GOULAS EYE, LLC

PATIENT INFORMATION

PATIENT NAME ______________________ DOB: ____/____/____ AGE:_____ SEX:_____

ADDRESS ______________________ CITY ______________________

STATE: __________ ZIP: ______________ EMAIL: ______________________

SS#: ______ - ______ - ________ HOME PH: (_____)______-_________ CELL: (_____)______-_________

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

CELL PH PROVIDER (TEXT CONFIRMATIONS): ______________________ STUDENT: YES ___ NO ___

MARITAL STATUS: ______________________ EMPLOYER:______________________

WORK COMP: YES ___ NO ___ SPOUSE: ______________ ______________ DOB: __________
FIRST NAME LAST NAME

EMERGENCY CONTACT OR PERSON WE CAN RELEASE MEDICAL INFORMATION TO:

NAME: ______________ ______________ RELATIONSHIP: ______________________
FIRST LAST

EMERGENCY CONTACT NUMBER: (HOME)______________________ (CELL)______________________

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 ______________________ ID # ______________________

SECONDARY INSURANCE ______________________ ID# ______________________

*** WE WILL BILL SECONDARY INSURANCE 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.E. 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 filed for payment to those Insurance plans with which Goulas Eye, LLC is 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: ____________________ DOB:____/____/_____

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)

____Overall Healthy	____Cataracts	____Nystagmus	____Amblyopia
____Diabetic Retinopathy	____Iritis	____Aphakia	____Dry Eye
____Keratoconus	____Retinal Detachment	____Astigmatism	____Glaucoma
____Macular Degeneration	____Retinal Vein Occlusion	____Bell's Palsy	____Graves' Disease
____Myopia (Near Sighted)	____Strabismus	____Blepharitis	____Herpes Zoster
____Narrow Angle Glaucoma	____Sjogren's	____Optic Neuritis	____Hyperopia (Far Sighted)

Other: ____

Ocular Surgeries: (mark all that apply)

____No prior ocular surgery	____Focal Laser	____Punctual Plugs	____Trabeculectomy (Glaucoma Surgery)
____Blepharoplasty	____LASIK	____Retinal injection	____Foreign Body Removal
____Vitrectomy	____Cataract Surgery	____RK	____Yag Surgery
____Corneal Transplant	____PRK	____Strabismus Surgery	

Other:____

Systemic Illnesses: (mark all that apply)

____Overall Healthy	____Headache	____Hyperthyroidism	____Polymyalgia	____Congestive Heart Failure
____Alzheimer's	____COPD	____Hearing Loss	____Hypothyroidism	____Psychiatric Disorder
____Anemia	____Dementia	____Hepatitis	____Kidney Disease.	____Skin Cancer
____Arrhythmia	____Diabetes	____Liver Disease.	____Arthritis	____High Blood Pressure
____Down Syndrome	____HIV	____Lung Disease	____Asthma	____Eczema
____High Cholesterol	____Lupus	____Fibromyalgia	____Bleeding Disorder	____Migraines
____Cancer	____Multiple Sclerosis			

Other: ____

Infections:

____Overall Healthy	____Hepatitis A/B/C	____Histoplasmosis	____Meningitis	____Syphilis
____Wound Infection	____Chicken Pox / Shingles	____HIV / AIDS	____MRSA	____Toxoplasmosis

Other:____

General Surgeries / Operations: (Please List) **Date of Surgery:**

______________________________ ____/____/______

______________________________ ____/____/______

______________________________ ____/____/______

Current Medications: (Please List)

____

____

____

Family History: (mark all that apply)

____**Arthritis** ____**Cancer** ____**Diabetes** ____**Kidney Disease** ____**Macular Degeneration** ____**Retina Disease**

____**Blindness** ____**Cataracts** ____**Glaucoma** ____**High Blood Pressure** ____**Lazy Eye** ____**Stroke** ____**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? ______________________________

Eyes
- ___Previous Surgery
- ___Contact Lens
- ___Pain
- ___Double Vision
- ___Glaucoma
- ___Cataract
- ___Macular Degeneration
- ___Dry Eye
- ___Flashes
- ___Floaters

Ear, Nose and Throat (ENT)
- ___Hard of Hearing
- ___Ringing in Ears
- ___Vertigo

Cardiovascular
- ___Chest Pain
- ___Dizziness
- ___Fainting Spells
- ___Shortness of Breath
- ___Irregular Heart Beat
- ___Difficulty Laying 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 Easily
- ___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 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 services.*

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.

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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 Heath 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 physician(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 ay 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 judgement, 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 organization:** 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, LC may disclose your health information to pubic 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. Request may be denied in limited circumstances
- Amend your health record. 45 CFR 164.528
  To request an amendment, complete and submit. 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 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 our request. If we 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 o 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 procedure 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 Drive, Ste 401
Bluffton, SC 29910
(843) 815-5454

If you believe your privacy rights have been violated, you can file a complaint with the Practice' Administrator, or you may file a complaint with the Secretary of the 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, 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 your eyeglass prescription. This is part of the exam where the doctor, or qualified technician 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.

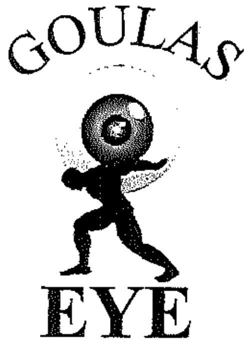
As with any exam you have the right to choose not to receive this service. If you decide not to have this portion of the exam performed please indicate by checking off this box with the understanding that a prescription will not be provided. [ ]

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 Platation Park Drive, Suite 401
Bluffton, SC 29910
Phone: (843) 815-5454
Fax: (843) 757-9665
General Ophthalmology
Cataract and Refractive Surgery

Medical Records Release Form:

Patient's Name: ____

Date of Birth: ______________________________ SSN: _______________

I hereby give permission to release or discuss any medical records or medical information to Mark T. Goulas, M.D.

From: ______________________________

Address: ______________________________

____

Phone: ______________________________

Fax: ______________________________

Patient Signature ___________________________________ Date: ____/____/____

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

Goulas Eye, LLC
23 Plantation Park Drive, Suite 401
Bluffton, SC 29910