

GOULAS EYE, LLC

PATIENT INFORMATION

PATIENT NAME: _____ SS#: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

MOBILE #: _____ HOME #: _____ EMAIL: _____

PREFERRED METHOD OF APPOINTMENT CONFIRMATION (TEXT OR EMAIL): _____

DOB: _____ AGE: _____ MARITAL STATUS: _____ SEX: _____

EMPLOYER: _____ WORK COMP: YES ___ NO ___ STUDENT: YES ___ NO ___

SPOUSE NAME: _____ PHONE#: _____ SPOUSE DOB: _____

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

EMERGENCY CONTACT OR PERSON WE CAN RELEASE MEDICAL INFORMATION TO:

NAME: _____ NUMBER: _____

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

INITIAL: _____

PRIMARY INSURANCE: _____

IF MEDICARE IS AN ADVANTAGE PROGRAM PLEASE GIVE US THAT CARD

SECONDARY INSURANCE: _____

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

PLEASE GIVE YOUR INSURANCE CARDS AND PHOTO I.D. TO THE RECEPTIONIST TO SCAN. WE REQUIRE A PHOTO 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.

INITIAL: _____

I hereby request evaluation and treatment necessary by Goulas Eye, LLC. I hereby authorize payment of insurance benefits directly to Goulas Eye, LLC for service 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 amount not covered by my insurance as addressed above including nonpayment due to incorrect insurance information being provided on non-coverage by secondary insurance.

SIGNATURE REQUIRED: _____ DATE: _____

MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE ___/___/___

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

Primary Care Physician: _____ Referring/ Specialty Dr.: _____

Pharmacy: _____ Location (street & city): _____

Race: ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ White

___ Native Hawaiian or Other Pacific Islander

Ethnicity: ___ Hispanic ___ Non-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)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperopia (Far Sighted) | <input type="checkbox"/> Nystagmus |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Iritis | <input type="checkbox"/> Optic Neuritis |
| <input type="checkbox"/> Aphakia | <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Vein Occlusion |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Graves' Disease | <input type="checkbox"/> Myopia (Near Sighted) | <input type="checkbox"/> Strabismus |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Herpes Zoster | <input type="checkbox"/> Narrow Angle Glaucoma | <input type="checkbox"/> Sjogrens |

Other: _____

Ocular Surgeries: (mark all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> No prior ocular surgery | <input type="checkbox"/> Focal Laser | <input type="checkbox"/> Punctual Plugs | <input type="checkbox"/> Trabeculectomy (Glaucoma Surgery) |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Retinal Injec. | <input type="checkbox"/> Vitrectomy |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> LASIK | <input type="checkbox"/> RK | <input type="checkbox"/> Yag Surgery |
| <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> PRK | <input type="checkbox"/> Strabismus Surgery | |

Other: _____

Systemic Illnesses: (mark all that apply)

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Headache | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Polymyalgia |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> COPD | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dementia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> HIV | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Graves' Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Multiple Sclerosis | |

Other: _____

Infections:

- | | | | | | |
|---|--|---|-------------------------------------|--|--|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Wound Infection |
| <input type="checkbox"/> Chicken Pox/Shingles | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> MRSA | <input type="checkbox"/> Toxoplasmosis | |

Other: _____

General Surgeries / Operations: (Please List)

Date of Surgery:

___/___/___
___/___/___
___/___/___

Current Medications: (Please List)

Family History: (mark all that apply)

Arthritis Cancer Diabetes Heart Disease Kidney Disease Macular Degeneration Stroke
 Blindness Cataracts Glaucoma High Blood Pressure Lazy Eye Retinal Disease TB

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? _____

Contact Lens Wearer: Yes No If yes, what brand of contact lens? _____

Eye <input type="checkbox"/> Previous Surgery	Constitutional	Psychiatric	Skin
<input type="checkbox"/> Pain	<input type="checkbox"/> Fatigue/Weakness	<input type="checkbox"/> Anxiety / Depression	<input type="checkbox"/> Rash / Sores
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Fever	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Lesions
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Weight Gain/ Loss	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Hives / Eczema
<input type="checkbox"/> Cataracts	Respiratory	Endocrine	Neurological
<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Cough	<input type="checkbox"/> Increased Thirst	<input type="checkbox"/> Seizures
<input type="checkbox"/> Flashes	<input type="checkbox"/> Congestion	<input type="checkbox"/> Increased Hunger	<input type="checkbox"/> Weakness / Paralysis
<input type="checkbox"/> Floaters	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Increased Urination	<input type="checkbox"/> Numbness
Ear, Nose, and Throat	<input type="checkbox"/> Asthma	<input type="checkbox"/> Increased Sweating	<input type="checkbox"/> Tremors
<input type="checkbox"/> Hard of Hearing	Gastrointestinal	<input type="checkbox"/> Fingernail Changes	Immunologic
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Heartburn	Blood / Lymph Nodes	<input type="checkbox"/> Hives
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Itching
Cardiovascular	<input type="checkbox"/> Jaundice / Hepatitis	<input type="checkbox"/> Gums Bleed Easy	<input type="checkbox"/> Runny Nose
<input type="checkbox"/> Chest Pain	Genito-Urinary	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Sinus Pressure
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pain / Difficulty	<input type="checkbox"/> Heavy Aspirin Use	
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Blood in Urine	Musculoskeletal	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> History of Kidney Stones	<input type="checkbox"/> Stiffness	
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> History of STD's	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Difficulty Lying Flat		<input type="checkbox"/> Joint Pain / Swelling	

