GALANIS
CATARACT & LASER EYE CENTER

PATIENT INFORMATION - Please complete and/or verify all information and make changes as necessary.

Today's Date:	**Are you here for an injury that is work-related?** YES NO N/A			
Patient Name (First-Middle-Last)	**Date of Birth**	**Age**	**Gender** M F	**Marital Status** M S D W
Home Phone No.	**Cell Phone No.**	**Patient Social Security No.**	**E-mail Address** □ I agree to receive email and/or text messages regarding my appointments	
Address Street #	**City/State**	**ZIP**	**Employment Status**: Retired Employed Unemployed Student	
Name of Employer/School	**Occupation**	**Employer Address (Street-City-State-ZIP)**	**Employer Phone No.**	
Emergency Contact	**Relationship**	**Phone No.**	**Best # To Reach You During the Day** Home Cell Other (Pls. specify)	

GUARANTOR INFORMATION/ INSURANCE INFORMATION

Name of person who is financially responsible for this patient?	**Relation to Patient**	**Phone No.**	**Date of Birth**
Primary Insurance Company Name	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**
Secondary Insurance Company Name	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**
Vision Plan	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**

LEGAL GUARDIAN (IF MINOR)

Legal Guardian Name (First-Middle-Last)	**Address Street #**	**City/State/ZIP**	**Phone No.**

MISCELLANEOUS (Please Complete All Entries)

Name of Primary Care Physician	**Phone Number**
Race: (please circle one) American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Or Other Race	**Ethnicity:** (please circle one) unknown Not Hispanic or latino Hispanic or latino

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby assign payment of authorized Medicare and/or any Insurance Carrier listed to include major medical benefits to which I am entitled, to be made on my behalf to Galanis Cataract & Laser Eye Center, LLC for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, and/or any Insurance Carrier listed, any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

_____ _____ _____

Patient or Legal Guardian's Signature **Patient or Legal Guardian's Printed Name** **Date**

MEDICARE: Galanis Cataract & Laser Eye Center, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

INSURANCE: I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that all office co-pays are due at time of service. In addition, I agree to pay any additional charges related to the cost of collection including but not limited to a 25% collection agency fee, and any reasonable attorney fees and court costs, in the event that I would fail to pay my bill.

_____ _____ _____

Guarantor's Signature **Guarantor's Printed Name** **Date**

HEALTH HISTORY FORM

NAME_____ **DATE**_____

Describe in your own words why you are seeing us. List any vision or eye problems you are having:

_____

In general, how are you feeling today? ☐ I feel well today ☐ If not, describe:_____

SURGICAL HISTORY-(Include date and type of each procedure). Heart Defibrillator? ☐ Yes ☐ No

Heart Stent ☐ Yes ☐ No , if yes list date stent placed-_____

_____

_____

Eye Surgery? ☐No If yes, Cataract Surgery? ☐Yes Right eye __/__/__ Left Eye__/__/__Other_____

EYE HISTORY- Have you been diagnosed with any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Cataract _____	☐	☐	Glaucoma _____	☐	☐	Diabetic retinopathy
☐	☐	Corneal disease_____	☐	☐	Eye Injury_____	☐	☐	Macular degeneration
☐	☐	Crossed/lazy eye_____	☐	☐	Iritis_____	☐	☐	Other_____

FAMILY HISTORY-Has any of your blood relatives had any of the following? If so, note which relative.

Yes	No		Yes	No		Yes	No	
☐	☐	Cataract _____	☐	☐	Glaucoma _____	☐	☐	Diabetes_____
☐	☐	Corneal disease_____	☐	☐	Macular degeneration_____	☐	☐	Stroke _____
☐	☐	Crossed/lazy eye_____	☐	☐	Retina Disease_____	☐	☐	Heart Disease _____

MEDICAL HISTORY-Have you been diagnosed with any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma_____	☐	☐	High blood pressure_____	☐	☐	Seizures or fainting
☐	☐	Cancer_____	☐	☐	Heart disease_____	☐	☐	Stroke
☐	☐	Carotid artery disease_____	☐	☐	Kidney disease_____	☐	☐	(Women) are you pregnant
☐	☐	Diabetes ___# of years____	☐	☐	Migraines_____	☐	☐	Rheumatoid arthritis
☐	☐	Head/spinal injury_____	☐	☐	Anxiety/depression_____	☐	☐	Other_____

Do you smoke? ☐ Yes ☐ Never ☐ Former Smoker **Drink Alcohol?** ☐ Occasional ☐ Never ☐ Regular

Do you use recreational drugs? ☐ No ☐ Yes If yes, please list _____

MEDICATIONS- List **all** medications (including eye drops) that you are currently using (include the dosage)

☐ **I have provided a copy of my list of medications.** If you have not provided a copy you may list below.

_____

_____

_____

ALLERGIES: Allergic to any medications? ☐ No ☐ Yes, If yes please list _____

PHARMACY NAME: _____ **PHARMACY PHONE #:** _____

GALANIS CATARACT & LASER EYE CENTER
VISION PLAN REGISTRATION FORM

Vision insurance may be an optional coverage under your health plan (similar to dental coverage). Please verify that you are covered for vision.

