SOUTHERN HILLS EYECARE

Individual Patient Insurance Information

4600 Singing Hills Blvd. • Sioux City, IA 51106 • (712) 271-4600 • southernhillseyecare.com

Name _____ Account _____

Thank you for choosing Southern Hills Eyecare for your eye and vision care needs. The primary objective of our clinic is to preserve and protect your gift of sight. This is our standard of care. We accomplish this by using the best technology combined with highly trained staff and doctors who provide patient-centered state-of-the-art care.

Government regulations, along with insurance payer rules, are continuing to change with stringent objectives. These objectives must be met to remain in compliance with new and existing health insurance contracts. As a courtesy to you, we will research your insurance benefits to help assist you in making informed decisions about your care. The information we obtain will be provided to us by your insurance company about your specific plan. This information we are given regarding your benefits is not a guarantee of service. Therefore, on occasion this will result in billable fees that will be your responsibility to pay. Payment in full will be due on date of service.

If options with your coverage allow, please choose one of the following to indicate your preference. Please note that we will always strive to honor your preference when your benefits allow.

Medical Insurance Options:

- ○ I wish to use my medical vision wellness benefit with an office co-pay. Co-pay as quoted by my insurance company is $_____. If there is a variation of this benefit we will present the details to you.

- ○ I wish to use my primary medical insurance for my visit today because I was instructed to return for monitoring of my eye health conditions, or I have a new symptom or a medical condition that requires evaluation. (See attached form for conditions and symptoms that apply for medical eye coverage). Fees charged are in accordance to the insurance plan that you have and the contract our physicians signed to accept the fees as stated by the plan. Office co-pays range from$0 to $150. You are required to pay the co-pay and any deductible amounts that have not been satisfied which, apply to your evaluation today as quoted by your insurance plan.

Co-Pay quoted by your insurance is $_____ .

Managed Vision Care Plan Options:

- ○ I wish to use my managed vision care plan benefits plus additional diagnostic screenings: retinal screening (OPTOS) $39 plus pathology screening $60. This $99 diagnostic screening fee is in addition to your examination co-pay. Expect to pay $99 to $119 for this service. ** If you are diabetic and using your managed vision care plan for your annual diabetic medical eye exam, there is and additional $20.00 fee for reporting services.*

Expected Pt Fee: $_____ .

- ○ I am choosing to use my vision plan for this clinic visit, and I understand that I will be responsible for the applicable co-pay associated with this plan. I also acknowledge that I am opting not to undergo the baseline diagnostic testing recommended by our doctors, which involves an additional co-pay of $99.00.

Cash Pay Options:

- ○ I wish to pay cash for the services received today with an administrative discount off the usual/customary fees. I am aware that additional diagnostic tests may be indicated for documenting medical eye conditions to aid in the management, treatment or protection of my vision during this evaluation. I will be informed of these costs prior to the care being provided. I agree that I will be responsible to pay these fees indicated at the time of checkout. I also accept responsibility for and will pay any out-of-pocket fees extended beyond my co-pay and applicable deductible that apply to the visit I have selected.

Initial_____

_____ _____

Patient Signature Date

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Systemic health conditions indicating heed for a medical eye exam:

- ○ Headache of any type
- ○ Diabetes
- ○ Poorly controlled
- ○ Hypertension
- ○ Arterial sclerosis
- ○ Graves disease: hyperactive thyroid
- ○ Multiple sclerosis
- ○ Sickle cell disease
- ○ AIDS
- ○ Any autoimmune disease
- ○ Patients using high-risk medication, oral steroids, Plaquenil

Eye conditions prompting need for medical eye evaluation:

- ○ Cataracts
- ○ Glaucoma
- ○ Macular degeneration
- ○ Allergies
- ○ Blepharitis
- ○ Floaters
- ○ Flashes and floaters
- ○ Eye fatigue and headaches
- ○ Red eyes
- ○ Blurred vision
- ○ Increased light sensitivity
- ○ Previous uveitis
- ○ High eye pressure/ocular hypertension
- ○ Family history of glaucoma
- ○ Peripheral degeneration of the retina
- ○ Contact lens associated conjunctivitis
- ○ Bumps of lumps along the eyelid margin
- ○ Droopy eyelids
- ○ Keratoconus
- ○ Dry Eyes

Visual or eye symptoms prompting need for medical eye examination:

- ○ Glare at night
- ○ Halos around lights
- ○ Morning crust along eyelids
- ○ Red eyes
- ○ Itchy eyes
- ○ Fluctuating
- ○ Blurred vision not corrected with current glasses or contacts
- ○ Headaches and eye fatigue
- ○ Double vision
- ○ Ghosting of vision
- ○ Vision improved by blinking
- ○ Pain around eyes
- ○ Irritation around eyelid
- ○ Gradual loss of vision
- ○ Flashes and floaters
- ○ Intolerance to contact lens
- ○ Twitching eyelid
- ○ Lights in vision that last 12-20 minutes
- ○ Pain on eye movement
- ○ Pain behind the eye
- ○ Change in color vision
- ○ Sudden distortion

- ○ I am not experiencing any of the above symptoms or conditions

Patient Signature _____ Date _____