



## WELCOME TO OUR PATIENT FAMILY!

Thank you for booking your appointment with us today. We look forward to meeting you soon and provide the exceptional eye care that you deserve.

Due to recent COVID-19 events, we have taken additional steps to maintain our commitment to everyone's safety and well-being, including our patients, staff, and doctors. Our office is following all recommended guidelines from the Centers of Disease Control (CDC), American Optometric Association (AOA), Massachusetts Society of Optometrists (MSO), and other public health and healthcare professionals. With any rapidly evolving situations, we will continue to closely monitor for updates and implement new protocols as suggested.

The following are new changes to our office policies to further protect all patrons and mitigate COVID-19 risk in our office:

- Staff members and doctors are to continuously practice hand hygiene. Multiple hand sanitizing stations are also available throughout our office for patrons to use.
- Clinic doors are **locked** and **only open for appointments**; thus no walk-ins are allowed to reduce the number of patrons in the office at one time. Since there are no walk-ins or unscheduled appointments, there is a \$25 no-show fee. A patient late by 15 minutes will be asked to reschedule so there would be sufficient time for the next appointment and provide appropriate disinfection.
- We check the temperature of everyone who enters our offices, including staff and doctors, every day. Anyone with 100.4 degrees or higher will be rescheduled or sent home.
- Face masks covering the nose and mouth are mandatory in the clinic. A patient will be asked to reschedule if not wearing a face mask.
- Everyone who enters our office has to answer a short questionnaire about COVID-19 symptoms and exposure when he/she arrives.
- The rooms are disinfected approximately every hour and after each patient.
- All eyeglass frames are properly disinfected after each handling per AOA recommendations.
- We offer high-resolution imaging technology that will screen for ocular health diseases, such as retinal bleeding, holes, and tears, and medical issues, such as diabetes and high blood pressure. There is a \$49 copay and will help limit your waiting time and exposure in the office. As such, this scan will be required for all annual comprehensive eye exams.
- We ask our patients to complete their medical history form at home prior to your visit. This form is attached with this email. You can bring the paperwork with you to your appointment or elect to fill it in the office.

Our team at Lifetime Vision is excited to see you at our practice for your scheduled appointment! If you have any questions or concerns, please call us at 617-481-1857 or email us at [contact@lifetimevisioneye.com](mailto:contact@lifetimevisioneye.com).



## Office Financial Policy

### **Co-payments, Co-insurances and Deductibles**

- It is the patient's responsibility to understand their insurance plan and policies regarding co-payments, co-insurances and/or deductibles that may apply to the visit. It is possible that an invoice or refund is generated for the visit. Unfortunately, the office does not have the ability to determine a patient's deductible at the time of visit.
- When applicable, co-payments are required by the patient at the time of service. An insurance company cannot be billed for a co-payment.
- For all services rendered to minor patients, we will look to the adult accompanying/parent/guardian for payment.

### **Wellness Exam Billing VS. Medical Exam Billing**

- If the wellness exam reveals NO medical ocular condition, and addressing refractive conditions with potential need for eyeglasses and/or contact lenses prescription, then the exam will be billed to the vision insurance.
- If the wellness exam reveals a medical condition or disease related to the eye that requires specific counseling, documentation, follow-up care, regular monitoring or a referral to a surgeon, or if the exam is related to a pre-existing ocular condition such as an eye infection, dry eyes, allergies, cataracts, glaucoma, macular degeneration, floaters, headaches and/or a medical condition such as diabetes, high blood pressure, high cholesterol, rheumatoid arthritis, to name a few examples, then the visit is medical and may be billed to the medical insurance. A separate consent form may need to be signed to allow for the testing of some conditions.
- The doctor will inform you if the visit qualifies as a medical exam. **Unfortunately, the doctor cannot tell if medical eye conditions exist before you are thoroughly examined, therefore we have no way of knowing if your insurance will be billed as a wellness visit or medical visit prior to your scheduled appointment.**

### **Canceled/No Show or Late Appointments**

- The clinic doors are locked and allow only scheduled appointments. When a patient cancels without giving enough notice, it prevents another patient from being seen. We make every effort to mutually respect scheduling conflicts, and require at least 1 business day notice if you need to cancel your appointment. The late policy will apply if it is 15 minutes past your scheduled appointment.
- **A cancel/no-show or late appointment fee of \$25 will apply per scheduled appointment.** This fee is charged to the patient, not the insurance company, and is **due at the time of your next visit.**
- We reserve the right to modify your appointment if you do not confirm via text, phone call or email 1 business day prior to your appointment. Two or more occurrences of a canceled or no show/ missed appointment may result in possible discharge of care.