Insurance eligibility information that is given to us by your insurance company is not a guarantee of coverage. Any balance is the sole responsibility of the billpayer.

Patient Name: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Subscriber # _____

Circle one: VSP * VBA * EyeMed * Other _____

□ **YES VISION PLAN**

I authorize Galanis Cataract & Laser Eye Center or the vision insurance company to release information required to process my claim. I authorize insurance benefit to be paid directly to Galanis Cataract & Laser Eye Center. I accept financial responsibility for all account balances.

_____ _____

Patient or Responsible Party Signature Date

□ **NO VISION PLAN**

By signing below I acknowledge that I DO NOT have Vision Coverage and will be financially responsible for any routine vision exams, refractions, contact lens fittings/exams, contact lenses, and glasses.

_____ _____

Patient or Responsible Party Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices
&
Authorization to Release Information to Specified Family Members and Close Friends

PATIENT NAME:_____ **Birthdate:**_____

Acknowledgement of Receipt

Galanis Cataract & Laser Eye Center, LLC reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for **Galanis Cataract & Laser Eye Center.**

_____ _____
Signature of Patient/Guardian/Parent Date

_____
Relationship of Patient Representative to Patient

Inability to Obtain Acknowledgement of Receipt

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- ❑ The parent/guardian/patient declined to sign the acknowledgement
- ❑ Other_____

_____ _____
Signature of Staff Member Date

Authorization to Release Health Information to Family Members & Close Friends

I authorize **Galanis Cataract & Laser Eye Center, LLC** to disclose health information to the following family members and/or close friends to the extent necessary to help with your healthcare or with payment for your healthcare.

Name	D.O.B.	Relationship to Patient	Phone #

_____ _____
Signature of Patient/Guardian/Parent Date

_____
Relationship of Patient Representative to Patient

GALANIS CATARACT & LASER EYE CENTER, LLC
Patient Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is part of this care. To help avoid misunderstandings, our financial policy is in writing. For your convenience, we have answered some commonly asked questions below. If you have further questions, please contact our billing department at 314-633-8575.

How may I pay?

We accept payment by cash, check or credit card (VISA, Mastercard and Discover Card).

What if my child needs to see the physician?

A parent or legal guardian must accompany all patients who are minors on the patient's first visit, and must sign the financial statement for the patient, accepting responsibility for the account.

What is your policy regarding missed appointments?

If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule your appointment. This will enable us time to use your slot for another patient. Patients who do not show up for an appointment, and do not call to cancel have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patient's insurance contract, we reserve the right to charge for missed appointments.

Do co-pays need to be paid at the time of my appointment?

Yes. According to your contract with your insurance company, all co-pays are to be paid at the time of service. Refusal to abide by this agreement may result in an additional billing charge (to cover the cost of having to bill you for the co-pay) and/or termination of your coverage.

Do I need a referral for my visit?

If you have an HMO plan or any insurance plan which we are contracted that requires a referral or authorization from your primary care physician and we have not received this referral or authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain one. If you are unable to obtain the referral at that time, you may reschedule your appointment for a time after the referral is received.

How am I to pay my portion after you bill the insurance?

Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Once we receive the explanation of Benefits from your insurance company, we will bill you for the balance that you owe. That amount is due upon receipt of the statement.

Refraction Fees?

An important part of an eye exam is the refraction which is the process of determining the need for glasses and/or contact lenses. Medicare will only pay for services that it deems to be "reasonable and necessary." Medicare will deny payment for a refraction regardless of how it is billed. Almost all other health insurances will deny payment for a refraction ONLY IF the refraction was deemed by the doctor a separate or additional charge at the time of your visit. The insurance co-pay is a separate fee and not included in the refraction fee.

What if I don't have insurance?

Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Office Coordinator or Practice Manager.

What if I need to see the doctor for a work-related injury?

If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our office. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

GALANIS CATARACT & LASER EYE CENTER, LLC
Patient Financial Policy

What if my check bounces?

If a check is returned for insufficient funds, or if payment has been stopped, you will be charged a $25 fee in addition to the amount of the check. If you have a second check returned, you may be asked to pay by cash, money order or cashier's check or credit card.

What if I do not pay my bill?

Accounts that are repeatedly ignored may be sent to collections. If this happens, you may have your credit adversely affected, and you will be dismissed from the practice and asked to find a new physician.

Are there other fees I may anticipate?

There will be additional charges for the completion of medical forms, copies of medical records and x-rays. These charges may vary. Payment is due before or at the time you pick-up the forms and/or records. If you would like them mailed to you or your insurance company, there may be an associated fee to cover mailing costs.

Acknowledgement

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-pays and deductibles, are my responsibility. I authorize insurance benefits be paid directly to Galanis Cataract & Laser Eye Center, LLC, and I authorize them to release any pertinent medical information to facilitate payment of a claim. I have received a copy of this policy.

_____	_____	_____	_____
Date	Signature of Responsible Party	Printed Name	Patient Name (if different)