



Welcome! We are very pleased you have chosen Price Vision Group for the care of your eyes.

Our office is at 9002 N. Meridian St, Ste 100, Indianapolis, Indiana 46260, in the Lakeview Medical buildings on the SE corner of the intersection of Meridian Street (North US Highway 31) and North 91st Street, less than one mile south of I-465 on Indianapolis' north side.

In preparation for your appointment, please note the following:

- **Plan on being with us for approximately 3-4 hours for your diagnostic evaluation and examinations by our doctors**, especially if we are scheduling surgery for you.
- **Bring a driver with you** as you may have your eyes dilated as part of your evaluation and should not drive with blurry vision.
- If you are coming for a **cataract** or **keratoconus** evaluation and wear contacts, you must stop wearing soft contacts 2 weeks before your appointment and stop wearing hard contacts 3 weeks before you are seen.
- **We ask that you pre-register for your visit by completing your registration forms on our online Patient Portal.**

If you have pre-registered online, please arrive **10 minutes** before your appointment time. If for any reason you did not pre-register through the portal, please arrive **30 minutes** before your appointment. If you are unable to keep your appointment we ask that you notify us at least 24 hours in advance by calling (317) 844-5530.

While on the Patient Portal, please review our **Financial Policy**. Highlights from this policy affecting your upcoming appointment:

- (1) Check with your health insurance and/or your primary care doctor to make sure the doctor you are seeing is an enrolled provider with your insurance and if you will need a referral authorization for this visit. Note that while standard Medicare Part B does not require a referral, some Medicare Advantage (replacement) plans or other Secondary plans may. **If you do need a referral authorization for your insurance to cover this visit, it is your responsibility to obtain this referral.** You may either bring it with you to the visit or have your doctor's office fax it to us at (317) 844-0882 at least 2 days before your appointment.
- (2) Our insurance contracts require that we collect any co-pays at the time of your visit. For your convenience, our practice accepts cash, personal checks, Mastercard, Visa, Discover Card, and American Express. If you have any questions about fees, insurance, or referral information, please call our office at (317) 844-5530, or toll free 800-317-EYES (3937) during normal business hours.

IN SUMMARY, BRING WITH YOU:

- Your current insurance card(s). Please bring your insurance cards to every visit. If we do not have your cards, we will not be able to bill your insurance and you will be responsible for the visit fees.
- A Driver's License or other Photo I.D. as for your protection we verify identity
- Any necessary referral forms or referral numbers if required by your insurance. Remember, unauthorized visits will not be covered by your insurance. Unauthorized, non-urgent visits will be rescheduled unless you are willing to pay in full at the time of service.

We look forward to your visit!



Price Vision Group

CORNEAL CONSULTANTS OF INDIANA, P.C., FINANCIAL POLICY

Whether you are new to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies. ***Please read this information carefully.*** You will be asked to sign an acknowledgement for this policy when you arrive for your appointment.

Registration. At each visit our receptionist will verify and update your name, address, phone, marital status, and insurance coverage and may periodically ask you to complete a new registration form with signature. **Please present your insurance cards at every visit so we may properly bill your insurance company. If you do not have your card with you, you may be required to make full payment that day.** We do not bill vision insurances for medical care. Because of federal laws designed to protect you from identity theft, we must also ask for **photo I.D.** such as Driver's License or other government-issued identification.

Insurance. Corneal Consultants of Indiana, P.C., d/b/a Price Vision Group, participates in traditional Medicare and many commercial insurance plans in the central Indiana area and cannot know the details of the coverage and benefits for your particular policy. Therefore, you will need to be familiar with your policy and know what is required to access medical care. Your insurance may have one or more of the following requirements:

