optomap®

Retinal Exam

At **Tuscaloosa EyeCare** we pride ourselves on providing our patients with the best possible standard of care. **Because of this, we now perform the *optomap*® Retinal Exam with all of our patients.**

Sight threatening diseases such as macular degeneration, glaucoma, retinal holes and detachments, melanomas, cancer and diabetic retinopathy often have no outward signs or symptom. The ***optomap*® Retinal Exam** is a non-invasive procedure that aids your doctor in the diagnosis of these diseases.

When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **The doctors of Tuscaloosa EyeCare believe that the *optomap*® Retinal Exam is an essential part of your comprehensive eye exam and recommend it for all patients once per year.**

This procedure is generally a non-covered service unless being used to actively follow disease. Any questions you have about the ***optomap*® Retinal Exam** can be directed to your doctor should you choose for your doctor to review the images with you during your examination.

_____ Yes, I would like my doctor to review my ***optomap*®** photos and saved to my medical file. I understand the charge for reviewing and saving my ***optomap*®** photos will be **$39.**

_____ No, I would not like my ***optomap*®** photos saved to my medical file.

_____ **Not Sure**

Patient Name(s): _____

_____

_____

_____

Patient or Responsible Party:

Print Name: _____ Relationship **to patient:** _____

Signature: _____ **Date:** _____

Rev. 03/09/2018

P-01

TUSCALOOSA
EYECARE
GREENE · HALE · PICKENS
www.eyecaretuscaloosa.com

Find us on Facebook

@Tuscaloosa EyeCare

Today's Date _____

Last _____

First _____ Middle _____

Mailing Address _____

_____

City _____ State _____

Zip Code _____ Sex M F

Date of Birth _____ Age _____

Patient's SSN _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

Race: ❑All Other Races
❑American Indian or Alaska Native
❑Asian
❑Black or African American
❑Native Hawaiian or Other Pacific Islander
❑White

Marital Status: ❑ Single ❑Married ❑Other

Patient: *(or Insurance Policy Holder)*

❑ Retired ❑ Disabled ❑ Student ❑ Military

❑ Employed Full Time ❑ Employed Part -Time

Employer: _____

If patient is under 18, or if patient is NOT the primary insurance **policy holder,** please provide the following:

Guarantor Name: _____

Guarantor DOB: _____

Guarantor SSN: _____

Our Mission Statement:

We the Doctors and Staff of Tuscaloosa, Pickens, & Hale Co. EyeCare focus on providing the most extensive, comprehensive eye health care to each and every patient.

It is our goal to provide an improved quality of life to you, your family, and the community by focusing on your vision wellness.

Our staff promises to exceed the expectations of each and every patient with a level of service and high-quality products which will ensure our patients will return and recommend our office to others without reservation.

Who is your primary health care **doctor**?

_____

Which **pharmacy/location** to do you use?

_____ / _____

How do you plan to pay? ❑ Cash ❑ Check
❑ Credit/Debit Card ❑ Care Credit

How did you hear about our office?
❑Advertisement ❑Facebook
❑Other Social Media ❑Friend/Relative:
Name: _____

Phone # _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company; not Tuscaloosa/Pickens/ Hale Co Eyecare.

If your insurance company has not reimbursed our office within 60-90 days; our office will transfer that balance to your account, and you will receive a bill.

Rev 07/20/18

Pickens EyeCare
206 1st Ave East
Reform, AL 35481
(205) 375-8200

Tuscaloosa EyeCare
3519 Watermelon Road
Northport, AL 35473
(205) 758-0242
www.eyecaretuscaloosa.com

Hale Co. EyeCare
703 Tuscaloosa St
Greensboro, AL 36744
(334) 624-9967

HIPAA & Privacy Agreement

Authorization for Release of Identifying Health Information

Tuscaloosa, Pickens, and Hale Co. EyeCare cares about you and the privacy of the medical information you provide us. It is our office policy to safeguard this information and to that end, we will release only information absolutely necessary in order to obtain payment on your behalf, to notify you of appointment status, or about an order you have placed with us. The Official Privacy Act and its declarations are available for your review at any time.

It is completely your decision to sign this authorization form. We can not by law refuse to treat you if you choose to not sign this authorization form. If you sign this authorization form; you may revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you wish to revoke your authorization please send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization the recipient often has no legal duty to protect confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I hereby authorize the release of medical or other information to other health care providers for the purpose of patient care. I also authorize release of such information to insurance companies to process claims. Payment of such claims to the physician is also authorized.

I have read and understand this form, and I am signing it voluntarily. I hereby authorize the professional office of my optometrist named above to release health information identifying me (including if applicable information about HIV infection, substance abuse treatment, and information about mental health services).

If you are signing this as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form. By signing this, you acknowledge that you were offered a copy of the HIPAA agreement.

PAYMENT AGGREEMENT

Our office is doing everything possible to maximize the efficiency and minimize the cost of your healthcare. **It is a "Courtesy" to our patients that we file your insurance**; however it is impossible for us to know if your insurance will deny, due to additional co-pays, deductibles or non-covered procedures or products. It is very important to have **ALL** your insurance cards and your ID present. **Co-pays are due at the time of service.**
Should it become necessary to bill you for the services rendered a **$12.00 billing fee** along with **1.5%** monthly finance charge will be added to your account each month there is an open balance.
Agreement to Pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

NO-SHOW / NO CALL / CANCELLATION POLICY

Failure to notify our office 24-hours prior to your appointment will result in a $25.00 "no call/no show" fee.

EXPRESS PRIOR CONSENT to CONTACT CONSUMER by CELL PHONE or EMAIL

You agree, in order for us to service your account or to collect monies you may owe, Tuscaloosa Pickens/Hale Co EyeCare and/or our agents, may contact you by email or by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices as applicable.
I/We have read this disclosure and agree that Tuscaloosa/ Pickens/Hale Co EyeCare, its employees and/or agents may contact me/us as described above.

Patient Name(s) _____

Patient or Responsible Party:

Print Name: X _____ **Relationship to Patient:** _____

Signature: X _____ **Date: X** _____