ADVANCED EYE CARE CENTER

"We are limited, not by our abilities, but by our vision."

WELCOME

Thank you for choosing Advanced Eye Care Center as your eye healthcare provider!

On behalf of Dr. Lawrence Shafron, Dr. Rodgers Eckhart, Dr. Lema Sbenaty and all of our staff, we would like to take this opportunity to welcome you to the Advanced Eye Care Center. We very much look forward to partnering with you to ensure the best care and treatment for your eye sight. We realize your time is valuable and we want to make every effort to ensure we meet your expectations efficiently.

To better serve you, we have provided you with important medical practice and policy information. This information will advise you as to what you can expect from your visit. Please carefully fill out all the required information in your packet. Please keep this information in a convenient location as a reference for you. Your participation in your care and treatment is essential to maximizing desired results.

Please remember to bring with you the New Patient forms completed, along with your insurance information cards and personal identification card. It is only necessary to arrive 15 minutes early to complete your check-in process. Due to the highly specialized nature of advanced eye care, your visit will consist of extensive testing and consultation. You can expect this to be a process of 90 minutes or more. Please allow plenty of time during your day for this visit. We understand that this can be inconvenient at times; however, our primary concern is providing you with the utmost eye care and treatment. Thank you in advance for your understanding and we look forward to your arrival.

We look forward to serving you with your eye care needs. Should you have any questions, please call us at 940-382-8000 so that we may assist you.

Patient Office Policy

Office Hours: Office Hours are Monday through Thursday, 8:00am to 5:00pm and
Friday, 8:00am to Noon.

Accepting Insurance – Our doctors consider many plans and contract with insurance companies that best meet the standard of excellent eye care. Because our physician's primary file claims through medical insurance plans we often are not contracted with carved out vision plans. If your insurance company requires a referral to see a specialist, you must bring the referral to your appointment or verify that our office has received the referral. If you are not sure whether or not you need an authorization or referral you should contact your primary care physician's office. In addition, if your insurance company denies your claim due to a pre-existing clause, you will be responsible for any and all charges not covered by your insurance company.

At the time of your visit you will be expected to provide payment in the amount of any co-payment required by your insurance plan, any unmet annual deductible amount where appropriate, and any services that are not covered. Payments can be in the form of cash, check or any major credit card.

Refraction Service & Fee - A very necessary portion of a medical eye examination is called refraction (92015 CPT codes). Medicare and some insurance companies **do not** cover this portion or code. However, it is essential for determining the need for corrective eyeglasses, contact lenses and it provides much needed information when vision is blurry or increasingly changing. Please be prepared to pay $68 for the refraction service in addition to your co-payment and/or deductible.

15 Minute Late Policy – Late arrival or failure to have all the paperwork completed for your appointment may result in a delay in your appointment and possible reschedule. Our doctors require a complete dilated exam with refraction for a new patient which will allow them to address any eye care health needs you may have.

Prescription Refills – As of Monday, September 1, 2008, we no longer handle prescriptions refill requests in person or over the phone. You are required to ask your pharmacy to fax in the request. Requests may be faxed to: (940) 383-2608. Please allow 24 hours from time of receipt from the pharmacy to process the prescription. Your prescription refill will only be processed if it included the correct name of the medicine, dosage, and instructions on how you are taking the medicine. Prescription refills will not be processed outside of normal business hours or after 12:00 pm on Fridays, nor weekends and evenings after the office has closed.

Physician Emergency on Call Policy – when the office is closed a physician is on-call 24 hours a day. The physician is to be contacted when the office is closed for MEDICAL EMERGENCIES ONLY. If you wish to make an appointment, have prescriptions refilled, obtain contacts or glasses you will not be called in over the weekend or when the office is closed. When attempting to contact a physician after office hours please remove any Caller I.D. or Call Intercept features that are operating on your phone line. Otherwise the physicians may be unable to contact you. In case of a true life threatening emergency call 911 or seek treatment at the nearest emergency room on weekends and after hours.

Financial/Payment – We are doing everything possible to hold down the cost of medical care and provide excellent service. Therefore payment is expected at the time of service. Due to the high cost of billing, patients unable to make payment at the time of service will be rescheduled. Accepted methods of payment include cash, check, credit card, and debit card. We will file any insurance that is properly provided at the time of service.

We will work with you during these difficult changes to insurance changes, but please understand that if we receive denials due to incorrect information or lapse/change of current insurance, you will be responsible for all charges. We require our patients to verify their information at each visit and a photo ID from the patient is required to file any insurance.

There is a $35 service fee for any returned checks. Since optical goods are a prescription item there are no returns once you have purchased. However, we will always work with our patients to strive for a perfect frame style and lenses that is best for your face and vision.

Form Completion – Please be aware that we need 7-10 business days to complete any forms. Patients are required to pay a $25 completion fee for disability forms. There is no charge for completing FMLA papers. Any form, letter or statement that requires the doctor's time to complete will be charged at $75 per hour.

We are in direct compliance with the Medical Privacy law of Texas or H.B. 300. Beginning September, 2012, we will provide patients with electronic copies of their electronic health record through a secure Patient Web Portal. The access information is provided to you after your visit upon request. This information is only available for a period of 5 days and should it need to be provided again a release of records request and fee must be completed.

