurance plan, and any deductibles or co-insurance requirements of your plan will apply.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

**Corneal & Contact Lens Evaluation**

Contact lenses are a medical device that are fitted to wear on top of the cornea. Due to this fact, we are required to check the contact lens fit every year, regardless of any change in vision. Our first concern is to make sure your eyes are healthy and viable for contact lens wear. Not all contact lenses fit the same way. All corneal evaluations for contact lenses will include 90 days of follow up care. After 90 days, a charge of \$75 will be applied for any additional visits. Once finalized by the doctor, a written prescription will be given with an expiration date of one year from the original date of service.

**Soft & RGP Contact Lens Fitting Fees:**

New Fittings: \$200

Annual Adjustments: \$100

**Dispensing and Cancellations**

Contact lenses are a medical device and therefore are non-refundable and cannot be returned. Orders may be cancelled or changed with no penalty if cancelled on the same day before close of business. Contacts must be picked up within 30 days after notification that the order is ready to be dispensed. Contacts not picked up within this timeframe will void any warranties and return policies. The order will be considered a cancelled order and no refunds or credits will be issued.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_