LIFETIME VISION

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 allows only scheduled appointments and doors may be locked at times. 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 48 hours 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 48 hours 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

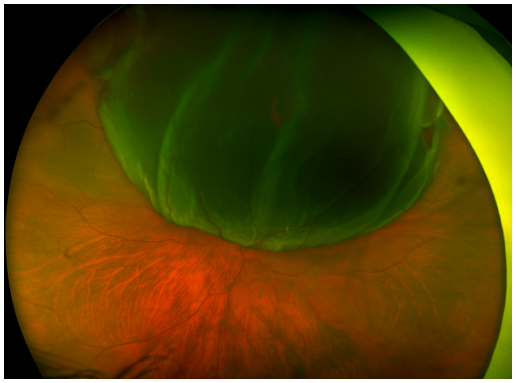
- The point-of-service collection policy is ONLY applicable to medical office visit(s). If this policy applies to your medical eye care, our staff will communicate to you ahead of time.
- Patients with health policies featuring an unmet annual deductible will be required to pay either $50 or $100 on 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

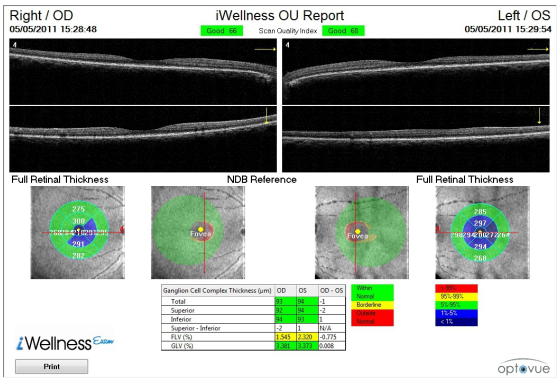
- Lifetime Vision will contact the patient regarding appointment reminders, clinic updates, and invoices by phone, email, mailing address, and/or text messages. Message/data rates may apply to messages sent under the patient's cell phone plan.
- The patient has the right to opt-out of receiving these 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 **$50 payment**. This is NOT covered by any insurance at this time.



Optomap showing retinal detachment



iWellness scan showing macular disease

Note: "You", "Your" referencing to patient. "We", "us", "our" referencing to Lifetime Vision.
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LIFETIME VISION

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 **$50 payment**. 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: _____

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WELCOME TO LIFETIME VISION!

Mr./ Mrs./ Ms._____ _____ _____
First Name MI Last Name

Address: _____

DOB:_____ SSN Last Four:_____ Sex: Male / Female

Phone Number: _____ Cell / Home / Work Email Address:_____

Primary Care Physician: _____
Name Address Phone

Health Insurance: _____
Plan Name Subscriber ID

Guarantor's Name: _____

Vision Plan: _____
Plan Name Member ID

REVIEW OF SYSTEMS

Constitution
- ❑ Developmental disabilities
- ❑ Cancer
- ❑ Fatigue Syndrome
- ❑ Other

ENT
- ❑ Hearing Loss
- ❑ Sinusitis
- ❑ Dry mouth
- ❑ Laryngitis
- ❑ Other

Neurological
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Cerebral Palsy
- ❑ Tumor
- ❑ Stroke/CVA
- ❑ Migraine
- ❑ Autism Spectrum Disorder
- ❑ Other

Psychological
- ❑ Depression
- ❑ Attention deficit
- ❑ Anxiety disorder
- ❑ Bipolar disorder
- ❑ Other

Cardiovascular
- ❑ Hypertension
- ❑ Stroke/CVA
- ❑ Heart disease
- ❑ Vascular disease
- ❑ Congenital heart failure
- ❑ Other

Respiratory
- ❑ Cigarette smoker
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic obstruction
- ❑ Sleep Apnea
- ❑ Other

GI
- ❑ Crohns
- ❑ Colitis
- ❑ Ulcer
- ❑ Acid Reflux
- ❑ Celiac disease
- ❑ Other

Genitourinary
- ❑ Kidney disease
- ❑ Prostate disease/cancer
- ❑ STD-herpetic/chlamydia
- ❑ Benign prostate hypertrophy
- ❑ Pregnant
- ❑ Nursing
- ❑ Herpes
- ❑ Chlamydia
- ❑ Other

Muscular / Skeletal
- ❑ Arthritis
- ❑ Osteoarthritis
- ❑ Fibromyalgia
- ❑ Muscular Dystrophy
- ❑ Ankylosing Spondylitis
- ❑ Osteoporosis
- ❑ Gout
- ❑ Other

Integumentary
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Herpes Simplex/cold sores
- ❑ Herpes Zoster/Shingles
- ❑ Other

Endocrine
- ❑ Type 2 Diabetes Mellitus
- ❑ Type 1 Diabetes Mellitus
- ❑ Thyroid dysfunction
- ❑ Hormone dysfunction
- ❑ Other

Hematological / Lymph
- ❑ Anemia
- ❑ Large volume blood loss
- ❑ Ulcer
- ❑ Hypercholesterolemia
- ❑ Other

Allergy / Immunological
- ❑ Drug allergies
- ❑ Environmental allergies
- ❑ Rheumatoid Arthritis
- ❑ Lupus
- ❑ Sjogren's Syndrome
- ❑ Other

OTHER NOT LISTED:

_____

_____

_____

MEDICATIONS Please include over the counter medications

_____

_____

_____

ALLERGIES Please include non-medication related allergies

- ❑ Penicillin
- ❑ Latex
- ❑ Other _____

PAST OCULAR HISTORY

- ❑ Glaucoma
- ❑ Glaucoma suspect
- ❑ Cataract
- ❑ Age-related macular degeneration
- ❑ Surgery
- ❑ Patching
- ❑ Inflammatory disorder
- ❑ Strabismus
- ❑ Amblyopia
- ❑ Retinal degeneration
- ❑ Retinal hole
- ❑ Retinal detachment
- ❑ Keratoconus
- ❑ Injury
- ❑ Dry eye
- ❑ Nystagmus
- ❑ Other_____
  _____
  _____
  _____

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
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
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: _____

Speed II Questionnaire for Dry Eye Disease/Ocular Surface Disease

Name: _____ **Date of Birth**: ___/____/_____ Male/Female **Date:** ___/___/___

Dry Eye Disease is the most frequent reason the patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questions below.

Repot the **FREQUENCY** of the dry eye symptoms. How many times are you experiencing the symptoms?

SYMPTOMS	Never 0	Sometimes 1	Often 2	Constant 3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of the dry eye symptoms

Never = No problems
Tolerable= not perfect but not uncomfortable
Uncomfortable = irritating but does not interfere with my day
Bothersome = irritating and interferes with my day
Intolerable= unable to perform my daily tasks

SYMPTOMS	Never 0	Tolerable 1	Uncomfortable 2	Bothersome 3	Intolerable 4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark and **X** if you have experienced these symptoms"
Today _____ Within the past 72 hours _____ Within past 3 months _____

Do you use eye drops and/or ointments? YES NO Have you used them today? YES NO
Name of drops:_____ How long are they effective?_____
Do the drops last 4 hours? YES NO Do any gels last 12 hours? YES NO

Did you use Moisturizer, lotions or creams around eyes today? YES NO
Did you use makeup today? YES NO
Have you touched/rubbed your eye(s) today? YES NO If yes, when? _____ , How?_____

Have you ever been told you have BLEPHARITIS? YES NO STYE? YES NO

Do you have fluctuating vision problems (that's gets better with BLINKING)
Never, Sometimes, Frequently, A lot/always

OFFICE USE ONLY
Total Speed Score
(Frequency + Severity) =