### **Referrals/Prior Authorizations**

- Some services may require referrals or prior authorizations from the patient's primary care physician in order to be seen. If such documentation is required by an insurance company, it is the patient's responsibility to obtain these prior to the appointment. Patients without a referral must reschedule their visit and coordinate a valid referral for that appointment.
- A patient, who does not have their insurance referral or wishes to be seen outside of their plan, may continue to be seen at the office. However, the patient will be financially liable for all services, including any co-payments, co-insurance, deductibles and fees not paid by the insurance carrier. The patient can also elect to pay in full for their visit at time of visit. Please discuss with staff members regarding payment options.

## Assignment and Release

- Medical information may be required in the determination of benefits for services rendered at Lifetime Vision. Use and disclosure of information may be used on Revolution, Apex EDI and other third party software programs. Description of information that may be used/disclosed includes: name, address, telephone number, email address and recall/next appointment date(s) and time(s) and prescription.
- Lifetime Vision has the right to send bills by mailing address, email, and text messages. For statement(s) with late balance after 45 days of the due date, an additional \$15.00 late fee will apply to the next billing cycle. After 90 days of non-payment to an account, the balance is forwarded to a collection company and an additional \$50 fee will be further applied to the account. For any billing questions, we will make every attempt to return your inquiries within 48 hours.

## Point of Service Collections

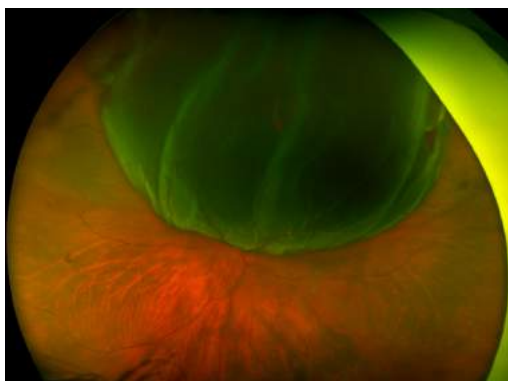
- The point-of-service collection policy is **ONLY** applicable to medical office visit(s). If this policy applies to your medical eye care, our staff will communicate to you ahead of time.
- Patients with health policies featuring an unmet annual deductible will be required to pay either \$50 or \$100 on the day of their office visit, in addition to any medical co-pays. The \$50 charge will be for the office visit only. The \$100 charge will be for the office visit with additional medical testing(s).
- This charge goes toward paying down the balance that the patient would owe if he/she has not met their full annual deductible. The remainder of the balance will be billed to the patient once the insurance claim is processed
- Our office will let you know if you have not met your health insurance deductible prior to your visit.

## Communication Consent

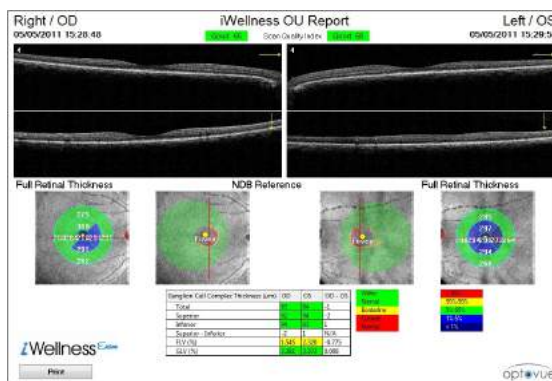
- Lifetime Vision will contact the patient regarding appointment reminders, clinic updates, and invoices by phone, email, mailing address, and/or text messages. Message/data rates may apply to messages sent under the patient's cell phone plan.
- The patient has the right to opt-out of receiving these communications by calling the office at 617-481-1857.

## Mandatory Retinal Screening for NEW Patients

- **All NEW** patients at their comprehensive eye exam are required to complete an evaluation of the overall health of the eye and assessment of the retina using **optomap®** and **iWellness Retinal Exam**.
- These advanced technologies will allow our doctors to monitor for retinal complications including macular degeneration, glaucoma, and retinal holes or detachments. It can also detect problems unrelated to the eye that may show early signs in the retina such as diabetes, hypertension, cancer/tumors, auto-immune disorders, and others, earlier than possible with traditional methods.
- The optomap® and iWellness Retinal Exam:
  - Is as fast as taking a picture.
  - DOES NOT REQUIRE DILATING DROPS. You may not need to be dilated today, avoiding side effects such as blurry vision and light sensitivity.
  - Saved in your file enabling your doctors to make important comparisons during your annual eye exam.
- This imaging is a **\$49 copay**. This is NOT covered by any insurance at this time.



