GOULAS EYE, LLC

PATIENT INFORMATION

PATIENT NAME: _____ ***SS#:*** _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

BEST # TO REACH YOU: _____ *ATL #:* _____ *WORK#:* _____

EMPLOYER: _____ *WORK COMP: YES* _____ *NO* _____

BIRTHDATE: _____ *AGE:* ___ *MARITAL STATUS:* _____ *SEX:* _____

SPOUSE NAME: _____ ***SS#:*** _____ ***SPOUSE DOB:*** _____

GUARDIAN NAME (IF UNDER 18): _____ *GUARDIAN DOB:* _____

GUARDIAN EMPLOYER: _____ *WORK #:* _____

EMERGENCY CONTACT NAME AND PHONE # (OR) PERSON WE CAN RELEASE MEDICAL INFORMATION TO: _____

INSURANCE INFORMATION

******IT IS YOUR RESPONSIBILITY TO SUBMIT THE CORRECT INSURANCE INFORMATION. IF WE ARE UNABLE TO BILL DUE TO INCORRECT INFORMATION SUPPLIED BY YOU THE BALANCE IS YOUR RESPONSIBILITY******

PRIMARY INSURANCE: _____

******IF MEDICARE IS AN ADVANTAGE PROGRAM PLEASE GIVE US THAT CARD******

SECONDARY INS: _____

******WE BILL YOUR SECONDARY AS A COURTESY – PMT IS NOT GUARANTEED AND REMAINS YOUR RESPONSIBILITY******

PLEASE GIVE YOUR INSURANCE CARDS AND PICTURE I.D. TO THE RECEPTIONIST TO SCAN. WE REQUIRE A PICTURE I.D. TO FILE YOUR INSURANCE CLAIMS. PLEASE BE PREPARED TO FILL OUT PAPERWORK AT THE BEGINNING OF EACH NEW YEAR FOR HIPPA COMPLIANCE.

Claims will be filled for payment to those insurance plans with which Goulas Eye, LLC is a contracted with as a participating provider. If your insurance is not one we are contracted with we will submit the claim but it will be processed as a non-participating provider and any difference in payments will be your responsibility. Co-insurance amounts, deductible and any remaining balances on your account will be collected at the time of service.

I hereby request evaluation and treatment necessary by Goulas Eye, LLC. I hereby authorize payment of insurance benefits directly to Goulas Eye, LLC for services rendered, including applicable Medi-Gap policies. I further authorize the use or disclosure of my health information for the purpose of treatment, payment or healthcare operations. I understand that I am responsible for payment of any amounts not covered by my insurance as addressed above including nonpayment due to incorrect insurance information being provided or non- coverage by secondary insurance.

SIGNATURE REQUIRED: _____ **DATE:** _____

MEDICAL HISTORY QUESTIONNAIRE

TODAYS' DATE _____ / _____ / _____

Name: _____ Nickname: _____ Date of Birth:____/_____/_____

Primary Care Physician: _____ Referring / Specialty Dr. _____

Pharmacy: _____ Location (street & city) _____

Race: _____ American Indian or Alaska Native _____ Asian

_____ Native Hawaiian or Other Pacific Islander _____White _____ Black or African American

Ethnicity: _____Hispanic _____Not Hispanic

Preferred Language: ____ English ____ French ____ Italian ____ Japanese ____ Portuguese ____ Russian ____ Spanish ____ Greek

Allergies: Reaction Severity_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (mark all that apply)

__ Overall Healthy
__ Cataracts
__ Hyperopia (Far sighted)
__ Myopia
__ Amblyopia
__ Diabetic Retinopathy
__ Iritis
__ Retinal Detachment
__ Astigmatism
__ Glaucoma
__ Macular Degeneration
__ Optic Neuritis
__ Aphakia
__ Dry Eyes
__ Keratoconus

Other_____

Ocular Surgeries: (mark all that apply)