- Referral from your primary care physician ("PCP") authorizing your visit with our doctor, done either by a specific form or by a tracking number assigned to your visit. (If your insurance card has a physician's name on it, it usually means that physician must authorize your care by a specialist.) *Note that if you were referred to us by another eye care professional, that may not meet your insurance plan's requirement for a referral authorization from your PCP.* If your insurance policy requires this referral, **it is your responsibility to make sure we have authorization prior to being seen by our doctor. Unless you have a medical emergency, if we do not have a referral authorization for your visit and you are unable to obtain one, the visit will be rescheduled.** While this may seem harsh, it is for your protection as much as ours, as some insurance plans will not pay for any tests or treatment that result from an unauthorized initial visit. Note that if you have a secondary insurance company, or are covered by a Medicare Advantage Plan through a commercial insurer which replaces traditional Medicare Part B coverage, please consider whether that insurance company may require prior referral authorization. If they do, and none has been obtained, they will deny payment and you will be responsible for the amounts they might have otherwise paid on your behalf. If you are unsure of what you need, call the number on your insurance card or your PCP before your visit.
- Co-pay that must be paid each visit
- Annual deductibles that apply. Note a separate deductible may apply for out-of-network services.
- Specific facilities that must be utilized for hospitalization, diagnostic, or surgical services to obtain the most favorable reimbursement. An HMO may not have any out-of-network benefits. Please note that most of the surgical services we offer will be provided either in the Laser Eye Center that is a part of Corneal Consultants of Indiana, P.C. (d/b/a the Price Vision Group) or at a separate and distinct ambulatory surgery facility, the Central Indiana Surgery Center. The CISC exclusively performs ophthalmology surgeries and our surgeons believe their experience in, and dedication to, the types of sophisticated procedures we perform provides our patients with an optimal experience and outcome. The CISC is contracted with many insurance plans but if you are scheduled for surgery there, you will need to check with your insurance company to determine whether they are in-network and if not, contact the CISC billing office (317-848-1763) to discuss your financial responsibility to them.

(Continued on next page)

Patient responsibility balances. You will be responsible for

- Co-pays (will be collected at check-in) and balances remaining after your insurance company has paid, including deductibles and co-insurance (percentage of the allowed amount that is your obligation).
- Self-Pay, Services not covered by insurance, and Large deductibles. If you do not have medical insurance, your insurance does not cover some or all of our services, or we are not contracted with your insurance plan, you will be expected to pay at the time of service, or, in some instances, prior to service. Similarly, if you have a large deductible on your insurance policy, we may require a prepayment towards the cost of certain surgical procedures. We are familiar with the payable diagnoses for our highly specialized office testing. You may be informed your insurance will not pay for a diagnostic test our physician feels is necessary to formulate your treatment plan. Should you wish to proceed with this particular diagnostic procedure, you will be given the cost and asked to sign a Waiver acknowledging you understand you are responsible for paying the cost of the test the day of the visit.
- If after speaking with your insurance company you still have unanswered financial questions, our insurance coordinators will be happy to help you plan to meet the costs of your care. Please call (317) 814-2815, or toll free at 800-317-3937 ext. 2815. Note that we are able only to give rough estimates of costs for any surgical services prior to your medical evaluation in our office.

Payment methods. For your convenience, in addition to cash or personal check, we also accept VISA, MasterCard, Discover, and American Express cards. Please be aware that checks returned for insufficient funds will result in a \$25.00 fee being added to your account; if returned a second time it may be referred for collection. For amounts over \$1,000, you may elect to apply for CareCredit, an outside financial program for medical services with options for both short-term interest-free and longer-term extended payment plans.

Disability and FMLA forms. There is also a \$15.00 charge for completing Disability insurance forms or FMLA paperwork. Payment should be presented with the form.

Medical Care to Minors. If both parents have insurance covering a minor, the insurance of the parent whose birthday falls first in the calendar year will be considered primary for the child, and the other parent's insurance will be secondary. When the parents are divorced, we will consider the parent/legal guardian who presents a child for care to be the responsible party for payment of services, regardless of financial responsibility established in a divorce decree. Further, care for a patient under 18 years of age must be authorized by a parent, legal guardian, or someone to whom you give written authorization to present the child for care.

Acknowledgement and Authorization. I have read, understand, and agree to the above policies. Regardless of any insurance I may have, I am ultimately responsible for payment for any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Corneal Consultants of Indiana, P.C., d/b/a Price Vision Group. If my account should become delinquent, I agree to pay the costs of collection, including legal fees and court costs.

Signature _____
Patient, or Guarantor if patient is a minor

Date _____

Patient Name (printed) _____

Date of Birth _____

PRICE VISION GROUP PATIENT REGISTRATION

Please print in black ink and either complete each field or mark N/A if it does not apply to you.

