MINNESOTA EYE CONSULTANTS

OFFICE USE ONLY
PN: _____
DOS: _____

PATIENT AGREEMENT

Consent for Treatment
I authorize Minnesota Eye Consultants to assess and treat me, complete tests, and administer medications considered necessary or advisable. I understand that my healthcare provider is available to explain the purpose of any procedure and that I have the right to refuse, even if against medical advice.

I understand that my pupils may be dilated as part of the appointment. For some, dilation and other drops used during the visit may cause light sensitivity and blurry vision for a period of time.

Minors
A minor child needs an Agreement signed by a parent or guardian. By signing the Agreement, the parent or guardian assumes responsibility for information on behalf of the patient. It is strongly recommended that a parent or guardian accompany a minor to all appointments. Minnesota Eye Consultants reserves the right to request identification of any adult accompanying a minor. In the event that a parent or guardian is unable to accompany a minor to an appointment, please contact us at 952-888-5800, in addition to signing this form.

Release of Protected Health Information to Health Care Providers
☐ I authorize the release or retrieval of my health information, including prescription medication history and other information related to health care services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my care and the continuation of my care for up to one year. A release may be revoked by me in writing at any time.

Communication
☐ I authorize Minnesota Eye Consultants to leave detailed voicemail at the phone number(s) I have provided.

Disclosure of Protected Health Information (PHI) to Specific Individuals
☐ I authorize disclosure of my health information, including appointment and billing information, to the following individual(s) involved in my care and the coordination of my care.

☐ Spouse / Significant Other: _____ ☐ Parent / Guardian: _____

☐ Child / Children: _____ ☐ Other: _____

If I would like a copy of my health information released to me or any individual(s), I will request and submit an Authorization for Release of Medical Information. A release may be revoked by me in writing at any time.

For medical records questions, please contact a medical records assistant at (952) 888-5800.

Research
☐ I understand that in order to provide patients access to the most advanced ophthalmic technology, Minnesota Eye Consultants works closely with numerous ophthalmic and pharmaceutical partners to participate in clinical trials and/or outcome studies involving the latest procedures, equipment and medications, and to teach other ophthalmologists about these advances. Medical records may be released for the purpose of medical or scientific research for up to one year unless revoked by me in writing at any time.

Notice of Privacy Practices
I acknowledge that I have been made aware of Minnesota Eye Consultants' privacy practices, which are posted in the waiting room. I understand that a copy of the Notice of Privacy Practices is available at my request, and if I would like a copy, I will ask for one.

Proprietary Interest
This is to inform you that your physician/surgeon may have a proprietary interest in the Minnesota Eye Laser and Surgery Centers. If you have further questions, please contact your physician or the Director of Surgical Operations.

Insurance Authorization & Assignment of Benefits
I authorize Minnesota Eye Consultants, on behalf of myself and/or my dependents, to furnish medical records and other information related to health care services provided by Minnesota Eye Consultants to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which Minnesota Eye Consultants participate, and the contractors and third party administrators of any of these parties, as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled, and I request payment of all such authorized benefits be made on my behalf, to Minnesota Eye Consultants for any services furnished by Minnesota Eye Consultants.

I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organization, including accountable care organizations, and their contractors and third party administrators, to share my medical records and information obtained from Minnesota Eye Consultants, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which Minnesota Eye Consultants participates, and the contractors and third party administrators of these parties, as needed for payment and health care operations.

For insurance and billing questions, please contact a patient account representative at (952) 567-6063.

Routine vs. Medical Coverage
Office visits may be categorized as either "routine" or "medical". A comprehensive "routine" vision exam may contain the same elements as a comprehensive "medical" eye exam. The type of eye exam you have is determined by the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. Routine vision exams typically produce diagnoses such as nearsightedness or astigmatism, while medical eye exams may produce diagnoses such as glaucoma or conjunctivitis. Please verify your routine and medical coverage with your insurance company.

Financial Responsibility
Minnesota Eye Consultants contracts with most major insurance plans; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. I understand that I am financially responsible and agree to pay any charges for care rendered to me not covered by my insurance plan or if I do not have active insurance coverage. I agree that for services rendered to me by Minnesota Eye Consultants, I will pay my account at the time of service or upon insurance claim processing.

If payment plan consideration is necessary, I understand that it is my responsibility to call and make financial agreements satisfactory to Minnesota Eye Consultants for payment.