__ LASIK
__ PRK Corneal Transplant
__ Strabismus Surgery(eye muscle surgery)
__ Cataract surgery
__ No prior ocular surgery
__ Foreign Body Removal
__ Punctal Plugs
__ Trabeculeclomy (Glaucoma Surgery)
__ Blepharoplasty
__ Retinal Laser Surgery
__ RK
__ Vitrectomy

Other:_____

Ocular significant Illnesses: (mark all that apply)

__ Overall Healthy
__ Herpes
__ Hypothyroidism
__Sjogrens
__ AIDS
__ HIV Positive
__ Lupus
__ Graves' disease
__ Diabetes
__ Hypertension
__ Multiple Sclerosis
__ Hyperthyroidism
Rheumatoid Arthritis

Other: _____

Systemic Illnesses: (mark all that apply)

__ No history of illnesses
__ Congestive Heart Failure
__ Hepatitis
__ Lung Disease
__ Anemia
__ COPD
__ Asthma
__ Fibromyalgia
__ Kidney Disease
__ Psychiatric Disorder
__ Bleeding Disorder
__ Headache
__ Skin Cancer
__ Cancer
__ Hearing Loss
__ Liver Disease
__ Stroke
__ Thyroid Disease
__ Lupus
__ Arthritis
__ Diabetes
__ High Cholesterol
__ Eczema
__ HIV
__ Polymyalgia
__ High Blood Pressure
__ Kidney Stones
__ Migraine
__ Arrhythmia

General Surgeries / Operations: (Please List) Date of Exam

_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____

Current Medications: (Please list)

_____

_____

_____

_____

_____

_____

Infection: (mark all that apply)

__ Overall Healthy __ Herpes Simplex __ HIV / AIDS __ Syphilis __ Chicken Pox __ Herpes Zoster / Shingles
__ Meningitis __ Toxoplasmosis __ Hepatitis A / B / C __ Histoplasmosis __ MRSA __ Wound Infection

Other: _____

Family History: (mark all that apply)

__ Arthritis __ Diabetes __ Kidney Disease __ Stroke __ Blindness
__ Heart Disease __ Macular Degeneration __ Cataracts __ High Blood Pressure __ Retinal Disease
__ Glaucoma __Lazy Eye __TB __Cancer

Other: _____

Social History: (mark all that apply)

Smoking: __ current every day smoker __current some day smoker __ former smoker __never smoked

Alcohol Use: Yes No If yes, how much and how often?_____

Drug use: Yes No If yes, what and how often?_____

Eyes
- __ Previous Surgery
- __ Contact Lens
- __ Pain
- __ Double Vision
- __ Glaucoma
- __ Cataracts
- __ Macular Degeneration
- __ Dry Eyes
- __ Flashes
- __ Floaters

Ear, Nose and Throat
- __ Hard of Hearing
- __ Ringing in Ears
- __ Vertigo

Cardiovascular
- __ Chest Pain
- __ Dizziness
- __ Fainting Spells
- __ Shortness of Breathing
- __ Irregular Heart Beat
- __ Difficulty Lying Flat

Constitutional
- __ Fatigue / Weakness
- __ Fever
- __ Weight Gain / Loss

Respiratory
- __ Cough
- __ Congestion
- __ Wheezing
- __ Asthma

Gastrointestinal
- __ Heartburn
- __ Nausea / Vomiting
- __ Jaundice / Hepatitis

Genito-Urinary
- __ Pain / Difficulty
- __ Blood in Urine
- __ History of Kidney Stones
- __ History of STD's

Psychiatric
- __ Anxiety / Depression
- __ Mood Swings
- __ Difficulty Sleeping

Endocrine
- __ Increased Thirst
- __ Increased Hunger
- __ Increased Urination
- __ Increased Sweating
- __ Fingernail Changes

Blood / Lymph nodes
- __ Easy Bruising
- __ Gums Bleed Easy
- __ Prolonged Bleeding
- __ Heavy Aspirin Use

