

# 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: \_\_\_\_\_

INSURANCE \_\_\_\_\_ ID # \_\_\_\_\_ PRIMARY

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)

<input type="checkbox"/> Overall Healthy	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Nystagmus	<input type="checkbox"/> Amblyopia
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Iritis	<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"/> Sjogren's	<input type="checkbox"/> Optic Neuritis	<input type="checkbox"/> Hyperopia (Far Sighted)

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"/> LASIK	<input type="checkbox"/> Retinal injection	<input type="checkbox"/> Foreign Body Removal
<input type="checkbox"/> Vitrectomy	<input type="checkbox"/> Cataract Surgery	<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"/> Headache	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Polymyalgia	<input type="checkbox"/> Congestive Heart Failure
<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"/> Liver Disease.	<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure
<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"/> Fibromyalgia	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Migraines
<input type="checkbox"/> Cancer	<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"/> 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     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

- Respiratory**
- Cough
  - Congestion
  - Wheezing
  - Asthma

- Blood / Lymph Nodes**
- Easy Bruising
  - Gums Bleed Easily
  - Prolonged Bleeding
  - Heavy Aspirin Use

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

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

- Ear, Nose and Throat (ENT)**
- Hard of Hearing
  - Ringing in Ears
  - Vertigo

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

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

- Cardiovascular**
- Chest Pain
  - Dizziness
  - Fainting Spells
  - Shortness of Breath
  - Irregular Heart Beat
  - Difficulty Laying Flat

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

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

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

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

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

# GOULAS EYE, LLC

23 PLANTATION PARK DR STE 202 - 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 \$40.00 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.

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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 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 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 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 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. 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 \$40.00 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 \$40.00 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

**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**





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

## Goulas Eye Policy for Missed Appointments

### Cancellations of appointments/no-shows

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.

If for any reason you need to cancel an appointment, please notify our office as soon as possible. (843) 815-5454 option 1. If you do not pick option one, we will not receive your call and it will be considered a no/show.

On your second no show occurrence, there will be a \$25.00 charge that will be your responsibility upfront prior to your next visit.

After three occurrences the practice may elect to terminate our relationship with you.

We offer several ways to alert you to your upcoming appointment. We can text you or e-mail you directly. If you do not have access to this type of communication, please be sure to note the appointment on your calendar.

We make every effort to make our services available to all our patients and not allowing us the opportunity to move another into your slot is no longer acceptable for the health of our other patients that rely on Goulas Eye for their care.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



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

## Goulas Eye Policy for Late Arrivals

When you do not arrive on time for a scheduled appointment, it creates a lack of room for us to be able to properly care for you and our other scheduled patients. **\*\*\*\*For new patients, you must arrive prior to your appointment with paperwork in hand in order to be on time for your appointment**.

We will be more than happy to reschedule your appointment as quickly as our schedule allows. We can also put you on our waiting list which we monitor daily.

We offer several ways to alert you to your upcoming appointment time. We text you or e-mail you directly if you have access to this type of communication, please be sure to note the appointment date and time on your calendar.

We make every effort to make our services available to all our patients, therefore being on time for your appointment is beneficial for your health and that of our other patients that rely on Goulas Eye for their care.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# DO YOU WEAR CONTACT LENSES OR GLASSES?

Your prescription **MUST** be updated **EVERY YEAR** as per South Carolina Law.

PLEASE ASK YOUR TECHNICIAN TO DO A REFRACTION IF YOU NEED A NEW RX.

**REFRACTION FEE: \$40.00**

**PAYABLE AT TIME OF SERVICE.**

**(NOT COVERED BY INSURANCE).**