PATIENT INFORMATION:

Date completed

Patient's Last Name:			Social Security No.:		
First Name & Middle Initial:			Occupation: <input type="checkbox"/> Retired		
Goes by:					
Address:			Employer: <input type="checkbox"/> N/A		
City:	State:	Zip:	Employer Address:		
Date of Birth:	Age:	Sex: M F	Employer City:		State: Zip:
Home Phone: ()	Cell Phone: ()	Work Phone: ()		Ext.	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			E-mail address:		
How did you hear about us? Check all that apply: <input type="checkbox"/> Eye Dr <input type="checkbox"/> Family Dr <input type="checkbox"/> Insur Co <input type="checkbox"/> Family/Friend <input type="checkbox"/> Internet Search <input type="checkbox"/> Website <input type="checkbox"/> Facebook <input type="checkbox"/> Other					
Referring Eye Care Dr:			Family Dr / Internist:		
Ref Eye Dr Address:			Fam / Int Dr Address:		
Ref Eye Dr City/State/Zip:			Fam / Int Dr City/State/Zip		
Ref Eye Dr. Phone: ()	Ref Eye Dr. Fax: ()	Fam / Int Dr. Phone: ()		Fam / Int Dr. Fax: ()	

RESPONSIBLE PARTY, IF OTHER THAN PATIENT (For minors, complete for parent or legal guardian):

Name:			Relationship to Patient:		
Address:			Social Security No.:		Date of Birth:
City:	State:	Zip:	Employer:		
Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell ()			Address:		
Work Phone: ()	Ext.		City:		State: Zip:

EMERGENCY CONTACT:

Name:		Relationship:	Home phone: ()	Cell phone: ()
Address:		City/State/Zip:		

Patient's Last Name:	Date of Birth:
PRIMARY INSURANCE:	SECONDARY INSURANCE:
Insur Name:	Insur Name:
Claims Address:	Claims Address:
City: State: Zip:	City: State: Zip:
Policy Holder's Name: <input type="checkbox"/> Retired	Policy Holder's Name: <input type="checkbox"/> Retired
Policy Holder's Birthdate: Sex: M F	Policy Holder's Birthdate: Sex: M F
Policy Holder Certificate/ID No:	Policy Holder Certificate/ID No:
Group or Policy No.:	Group or Policy No.:
Patient's Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Patient's Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

AUTHORIZATION & ASSIGNMENT:

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid or any other insurance company with which my/my dependent's care is covered any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Corneal Consultants of Indiana, P.C. (d/b/a Price Vision Group), for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, non-covered services, and services obtained without prior authorization from my insurance when required. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees. By providing a cell phone number, I consent to receive calls and/or text messages, including those made by pre-recorded, artificial voice or automatic telephone devices from the office and its' affiliates including collection agencies. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Patient/Legal Representative Signature: _____ Date: _____

PHARMACY AND PRESCRIPTION BENEFITS INFORMATION

Should the doctor decide to prescribe a medication, we are able to transmit prescriptions directly to your pharmacy so your medication can be ready for you upon arrival. Please provide the name and address of the pharmacy to which you would wish to have your prescriptions sent. You may also provide information on an alternate pharmacy, in case you have one close to home and another close to your work. At the time a prescription is issued, we will verify with you the pharmacy to which you want the prescription sent but having the information in our system will speed up the process of getting your prescription on its way.

PREFERRED PHARMACY:	ALTERNATE PHARMACY:
Name:	Name:
Address:	Address:
City: State: Zip::	City: State: Zip::
Phone: () Fax: ()	Phone: () Fax: ()

You may have a separate identification card for your prescription drug benefits. **If this information is on the insurance identification cards you are presenting at registration, you may skip this section.**

PRESCRIPTION DRUG BENEFITS – 30 day supply

MAIL ORDER – 90 day supply

Rx Insur Plan:	Mail Order Rx Insur Plan:
Claims Address:	Claims Address:
City: State: Zip:	City: State: Zip:
Rx Group No.	Rx Group No.
Patient's Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Patient's Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

PRICE VISION GROUP - HEALTH HISTORY DATA SHEET

NAME: _____ **Date of Birth** _____

Have you been out of the country in the last year? Yes____ No____

If yes, please list location:_____

CIRCLE YES OR NO TO EACH OF THE FOLLOWING:

SKIN

- Y N ECZEMA
- Y N RASHES IN LAST 6 MOS.
LOCATION:_____
- Y N ULCERS(LEGS)