Musculoskeletal
- __ Stiffness
- __ Arthritis
- __ Joint Pain / Swelling

Skin
- __ Rash / Sores
- __ Lesions
- __ Hives / Eczema

Neurological
- __ Seizures
- __ Weakness / Paralysis
- __ Numbness
- __ Tremors

Immunologic
- __ Hives
- __ Itching
- __ Runny Nose
- __ Sinus Pressure

GOULAS EYE, LLC

23 PLANTATION PARK DR STE 401 - BLUFFTON, SC 29910 - (843) 815-5454

WRITTEN FINANCIAL POLICY

Thank you for choosing Goulas Eye, LLC as your destination for optimum eye care. Our primary mission is to provide the best and most comprehensive eye care available. An important part of our mission is making the cost of optimal eye care as easy and manageable for our patients a possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, Discover Card or Care Credit
  1. NO INTEREST Payment Plans from Care Credit *
     a. Allows you to pay over time
     b. Convenient, low monthly payment plans available
     c. No annual fees or pre-payment penalties

Please note:

*For patients with insurance, Goulas Eye, LLC is happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.** Goulas Eye, LLC will bill your secondary insurance as a courtesy to you. You will be billed your portion of the remaining fees after your insurance processes your claim other than co-pays and deductibles and any remaining balances on your account which are due at time of service.*

If you have no insurance, Goulas Eye, LLC requires payment in full at the time of treatment.

For non-covered lenses Goulas Eye, LLC requires payment in full prior to surgery.

- Goulas Eye, LLC charges $25.00 for refractions (the test that determines your prescription for glasses and/or contacts). This is considered non- covered by most insurance with the exception of certain Tricare plans. There is no exception. If you think your insurance will pay for this service, we will be happy to bill them for you but still require the fee be paid up front. If your insurance remits payment we can either credit your account against future services or refund the fee directly to you.
- Goulas Eye, LLC charges a $50.00 fee for returned checks.

By signing this form, you authorize Goulas Eye, LLC to receive payments on your behalf from your insurance carrier for any treatment provided to you.

IT IS YOUR RESPONSIBILITY TO SUBMIT THE CORRECT INSURANCE INFORMATION. IF WE ARE UNABLE TO BILL DUE TO INCORRECT INFORMATION SUPPLIED BY YOU THE BALANCE IS YOUR RESPONSIBILITY

If you have any questions, please do not hesitate to ask. We are here to help you get the eye care you want/or need.

Patient, Parent or Guardian Signature: _____ Date: _____

Patient Name: (Please Print): _____

**If paid within the promotional period. Otherwise, interest assessed from the purchase date. Minimum monthly payment required. Subject to credit approval.*

***If we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance company.*

Privacy Notice – Protected Health Information –Goulas Eye, LLC.

This notice describes how health information about you may be used, disclosed and how you can get access to this information. We are required by law to give you this notice. Please review it carefully.

Introduction:

At Goulas Eye, LLC, we are committed to treating and using Protected Health Information (PHI) about you responsibly. Under the HIPPAA 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 affect 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. You may request a copy of the Notice at any time. Your PHI may be used and disclosed by your physicians(s), our office staff and others outside of our office that are involved in your care for the purpose of Treatment, Payment and Healthcare Operations (TPO).

For 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 or that 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, health care facilities, laboratories for continuing of your healthcare.

For 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. We may need to disclose your PHI to your health plan when obtaining pre-approval for diagnostics or surgical procedures. Bills sent to your or a third party payer may include information that identifies you, as well as your diagnosis and procedures performed.

For Health Care 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, training of medical professionals, auditing functions, or other business aspects of running our practice; an example would include a periodic assessment of our documentation protocols, etc. Additionally, we may use a sign-in sheet at the registration desk, where you will be asked to sign your name when you arrive. We may also call you by name from the lobby or other area in the building.

Disclosure of PHI for special circumstances:

We may disclose or use Protected Health Information about you without your permission for the following special circumstances, subject to all applicable legal requirements and limitations.

