GREG WACASEY, O.D.

How will you be paying today? Cash ___ Credit Card ___ Insurance____

NOTE: WE ARE NO LONGER ACCEPTING CHECKS

Name: _____ Birth Date: ___/___/____ Age: ____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____ - _____ Cell Phone: (____) ____-_____

Employer: _____ Occupation: _____

Primary Care Doctor_____ Doctor's phone #_____

Name of Insurance:_____

Social Security #: _____-_____-_____ Height: _____ Weight: _____

Responsible Party for Minors _____ Social Security #_____

***To whom information can be released: _____Relationship:_____ Full/Partial

Do you wear glasses? ***Yes / No*** Contacts? ***Yes / No*** Full-time / Part-Time

Are you interested in contacts? ***Yes / No*** Tobacco Use? ___YES ___NO

Date of Last Eye Exam: _____

Your Reasons for Visiting Our Office Today: Please Check

____ General Checkup ____Lost or Broken Glasses or Contacts

____ Blurred Vision ____ Near ____ Distant ____ Both

____ Headaches ____ Pain ____ Glare ____Itching ____Watering

Your General Health and Ocular Health: Please Check if these apply to you

___High Blood Pressure	___Cancer	___Macular Degeneration
___Diabetes	___Thyroid	___Cataracts
___High Cholesterol	___Heart Disease	___Glaucoma
___Respiratory Problems	___Multiple Sclerosis	___Allergies
___Seizures	___Arthrits	___Stroke

___Eye Injuries/ Surgeries Specify: _____

___Other Specify: _____

Do any of your family members have any of the above conditions? ***Yes / No***

If yes, Specify: _____

Are you currently taking any medications? ***Yes / No***

If yes, Specify: _____

(**Please** include all prescriptions, vitamins, eye medications and over the counter)

Are you allergic to any medications? ***Yes / No***

If yes, Specify: _____

How did you hear about us? Please Check

Radio ___Phone Book ___Newspaper ___Friend/Family ___Online_____

PAYMENT DUE WHEN SERVICES ARE RENDERED. PROFESSIONAL'S FEES ARE NON-REFUNDABLE. EVEN WHEN THERE IS NO CHANGE IN YOUR PRESCRIPTION, GLASSES EXAM FEE DOES NOT INCLUDE A CONTACT LENS PRESCRIPTION. UPON REQUEST, A FINAL CONTACT LENS PRESCRIPTION WILL BE RELEASED AFTER NECESSARY FOLLOW-UP VISITS.

Signature: _____ **Date:** _____

Financial Information

REFRACTION POLICY

A refraction is a test where a series of lenses are used to determine what combination will help you obtain your best corrected vision, or your need for corrective lenses (glasses). Unfortunately, a refraction is NOT a covered service by Medicare or most medical insurance companies. Our office fee for a refraction is $45.00 and this fee will be collected in addition to the patient's co-pay.

TRADITIONAL MEDICARE PATIENTS

We file all office visits for Medicare patients. Although we do not file on all Medicare supplements, please be sure to give our office that information. If your supplement is a Medigap Insurance, Medicare will forward your claims directly to that company. If Medicare does not forward your claim, you will be responsible for the 20 percent that Medicare does not pay plus the cost of refraction and any deductible you have not met, at the time on your visit. We will furnish a paid itemized bill for you to send to your supplement insurance for reimbursement.

MEDICARE HMO PATIENTS

Medicare HMO patients must obtain an insurance referral from your primary care physician prior to each visit. We will not be able to see you without this referral number authorized by your insurance company.

INSURANCE PATIENTS

We do not file insurance for office visits unless you are covered by a Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) with which we are participating. If we are out of your network or if you visit is for a routine vision exam (most insurance companies will not cover a routine eye exam even if it is a PPO or HMO), payment is required at the time of service. We will provide you with the necessary information for you to file for your visit. You will be responsible for any services, tests, or procedures performed that are denied or not covered by your insurance carrier. It is very important that you check with your Insurance Carrier or your Human Resource Department at work, to determine if your insurance requires you to see a certain doctor or has other special requirements such as a Referral Number that we must have prior to your upcoming visit. If you should discover that we are not in your plan, please call us as soon as possible so that we may reschedule you. Most insurance companies will not provide us with this information; therefore we cannot call for you. If you see a doctor out of your network, you usually have to pay a greater portion of the fee and often have a deductible as well.

NO INSURANCE

If you do not have any insurance coverage, payment is required at the time of service.