GASTROINTESTINAL

- Y N HERNIA
- Y N STOMACH TROUBLE
- Y N ULCERS (STOMACH)
- Y N ULCERS (DUODENAL)

ENDOCRINE

- Y N AUTOIMMUNE DISEASE
- Y N CANCER-TUMORS
- Y N DIABETES
- Y N DIVERTICULOSIS
- Y N GOUT
- Y N LIVER DISEASE
- Y N PANCREATITIS
- Y N THYROID DISEASE
- Y N UNEXPLAINED WEIGHT
LOSS / GAIN

EYES

- Y N EYE DISEASE
- Y N GLAUCOMA

GENITOURINARY

- Y N HEMORRHOIDS
- Y N KIDNEY DISEASE
- Y N VENEREAL DISEASE

RESPIRATORY

- Y N ALLERGIES
- Y N ASTHMA
- Y N BRONCHITIS
- Y N EMPHYSEMA
- Y N TUBERCULOSIS

MUSCULOSKELETAL

- Y N LUPUS
- Y N RHEUMATOID ARTHRITIS
- Y N SWOLLEN / RED JOINTS

HEMATO-IMMUNOLOGIC

- Y N EXPOSURE TO AIDS
- Y N POSITIVE HIV
- Y N CHICKEN POX
- Y N HEPATITIS
- Y N MALARIA
- Y N MEASLES
- Y N MUMPS
- Y N MONONUCLEOSIS
- Y N RHEUMATIC FEVER
- Y N BLEEDING TENDENCIES
- Y N EXPOSURE TO MRSA
- Y N EXPOSURE TO MRSE

CARDIOVASCULAR*

- Y N HEART DISEASE
- Y N STROKE
- Y N HIGH BLOOD PRESSURE

NEUROLOGICAL

- Y N CHRONIC HEADACHES
- Y N EPILEPSY
- Y N NEURITIS

*Cardiologist:_____

Phone:_____-_____-_____

LIST OTHER ILLNESSES

PSYCHIATRIC

- Y N NERVOUS BREAKDOWN

OPERATIONS - TYPE / FRACTURES

MONTH-YEAR

NAME OF HOSPITAL

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: CHECK BELOW IF YOU'RE ALLERGIC

IMMUNIZATIONS YEARS

- _____PENICILLIN OTHERS: _____
- _____SULFA _____
- _____CODEINE _____
- _____DEMEROL _____
- _____ASPIRIN _____
- _____MORPHINE _____
- _____LATEX _____

- _____FLU _____
- _____MEASLES _____
- _____MUMPS _____
- _____POLIO _____
- _____SMALLPOX _____
- _____TETANUS _____
- _____TYPHOID _____

NAME: _____

Date of Birth: _____

PAGE 2 - FAMILY HISTORY DATA SHEET

CHECK BELOW IF ANY OF THE CONDITIONS HAVE OCCURRED ON EITHER SIDE OF PATIENTS FAMILY

- | | | |
|---|---|--|
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> CONGENITAL DEFORMITIES | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> BONE DISEASE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> GASTROINTESTINAL DISEASE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CANCER OR TUMORS | <input type="checkbox"/> MENTAL DISEASE | <input type="checkbox"/> BLEEDING TENDENCIES |
| <input type="checkbox"/> CARDIOVASCULAR DISEASE | <input type="checkbox"/> PULMONARY DISEASE | |

LIST OTHER ILLNESSES

FAMILY	HEALTH STATUS				KNOWN ILLNESSES	AGE OF DEATH	IF DECEASED
	AGE	GOOD	FAIR	POOR			CAUSE OF DEATH
FATHER							
MOTHER							
BROTHERS							
SISTERS							
SPOUSE							
SONS							
DAUGHTERS							

HAVE YOU EVER TAKEN CORTISONE? **Y N**

When? MONTH _____ YEAR _____ MONTH _____ YEAR _____ MONTH _____ YEAR _____

ARE YOU TAKING ANY MEDICATIONS NOW ?
N Y - PLEASE LIST:

MEDICATION	DATE STARTED	DIRECTIONS & DOSAGE

ADDITIONAL HISTORY CONSIDERED PERTINENT BY PHYSICIAN:

PATIENT'S SIGNATURE: _____

PHYSICIAN'S SIGNATURE: _____

Date _____

Date _____