- **Appointment reminders:** GOULAS EYE, LLC may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.
- **Health-related benefits and services:** GOULAS EYE, LLC may use your health information to inform you of services or programs that we believe would be beneficial to you. For example, we may contact you to make you aware of new services or products.
- **Required by laws or law enforcement:** GOULAS EYE, LLC may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. We will disclose PHI about you when required to do so by federal, state or local law.
- **To prevent serious threat to health or safety:** GOULAS EYE, LLC may disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Communication with family:** GOULAS EYE, LLC health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. In situations where you are incapable of giving consent, we may, using our professional judgment, determine that a disclosure to your family or a friend is in your best interest.
- **Research:** GOULAS EYE, LLC may disclose 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 health information.
- **Coroners, funeral directors or medical examiners:** GOULAS EYE, LLC may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- **Organ procurement organizations:** Consistent with applicable law, GOULAS EYE, LLC may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.
- **Worker's Compensation:** GOULAS EYE, LLC may disclose health information to the extent necessary to comply with laws related to workers compensation or other similar programs established by law.
- **Public Health:** As required by law, GOULAS EYE, LLC may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- **Military, Veterans, National Security:** If you are a member of these, GOULAS EYE, LLC may be required by government authorities to release health information about you.
- **Health Oversight Agencies:** GOULAS EYE, LLC may disclose PHI to a health oversight agency for audits, investigations, inspections or licensing purposes. Disclosure may be required by state or federal agencies to monitor health care, government programs and compliance with laws.
- **Legal, Lawsuits, Disputes:** GOULAS EYE, LLC may disclose PHI about you in response to a court order, administrative order or subpoena.

Your Health Information Rights:
Although your medical record is the physical property of GOULAS EYE, LLC, you have the right to:

- Obtain a copy of this privacy notice
- Inspect and receive a copy of your health record as provided, 45 CFR 164.524
  You must submit a written request and a fee may be charged. Requests may be denied in limited circumstances.
- Amend your health record. 45 CFR 164.528
  To request an amendment, complete and submit a medical record amendment/correction form, which is available at GOULAS EYE, LLC. We may deny your request if you ask information to be amended that:
  1. *GOULAS EYE, LLC did not create.*
  2. *Is not part of your PHI or medical record.*
  3. *Is already accurate and complete.*
- Obtain an accounting of disclosures. 45 CFR 164.528
  This is a list of disclosures GOULAS EYE, LLC *made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing. It must state a time period, not longer than six years and may not include dates before April 14, 2003. We may charge you for the costs of providing this list.*
- Request communications of your health information by alternative means or at alternative locations.
  You have the right to request we communicate with your regarding your medical health in certain ways or at certain locations. Example: You may ask that we only contact you at home or by mail, not at work.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
  You have the right to request restrictions on disclosures. Example: You may request we not disclose information about your surgical procedures.
- Revoke your authorization to disclose health information except to the extent that action has already been taken.
  To request restrictions, these restrictions will need to be listed on the consent form. We are not required to agree to your request. If we do agree, we will comply with your request unless the PHI is needed to provide you with emergency treatment.

Our Responsibilities:
GOULAS EYE, LLC is required to:

- Maintain the privacy of your health information. Privacy cannot be ensured for calls to GOULAS EYE, LLC on a cellular phone.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means.

GOULAS EYE, LLC reserves the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will supply you with a revised notice.

GOULAS EYE, LLC will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue usage or disclose your health information after we have received a written revocation of the authorization according to the procedures included in this authorization.

For more information or to report a problem:
If you have any questions or would like additional information, you may contact the following staff:
Mark Goulas, MD
23 Plantation Park Dr Ste 401
Bluffton, SC 29910
(843) 815-5454

If you believe your privacy rights have been violated, you can file a complaint with the Practices' Administrator, or you may file a complaint with the Secretary of Department of Health and Human Services.

Secretary of the Department of Health and Human Services:
P.O. Box 8206
Columbia, SC 29202-8206

ACKNOWLEDGMENT
I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature	Print Name	Date