*Optomap showing retinal detachment*



*iWellness scan showing macular disease*



**MEDICATIONS**

Please include over the counter medications

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**ALLERGIES**

Please include non-medication related allergies

- 
- Penicillin
- 
- Latex
- 
- Other \_\_\_\_\_

**PAST OCULAR HISTORY**

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Glaucoma                         | <input type="checkbox"/> Inflammatory disorder | <input type="checkbox"/> Injury      |
| <input type="checkbox"/> Glaucoma suspect                 | <input type="checkbox"/> Strabismus            | <input type="checkbox"/> Dry eye     |
| <input type="checkbox"/> Cataract                         | <input type="checkbox"/> Amblyopia             | <input type="checkbox"/> Nystagmus   |
| <input type="checkbox"/> Age-related macular degeneration | <input type="checkbox"/> Retinal degeneration  | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Surgery                          | <input type="checkbox"/> Retinal hole          | _____                                |
| <input type="checkbox"/> Patching                         | <input type="checkbox"/> Retinal detachment    | _____                                |
|   | <input type="checkbox"/> Keratoconus           | _____                                |

**SOCIAL HISTORY**

Drinking: Yes / No, Never      If yes, amount: \_\_\_\_\_

Tobacco Use: Yes / No, Never      If yes, amount: \_\_\_\_\_ everyday / someday / former

Hobbies: \_\_\_\_\_      Occupation: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Check all that apply

Father      Mother      Brother      Sister      Son      Daughter

	Father	Mother	Brother	Sister	Son	Daughter
Family Hx of Cancer						
Family Hx of Diabetic Mellitus Type 2						
Family Hx of Diabetic Mellitus Type 1						
Family Hx of Hypertension						
Family Hx of Hyperthyroidism						
Family Hx of Hypothyroidism						

**FAMILY OCULAR HISTORY**

Check all that apply

Father      Mother      Brother      Sister      Son      Daughter

	Father	Mother	Brother	Sister	Son	Daughter
Family Hx of Macular Degeneration						
Family Hx of Cataracts						
Family Hx of Glaucoma						

**CONTACT LENS HISTORY**

Current wearer: Yes / No / No, but I am interested

If YES, Brand: \_\_\_\_\_ Contact lens Solution used: \_\_\_\_\_

Average daily wear time (hours): \_\_\_\_\_ Average Replacement period: \_\_ Daily \_\_ Bi-weekly \_\_ Monthly

Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

\* If under 18, Signature of responsible party. Print your name: \_\_\_\_\_



Thank you for reviewing our policies. Please initial for each statement and sign below to acknowledge consent of our policies. A detailed copy of Lifetime Vision's Office Policies, including "Notice of Privacy" is available for your records.

**NAME:** \_\_\_\_\_

**HIPAA POLICY**

\_\_\_\_\_ I understand my rights under the Notice of Privacy. I understand I can go to CMS.org for complete details.

**FINANCIAL POLICY**

\_\_\_\_\_ I understand I am responsible for all charges for services rendered under Lifetime Vision, including all applicable co-payments, co-insurance, deductibles, and fees from my insurance. I understand that I must obtain appropriate referrals and/or prior authorizations before my visit, otherwise I would be financially liable for the visit. I understand that there is a difference between wellness and medical eye exams, and that my claim may be billed as a medical eye examination.

\_\_\_\_\_ I understand that there is a \$25 no-show or late appointment fee. I understand the charge will be applied to my next visit. I understand that multiple occurrences can result in possible modification to appointment and/or discharge.

\_\_\_\_\_ I understand that there are late fees and collections fees for any balances that are not paid in time.

\_\_\_\_\_ I understand that Lifetime Vision may contact me by phone, email, direct mail, and/or text.

\_\_\_\_\_ I understand that if my visit today is a new patient for a comprehensive eye exam that my retina will be evaluated using optomap® and iWellness scans. I understand that this is not covered by my insurance and that there is a **\$49 copay**. I understand that this is not a replacement for a dilation and that I am entitled or may need a dilation to evaluate the internal ocular health.

**RELEASE OF RECORDS**

I authorize the office of Lifetime Vision to release protected health information to the following person(s):

- 1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_
- 2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_
- 3. Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONTACT LENS POLICY** (if applicable)

\_\_\_\_\_ I agree to be fitted for contact lenses or to update my contact lenses prescription. I understand I am responsible for the fitting fee, and the I&R class if applicable. All contact lenses purchased, opened or unopened, are non-refundable.

Signature\*: \_\_\_\_\_

Date: \_\_\_\_\_

\*If under 18, signature of responsible party. Print your name here: \_\_\_\_\_