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 as 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 HIPAA privacy regulations, we are required by federal law to maintain the privacy of your Protected Health Information (PHI). PHI is information about you that may identify you and that relates to your past, present, or future physical or mental health condition and related healthcare services. Federal law also requires us to provide you with notice of our legal duties and privacy practices with respect to PHI, and we are required to abide by the terms of the notice currently in effect. We reserve the right to change our Notice of Privacy policies and this change will 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 you 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 you 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

Goulas Eye, LLC
23 Plantation Park Drive, Suite 401
Bluffton, SC 29910
(843)815-5454

Refraction Service and Fee

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

Medicare and most other insurances (including HMO, PPO and ADVANTAGE plans) DO NOT cover refractions. Medicare dictates that we charge separately for that portion of the examination since it is NOT a covered service. We will collect the fee if you take the prescription. If your insurance does pay for the refraction once the claim is processed, we will reimburse this charge back to you.

Our fee for a refraction is \$25.00. This will be collected at the time of service in addition to any co-payment your insurance plan may require.

We strive to ensure your glasses prescription is accurate. On the rare occasion, your prescription and/or glasses may not correct your vision as clearly as you would like. This may be due to multiple reasons, including the refraction testing itself, existing eye diseases (dry eyes, cataracts and macular degeneration as examples) or the way the lenses were made and fit. Most optical shops understand these variables and will offer their customers a 30-day remake warranty on the new glasses.

If you receive your glasses and are having difficulty seeing clearly after the recommended adjustment period, please contact our office for a prescription/glasses **check within the 30-day warranty period**. Any delay in reporting this issue past the warranty period will make it impossible for us to make corrections to your prescription. We will gladly check the glasses and if necessary recheck your refraction (actual prescription) to determine why your vision is not as clear as you would like. We **DO NOT** recommend purchasing your glasses online as there are important measurements opticians need to take to properly make and fit eyeglasses, particularly with bi-focal lenses. **We do not take responsibility for the cost of glasses and will not reimburse you for any cost of glasses.** If you are not happy with your glasses and do not have us check your glasses **within the warranty period** we will not be held responsible.

Goulas Eye does work closely with the below optical stores:

Darling Eye Center: 19 Promenade Street, Bluffton (843) 815-4343

576 William Hilton Parkway, Hilton Head (843) 706-2020

The Eye Site of Bluffton: 104 Buckwalter Parkway, Suite 1C, Bluffton (843) 757-9588

Bluffton Total Eyecare: 80 Baylor Drive, Suite 104, Bluffton (843) 706-3022

(At the Publix shopping center)

It's a beautiful day. Let us help you see it!

GOULAS EYE, LLC
23 Plantation Park Drive, Ste 401
Bluffton, SC 29910
(843) 815-5454

REFRACTION SERVICE AND FEE

Why do I have to pay for it?

CMS, the department of the federal government that controls Medicare and Medicaid, has decided that refractions are not a payable part of an eye exam.

CMS, directly under control of the US Congress, has determined this is a "non-covered" service by them. That means you are responsible for payment of that portion of the eye exam.

What does it do?

This instrument determines your need for lenses to correct your refractive error, also referred to as your refraction or you eyeglass prescription.

This part of the exam where the doctor, or qualified tech flips various lenses inside the phoropter and asks questions like "Better 1 or Better 2?" We keep asking these questions until we have helped you achieve the best possible vision.

Is this new?

Refraction (CPT code 92015) has been a "non-covered" service since Medicare was created in 1965.

Since 2007, Medicare has been enforcing the policy that eye doctors are to charge separately for refractions.

The refraction fee is **\$25.00** and we will collect this fee at the time of your office visit along with any other non-covered services or co-payments according to your insurance plan.

Do not hesitate to ask us any questions you have regarding this policy if there is something that you do not understand.

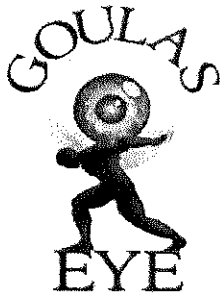
As with any exam you have the right to choose not to receive this service. If you decide not to have this portion of the exam performed please indicate by checking off this box with the understanding that a prescription will not be provided. []

Patient acknowledgement

I have read the above information concerning the refraction and I understand that it is a non-covered routine vision service. I accept financial responsibility for the \$25.00 charge and acknowledge that it is due on the day of my visit. Any co-payment, deductible, or coinsurance there may be is separate from and not part of the refraction fee.

Patient Signature (Parent for Minor)

Date



Mark T. Goulas, MD

23 Plantation Park Drive, Suite 401

Bluffton, SC 29910

Phone: (843) 815-5454

Fax: (843)757-9665

General Ophthalmology

Cataract and Refractive Surgery

Permission to Release Medical Information:

Patient's Name: _____

Date of Birth: _____ SSN: _____

I hereby give permission for _____

Address: _____

Phone: _____

Fax: _____

To release or discuss any medical records or medical information to **Mark T. Goulas, MD**

Patient Signature: _____

Date: _____

Please fax Records to (843)757-9665, Attn: Medical Records, or mail them to:

Goulas Eye, LLC

23 Plantation Park Drive, Suite 401

Bluffton, SC 29910