CORNEAL CONSULTANTS OF INDIANA®

Price Vision Group
www.pricevisiongroup.com

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

- Failure to arrive for an appointment, or failure to cancel an appointment within one business day, may result in a failed appointment fee of $75.00. The fee may be charged for each occurrence of a failed appointment. These fees are not covered by insurance and are your responsibility.
- 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 ____ Date______________________

Patient, or Guarantor if patient is a minor

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: Goes by:	Occupation: ❒ Retired
Address:	Employer: ❒ 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: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced	E-mail address:
How did you hear about us? Check all that apply: ☐ Eye Dr ☐ Family Dr ☐ Insur Co ☐ Family/Friend ☐ Internet Search ☐ Website ☐ Facebook ☐ 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: ☐ Home ☐ Cell ( )	Address:
Work Phone: ( ) Ext.	City: State: Zip:

EMERGENCY CONTACT:

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

rev 06-17

CONTINUED ON NEXT PAGE

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: ❒ Retired	Policy Holder's Name: ❒ 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: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's Relationship: ☐ Self ☐ Spouse ☐ Child ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's Relationship: ☐ Self ☐ Spouse ☐ Child ☐ 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)

EYES
- **Y N** EYE DISEASE
- **Y N** GLAUCOMA

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

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

*Cardiologist:____________________
Phone:______-______-___________

PSYCHIATRIC
- **Y N** NERVOUS BREAKDOWN

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

GENITOURINARY
- **Y N** HEMORRHOIDS
- **Y N** KIDNEY DISEASE
- **Y N** VENEREAL DISEASE

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

NEUROLOGICAL
- **Y N** CHRONIC HEADACHES
- **Y N** EPILEPSY
- **Y N** NEURITIS

LIST OTHER ILLNESSES
____
____
____
____

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

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

OPERATIONS - TYPE / FRACTURES	MONTH-YEAR	NAME OF HOSPITAL

ALLERGIES: CHECK BELOW IF YOU'RE ALLERGIC

______PENICILLIN
______SULFA
______CODEINE
______DEMEROL
______ASPIRIN
______MORPHINE
______LATEX

OTHERS:
____
____
____
____
____

IMMUNIZATIONS	YEARS
_______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

____ALLERGIES
____BONE DISEASE
____BLOOD DISEASE
____CANCER OR TUMORS
____CARDIOVASCULAR DISEASE
____CONGENITAL DEFORMITIES
____DIABETES
____GASTROINTESTINAL DISEASE
____MENTAL DISEASE
____PULMONARY DISEASE
____KIDNEY DISEASE
____THYROID DISEASE
____TUBERCULOSIS
____BLEEDING TENDENCIES

LIST OTHER ILLNESSES

____

____

	HEALTH STATUS					IF DECEASED	
FAMILY	**AGE**	**GOOD**	**FAIR**	**POOR**	**KNOWN ILLNESSES**	**AGE OF DEATH**	**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_____________________