NOTICE

If for any reason a claim that we file with your insurance carrier remains unpaid sixty (60) days from the date services are provided you will be responsible for payment of the entire balance. Please understand that most insurance companies have a limited amount of days to file a claim so therefore it is the patients' responsibility to provide us with the correct insurance information before your scheduled appointment. Failure to provide our office with correct insurance information could result in you being responsible for payment of the entire balance from the date of service provided.

By signing below I acknowledge that I have read and understand Dr. Greg Wacasey's' payment policy.

_____ Name

_____ Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Dr. Greg Wacasey accepts most insurance plans in both categories: 1) Vision plans (such as VSP, EyeMed and others) and 2) Medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

- Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).
- Medical insurance must be used for medical eye care.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

I have read and accept these policies.

_____ _____

Patient signature (parent if child) Date

HIPAA / PRIVACY

Notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read the provided copy of Dr. Greg Wacasey's Notice of Privacy Practices.

Patients Name: _____

Signature of Patient: _____

(Or Patients Legal Representative)

Date: _____

I _____ agree to receive my spectacle and/or contact lens prescription electronically.

Missed Appointment and Cancellation Policy

IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, PLEASE GIVE 24 HOURS ADVANCE NOTICE TO ENSURE THAT YOU WILL NOT BE CHARGED FOR THE APPOINTMENT.

IF LESS THAN 24 HOURS NOTICE IS GIVEN AND WE ARE UNABLE TO FILL YOUR TIME SLOT, YOU WILL BE CHARGED A $100 CANCELLATION/NO SHOW FEE.

THANK YOU.

Patient Signature: _____

Date: _____

PATIENT QUESTIONNAIRE

Dear Patient,
Your lifestyle, as well as your personal vision requirements and expectations are all important factors to consider when selecting an appropriate intraocular lens (IOL) for your cataract surgery. Please answer the following questions to help us choose the right treatment option for you.

1 **Please insert your personal data:**

Name: Age: Profession:

2 **What hobbies / leisure activities do you pursue?**

3 **How many hours do you spend on these activities every day?**

○____Computer work	○____Reading	○____Watching TV	○____Garden work
○____Fine handwork	○____Driving	○____Cooking	○____Shopping
○____Playing chess / cards	○____Walking	○____Biking	○____Other

4 **How good is your vision without glasses for the following distances and conditions?**

a) Close distance (reading fine print)	○ very good	○ good	○ poor	○ very poor
b) Intermediate distance (computer work)	○ very good	○ good	○ poor	○ very poor
c) Far distance (driving)	○ very good	○ good	○ poor	○ very poor
d) Dim light (at night)	○ very good	○ good	○ poor	○ very poor

5 **Do you currently wear glasses and, if yes, for what distances / activities? (please choose all relevant answers)**

○ Yes, for close distance (reading fine print).
○ Yes, for intermediate distance (computer work).
○ Yes, for far distance (driving).
○ No, currently I do not wear glasses.

6 **What kind of glasses do you have?**

○ Progressive spectacles
○ Bifocal spectacles
○ Different types of spectacles (each one for a different distance)
○ I do not know what type of glasses I have.

7 **Does it bother you to wear glasses?**

○ Yes, wearing glasses bothers me a lot.
○ In some situations – I would prefer not having to wear glasses the whole time.
○ No, I do not mind wearing glasses at all.

8 **How important is it for you NOT to have to wear glasses for the following distances / activities after surgery:**

a) Seeing up close (reading, fine handwork)

○ very important ○ quite important ○ not so important ○ completely unimportant

b) Intermediate vision (computer work, shopping, cooking)

○ very important ○ quite important ○ not so important ○ completely unimportant

c) Seeing in the distance (driving, sports)

○ very important ○ quite important ○ not so important ○ completely unimportant

9 **Which statement best describes your vision requirements at night:**

○ Good vision is very important to me in all light conditions.
○ I stay up late performing different activities such as driving so I need good vision also at night.
○ I am not very active at night, so my night vision does not need to be perfect.

10 **Do you experience any disturbing light phenomena at night such as light reflections, dazzle, etc.?**

○ Yes, very often ○ From time to time ○ No, never ○ I am not sure

11 **How do you react to light phenomena at night such as light reflections, dazzle, etc.?**

○ I am very sensitive to all light phenomena, I find them very disturbing.
○ The night light phenomena annoy me.
○ I can tolerate light phenomena quite well.
○ Light phenomena do not bother me at all.

12 **Please choose the statements that best describe you as a person (tick all that apply)**

○ I do a lot in my spare time.
○ I like spotting and correcting mistakes.
○ I always know where I have put my personal things like keys, glasses or my mobile phone.
○ I set high standards for myself and others.
○ I enjoy talking to my friends and family.
○ I don't like compromises: I always go for the best.
○ I am very well informed about medical topics.