Records Release and/or Copying of Medical Records – We follow the Texas Medical Board *Rule 165.2* in responding to all releases of medical records.

"The physician responding to a request for such information shall be entitled to receive a reasonable, cost-based fee for providing the requested information. A reasonable fee shall be a charge of no more than $25 for the first twenty pages and $.50 per page for every copy thereafter….. A physician may charge separate fees for medical and billing records requested." *Rule 165.2(e)(1)*

"The physician providing copies of requested medical and/or billing records or a summary or a narrative of such records shall be entitled to payment of a reasonable fee prior to release of the information unless the information…." *Rule 165.2(f)*

"....the physician may retain the requested information until payment is received. If payment is not routed with such a request, within ten calendar days from receiving a request for the release of such records, the physician shall notify the requesting party in writing of the need for payment and may withhold the information until payment of a reasonable fee is received." *Rule 165.2(g)*

It is the policy of Advanced Eye Care Center that we do not **FAX** records because of the lack of safety of personal information.

No Show Policy – Patients who schedule appointments but fail to show up are documented as "no shows." Patients who continue to "no show" may be charged a $50 fee. In addition, patients with multiple "no shows" may be dismissed from the practice. The definition of a "no show" is failing to cancel an appointment within 10 minutes of an appointment.

Patient Termination Policy – Although it is an infrequent occurrence, a patient may be terminated from the office. It is at the discretion of the patients' provider for any dismissal action. Common reasons for dismissal include, but are not limited to, use of foul language, chronic noncompliance with recommended therapy, non-compliance with medications, abusive behavior of staff, physicians, visitors or other patients. Once a patient is dismissed that record will not be re-opened for any provider in the practice.

ADVANCED EYE CARE CENTER

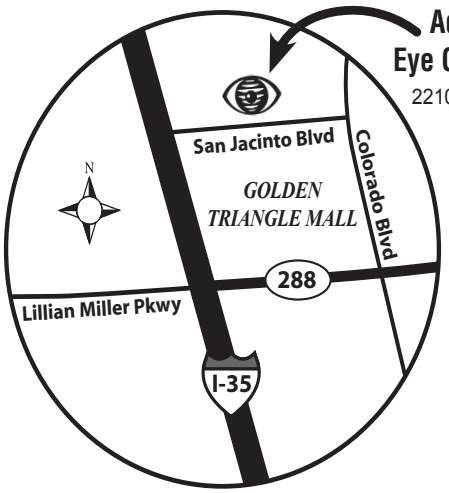
WHAT TO BRING TO YOUR FIRST APPOINTMENT

BRING SUNGLASSES!

- ❑ Driver's License or other photo identification
- ❑ Insurance card(s) (Policy holder's information as necessary)
- ❑ Medical Records from past eye physicians
- ❑ List of current medications
- ❑ Insurance Referral (as necessary)

Thank you for choosing Advanced Eye Care for your eye care.
We strive to provide the best possible medical care.
It is our pleasure to welcome you as a new patient.

2210 San Jacinto Blvd., Suite 1 | Denton, TX 76205-7531
Phone: 940-382-8000 | Toll Free: 800-375-4555 | Fax: 940-383-2608
Lawrence A. Shafron, M.D. | Rodgers L. Eckhart, M.D. | Lema Sbenaty, O.D.



ADVANCED EYE CARE CENTER

OPHTHALMOLOGY • OPTOMETRY • OPTICAL

NEW PATIENT INFORMATION

PERSONAL INFORMATION (PLEASE PRINT)

Name:_____Date:_____

Date of Birth: _____ M: ____ F: ____ SS#:_____

Mailing Address:_____
Street City State Zip

Phone:_____Email:_____
Home

Phone: _____
Cell

Marital Status: Single: ____ Married: ____ Widowed: ____ Divorced: ____

COMPLETE IF UNDER 18 YEARS (Patient must be accompanied by an adult if under 18)

Father:_____Phone:_____

Address:_____

Mother:_____Phone:_____

Address:_____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holders Name: _____ Employer: _____

DOB:_____ID:_____Group:_____

SecondaryInsurance:_____

Policy Holders Name: _____ Employer: _____

DOB:_____ID:_____Group:_____

TertiaryInsurance:_____

Policy Holders Name: _____ Employer: _____

DOB:_____ID:_____Group:_____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE NO. (INCLUDING AREA CODE) _____

MISCELLANEOUS

Have you ever met one of our doctors? Yes No (Dr. Shafron, Dr. Eckhart, Dr. Sbenaty) circle please.

How/where did you hear about our doctors? (Dr. Shafron, Dr. Eckhart, Dr. Sbenaty) circle please. Friend (Whom may we thank) _____ Relative _____ Insurance/Phone Book _____

ADVANCED EYE CARE CENTER

Do not sign this form until you have read and fully understand its contents

NOTIFICATIONS & AUTHORIZATIONS

Financial Policy

Our office is a participating provider for Medicare and most managed care plans. It is the patient's responsibility to provide their most current insurance card(s) and/or referrals at each visit. If you fail to provide your current insurance information, it may be necessary to reschedule your appointment or we will accept you as a "self-pay" patient and expect you to pay in full at the time of service and we will not file an insurance claim for that date of service.