Any benefits of any type under any policy of insurance or any other party liable to the patient, is hereby assigned to Minnesota Eye Consultants. If copayments and/or deductibles are assigned by my insurance company or health plan, I agree to pay them to Minnesota Eye Consultants. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

By signing below, you acknowledge that you have read and understand the above Patient Agreement.

(Signature of Patient/Authorized Representative)	(Date)
(Patient Name)	(Date of Birth)

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth**: _____

Vision Correction – Do you wear glasses? ☐ No ☐ Yes Do you wear contact lenses? ☐ No ☐ Yes

Reason(s) for Visit – In your own words, please describe the reason for your visit today:

_____

_____

Visual Function Questions – Please check if you are experiencing difficulty with any of the following:

No	Yes		No	Yes	
		Reading Small Print			**Watching Television**
		Reading Traffic or Street Signs			**Driving at Night**
		Driving in Bright Light			**Seeing Steps, Curbs or Stairs**
		Glare or Halo			**Floaters or Flashes**
		Dry, Red, Sandy or Itchy Feeling			**Other:**

Allergies – Please list all known medication (including intravenous contrast dye and anesthetics) and environmental (including seasonal, food and latex) allergies or indicate ☐ NO KNOWN ALLERGIES.

Allergy	Reaction	Allergy	Reaction

Current Medications – Please list all current prescribed medications (including eye drops and medical cannabis), over-the-counter medications, vitamins and supplements or indicate ☐ NO MEDICATIONS.

Name	Dosage	Frequency	Name	Dosage	Frequency

Review of Symptoms – Please check if you are experiencing any of the following:

N	Y	Constitutional	N	Y	Cardiovascular	N	Y	Endocrine	N	Y	Integumentary
		Fatigue			Chest Pain/Pressure			Cold Intolerance			Hives
		Fever			Irregular Heartbeat			Heat Intolerance			Rash

N	Y	HEENT	N	Y	Gastrointestinal	N	Y	Neurological	N	Y	Musculoskeletal
		Bulging Eyes			Abdominal Pain			Imbalance			Back Pain
		Hearing Loss			Constipation/Diarrhea			Headache			Joint Stiffness
		Sinus Problems			Nausea/Vomiting			Memory Difficulty			Muscle Weakness

N	Y	Respiratory	N	Y	Genitourinary	N	Y	Psychiatric	N	Y	Hematologic
		Asthma			Pain with Urination			Depressed Mood			Bleeding
		Cough			Blood in Urine			Irritability			Bruising
		Wheezing									Tender Lymph Nodes

Current Height: _____ **Current Weight**: _____

Past Ocular and Surgical History – Please check if you have received treatment (including eye drops and medical cannabis) or had surgery for any of the following conditions (note type):

No	Yes		No	Yes	
		Cataract:			**Cornea:**
		Glaucoma:			**LASIK:**
		Oculoplastic:			**Retina:**
		Other:			**Other:**

Personal and Family Health History – Please check if you or a family member have / have had any of the following or indicate ☐ NO RELEVANT PERSONAL HISTORY ☐ NO RELEVANT FAMILY HISTORY.

	Self	Mother	Father	Sister	Brother
Allergies					
Anxiety					
Auto-Immune Disorder (note type)					
Blindness					
Cancer (note type)					
Cataracts					
Corneal Disease					
Diabetes (note type)					
Depression					
Glaucoma					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Lazy Eye					
Macular Degeneration					
Migraines					
Retinal Disease					
Seizure Disorder					
Stroke					
Thyroid Disorder					
Other:					
Other:					

Females: Are you currently pregnant? ☐ No ☐ Yes Are you currently breastfeeding? ☐ No ☐ Yes

Social History

Have you ever used tobacco? ☐ No ☐ Yes - If yes: ☐ Former ☐ Current Every Day ☐ Current Some Day

Tobacco Product: ☐ Cigarette ☐ Cigar/Cigarillo ☐ Pipe ☐ Snuff/chew ☐ Smokeless ☐ Other: _____

Do you drink alcohol? ☐ No ☐ Former ☐ Yes - - If yes: ____ drinks per ☐ Day ☐ Week ☐ Month ☐ Year

Do you drink or consume caffeine? ☐ No ☐ Yes - - If yes: ☐ Coffee ☐ Energy Drinks ☐ Soda ☐ Tablets

Occupation: _____ Status: ☐ Full Time ☐ Part Time ☐ Retired / Other

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Insurance and Billing Information

As a courtesy, Minnesota Eye Consultants has compiled commonly requested insurance and billing information for your reference. If you have questions, contact a Patient Account Representative at (952) 567-6063.

Co-pays and payment for any non-covered services are due at the time of service.

Medicare
If you have Medicare, our office will bill Medicare and any secondary insurance. You are responsible for the following:

- Any deductibles and co-pays
- Up to 20% of allowed charges
- Routine eye examinations and refraction charges
- Payment of any service that does not meet Medicare guidelines for medical necessity
- Payment of any other non-covered service

Medicaid (Minnesota Only)
If you have Medicaid, you are required to present a current Medicaid card at every visit. You are responsible for the following:

- A $3.00 co-pay
- Payment of any non-covered service

Managed Care HMO & PPO Plans
If you have HMO or PPO coverage, you may be required to obtain an insurance referral for many of our services. It is your responsibility to obtain all insurance referrals before services are provided. You may obtain an insurance referral by calling the referral department of the clinic listed on your insurance card. If you fail to obtain an insurance referral and service coverage is denied, you are responsible for payment of the balance in full.

Commercial Plans
If you have a commercial plan, our office will bill your insurance. If payment from your insurance has not been received within 30 days, you are responsible for payment of the balance in full. You are also responsible for any deductibles and co-pays, and payment of any non-covered services.

Routine Vision Plans
Some employers offer separate vision benefit plans that cover routine eye examinations, often called “Carve Out” plans, which are different from your medical coverage. Minnesota Eye Consultants *DOES NOT* participate with the following plans:

- VSP (Vision Service Plan)
- EyeMed
- Spectera
- Cole Managed Vision
- Amerisight

If you have this type of vision plan, you will be responsible for payment of the balance in full. If you are scheduled for a routine eye examination, please review your vision benefits carefully. *This DOES NOT apply to LASIK or Refractive Evaluation services.*

Routine versus Medical Coverage
Coverage of routine eye examinations and refraction vary by insurance plan, and coverage may change from year to year. Please verify coverage before your appointment.

An appointment may be billed as a routine or medical visit depending on the reason for your visit, tests and/or procedures performed, and ocular pathology discovered during your visit. Generally, an examination may be billed as "routine" when a patient has no specific illness or injury, symptom or complaint that requires diagnosis and treatment.

A *refraction* is a test that is used to determine any optical defect present in the eye. A refraction is necessary for the following:

- A prescription for best corrective lenses
- A determination of the progression or diagnosis of certain ocular conditions
- A determination for the basis of your visual complaints

Minnesota Eye Consultants will submit any charge for refraction on your behalf to your insurance for determination of coverage. However, if you know that refraction is not covered, you may pay at the time of service and receive a 20% discount.

Billing Cycle
If your insurance information has been verified at the time of your appointment, you will not receive a billing statement until:

- Your insurance company has denied a claim
- Your insurance company has paid a claim, leaving co-insurance before deductible or a non-covered service
- Your insurance company has not responded to a claim

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Contact Lens Removal Policy
Refractive or Cataract Surgery Evaluations ONLY

The physicians and staff at Minnesota Eye Consultants want to make every effort to ensure you have the best visual outcome following any refractive or cataract procedure. Therefore, we ask that you adhere to the recommended clinical protocols for the removal of contact lenses in advance of your evaluation.

Wearing contact lenses, especially over a long period of time, may temporarily alter the shape of the front surface of the eye (the cornea). This alteration of shape may influence critical measurements taken in preparation for your procedure.

It is essential that contact lenses are removed, and your eyes allowed to "rest," for a period of time in advance of your appointment. *If contact lenses are worn during the recommended removal period, there is a strong possibility that the measurements and procedure will need to be rescheduled for a later date.*

Please Adhere to the Following Guidelines for Contact Lens Removal

For those who have not had an eye examination to take the following measurements:

- ☐ Toric lenses and hard contact lenses, including gas permeable, must be removed for a minimum of 3 weeks before a *refractive or cataract evaluation.*
- ☐ Soft contact lenses must be removed for a minimum of 2 weeks before a *refractive or cataract evaluation.*

For those who have had an evaluation and the necessary measurements taken by your primary eye care provider, but who have not been evaluated by Minnesota Eye Consultants:

- ☐ Toric lenses and hard contact lenses, including gas permeable, must be removed for a minimum of 3 weeks before the date of *refractive or cataract surgical procedure.*
- ☐ Soft contact lenses must be removed for a minimum of 2 weeks before the date of *refractive or cataract surgical procedure.*

If you have questions or concerns related to the contact lens removal guidelines, please contact a Patient Care Coordinator at (952) 888-5800.