Payment for any co-pay, deductible, or co-insurance is expected at the time of check-in. If your insurance denies coverage, or does not pay for certain services, you will be financially responsible for these fees. For services rendered to minor patients, we expect payment from the adult accompanying the patient at the time of service.

This office does not file claims for insurance companies that we are not participating providers for and we only file a maximum of two (2) insurance companies. All tertiary insurance policies are the responsibility of the patient. Please know we are not Medicaid providers and cannot file any insurance claims to Medicaid.

I have read and understand the patient office policies, including financial, procedures, Prism, Refraction, self-pay fees along with any co-payments, co-insurances, and/or deductibles will need to be paid at the time of service.

_____ Date: _____

Patient/Guardian/POA

Assignment of Benefits

I authorize Advanced Eye Care Center to release any information necessary to my insurance carrier(s) to process medical claims. I assign all insurance benefits to be paid directly to Advanced Eye Care Center/Lawrence A. Shafron, MD PA. (A photocopy of this assignment is to be considered as valid as the original.)

_____ Date: _____

Patient/Guardian/POA

General Consent for Treatment

I have requested medical services from Advanced Eye Care Center for myself and/or my dependent. I give permission to Advanced Eye Care Center to examine and treat myself and/or my dependent as they deem necessary.

_____ Date: _____

Patient/Guardian/POA

ADVANCED EYE CARE CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment but, in refusing, *we will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Advanced Eye Care Center**. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***print*** your name | Please ***sign*** your name

Last 4 digits of SS# _____ DOB_____

_____ _____

Legal Representative | Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR MEDICAL INFORMATION:
(This includes step parents, grandparents and any other care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY MEDICAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ❑ Cell Phone Confirmation
- ❑ Home Phone Confirmation
- ❑ Work Phone Confirmation
- ❑ Email Confirmation _____ Email
- ❑ U.S. Mail

I AUTHORIZE **INFORMATION ABOUT MY MEDICAL HEALTH** BE CONVEYED VIA:

- ❑ Message on Cell Phone
- ❑ Message on Home Phone
- ❑ Message on Work Phone
- ❑ Email Message
- ❑ U.S. Mail

❑ **Any of the above**

This Authorization will remain in effect for one year from the date of signature unless changed by patient.

_____ _____

Patient/Guardian/POA | Date

_____ _____

Patient/Guardian/POA | Date

_____ _____

Patient/Guardian/POA | Date

_____ _____

Patient/Guardian/POA | Date

ADVANCED EYE CARE CENTER

2210 San Jacinto Blvd., Suite 1
Denton, TX 76205
940-382-8000 . 1-800-375-4555

MEDICAL HISTORY QUESTIONNAIRE

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

Primary Care Physician: _____ Referring /Specialty Dr._____

Any other specialist (i.e. Endocrinologist, Cardiologist, etc.) _____

Pharmacy:_____ Location(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Medication Allergies: Reaction Severity □ **NONE**

_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe

Past Eye History: (Please mark all that apply) □ **NONE**

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other_____

Eye Surgeries: (Please mark all that apply) □ **NONE**

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery (eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other_____

Ocular (Eye) Significant Illnesses: (Please mark all that apply) □ **NONE**

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other_____

Current Eye Medications including Over the Counter Eye drops: (Please list)

_____

_____

_____

Initials _____

ADVANCED EYE CARE CENTER

Systemic Illnesses: ☐ **NONE**

☐ No history of illnesses	☐ Congestive Heart Failure	☐ Hepatitis	☐ Lung Disease
☐ Anemia	☐ COPD	☐ High Blood Pressure	☐ Lupus
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Migraine
☐ Arrhythmia	☐ Eczema	☐ HIV	☐ Polymyalgia
☐ Asthma	☐ Fibromyalgia	☐ Kidney Disease	☐ Psychiatric Disorder
☐ Bleeding Disorder	☐ Headache	☐ Kidney Stones	☐ Skin Cancer
☐ Cancer	☐ Hearing Loss	☐ Liver Disease	☐ Stroke
☐ Thyroid Disease			

Other_____

General Surgeries / Operations: (Please list) ☐ **NONE**

_____

_____

_____

Current Other Medications including Over the Counter Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply) ☐ **NONE**

☐ Overall Healthy	☐ Herpes Simplex	☐ HIV / AIDS	☐ Syphilis
☐ Chicken Pox	☐ Herpes Zoster / Shingles	☐ Meningitis	☐ Toxoplasmosis
☐ Hepatitis A / B / C	☐ Histoplasmosis	☐ MRSA	☐ Wound Infection

Other_____

Family History: ☐ **NONE**

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

Other_____

Social History: (Please 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?_____

Initials _____

ADVANCED EYE CARE CENTER

Review of Systems: (Please mark all that apply) □ **NONE**

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

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

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genitourinary
- □ 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 / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ 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

Patient/Representative Signature _____ Date _____