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: ☐ Bridal Expo ☐ Health Fair @ work ☐ Healthcare provider referral ☐ Family/Friend/Employee ☐ IERC Expo ☐ Rouff concert ☐ Facebook ☐ Instagram ☐Twitter ☐ LinkedIn ☐YouTube ☐WISH-TV8 ☐ Website ☐ Other _____	
Referring Eye Care Dr:	Family Dr / Internist:
Ref Eye Dr Address:	Family / Internist Dr Address:
Ref Eye Dr City/State/Zip:	Family / Internist Dr City/State/Zip
Ref Eye Dr. Phone: ( ) Ref Eye Dr. Fax: ( )	Fam / Internist Dr. Phone: ( ) Fam / Internist 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:

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.:	Employer:	Group or Policy No.:	Employer:
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

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—front and back sides—sign on the reverse, and turn in to the receptionist***. We will be happy to give you another copy to keep for your reference.

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 treatments 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 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 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 all office visits at the time of service and all procedures need to be paid at scheduling or 7-10 days prior to the date of 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 are 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 coordinator will be happy to help you plan to meet the costs of your care. Please call her at (317) 814-2852, or toll free at 800-317-3937 ext 2852. If you reach her confidential voicemail, please leave your name, phone number(s), and appointment date as well as your question. Note that we are unable to estimate costs for any surgical services prior to your medical evaluation in our office.

- If patient is referred for a cataract eval and has had previous LASIK elsewhere there will be a $500 charge for additional testing that is the responsibility of the patient as it is non billable to insurance.

- 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 occurence of a failed appointment. These fees are not covered by insurance and are your responsbility.

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 $35.00 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_____

Corneal Consultants of Indiana

Acknowledgment

I hereby acknowledge that Corneal Consultants of Indiana has made available a copy of their Notice of Privacy Practices on their website at pricevisiongroup.com.

_____ _____

Patient or Patient's Representative **Date**

_____

Representative's Relationship to Patient

Patient refused to sign:

_____ _____

Employee **Date**

Price Vision Group- Health History Data Sheet

Name: _____ Date of Birth: _____

Have you ever been exposed to MRSA? Yes or no, if yes, when was it and who had it

_____

Have you ever had MRSA? If **yes**, **when** _____

Recent travel out of the country, when and where? _____

Do you require mobility assistance such as a wheelchair or walker? Yes or No. Can you transfer? Yes or No

What is your primary language? _____

Circle Yes or No to EACH of the following as they apply to your history, please don't leave blank:

SKIN:
- Y N Eczema
- Y N Rashes in the last 6 months
  - Location:_____
- Y N Shingles
- Y N Skin Cancer
- Y N Ulcers (legs)

EARS:
- Y N Hard of hearing
- Y N Hearing aide(s)

EYES:
- Y N Glaucoma
- Y N Macular Degeneration
- Y N Fuchs Dystrophy
- Y N Retinal Detachment
- Y N Keratoconus
- Y N Cataracts

PSYCHIATRIC:
- Y N Anxiety
- Y N Depression
- Y N ADHD

Other: _____

RESPIRATORY:
- Y N Allergies
- Y N Asthma
- Y N Bronchitis
- Y N COPD
- Y N Emphysema
- Y N Sleep apnea
  - C-pap machine_____
- Y N Tuberculosis
- Y N Pneumonia

GASTROINTESTINAL:
- Y N Diverticulosis
- Y N Hernia
- Y N Stomach trouble
- Y N Ulcers (stomach or duodenal)
- Y N Heartburn/Reflux

CARDIOVASCULAR:
- Y N Heart disease
  - Specify:_____
- Y N Stroke/TIA
- Y N Heart Attack
- Y N High Blood Pressure
- Y N High Cholesterol
- Y N Pacemaker

GENITOURINARY:
- Y N Hemorrhoids
- Y N Kidney Disease
- Y N Kidney Stones
- Y N Syphilis (past or present)
- Y N Other STD/ Venereal Disease

MUSCULOSKELETAL:
- Y N Arthritis/ rheumatoid arthritis
- Y N Lupus
- Y N Osteoporosis
- Y N Neuropathy
- Y N Difficulty walking

NEUROLOGICAL:
- Y N Chronic headaches/migraines
- Y N Epilepsy
- Y N Alzheimers/Dementia
- Y N Tremors
- Y N Neuritis
- Y N Neurodevelopment Disorder _____

ENDOCRINE/OTHER:

Y N Autoimmune disease
Specify:_____
Y N Cancer or tumors
Specify:_____
Y N Diabetes- type 1 or type 2
Last A1c & blood sugar w/ date:_____
Y N Gout
Y N Liver disease
Y N Pancreatitis
Y N Thyroid disease
Y N Weight loss/gain

HEMATO-IMMUNOLOGIC:

Y N Exposure to AIDS
Y N HIV positive
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 Lyme disease
Y N COVID

List other illnesses:

_____
_____

Eye Surgery/Operation:	**Month & Year**	**Name of Surgeon or Hospital**
R or L _____	_____	_____
R or L _____	_____	_____
R or L _____	_____	_____

Other surgeries/operations:

_____
_____

Do you currently or have you ever worn glasses or contacts? Please specify

_____

Current providers: primary care, cardiologists, neurologists, ophthalmologist/optometrists, ETC.

Name:	**Speciality:**	**Phone Number:**	**Last Seen:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Last Vision Exam:

When: _____ Where/Who with: _____

Any alcohol consumption: _____ How often: _____
Any tobacco use currently or formerly? If currently, then how often _____
Current Occupation, Unemployed, Disabled or Retired? _____
Any drug use: _____

Immunizations: Give most recent year

Flu:_____ COVID:_____ Pneumonia:_____ Shingles:_____

Allergies w/ reaction:

Penicillin _____	Demerol _____	LATEX _____
Sulfa _____	Aspirin _____	Other: _____
Codeine _____	Morphine _____	_____

Have you ever taken Flomax? Yes or No, if yes, when? _____

Family History- Eye conditions and medical conditions

Family:	Living or deceased	Cause of death	Eye Conditions	Systemic Illnesses
Father				
Mother				
Sister				
Brother				
Son				
Daughter				
Aunt/Uncle				
Grandparent				

Please list below: please let us know if you are providing a list (circle yes or no if list is attached) YES NO

Are you using any prescribed or over the counter eye drops? Yes or No?

Name:	Dosage/Strength:	Directions:	AM or PM

Are you taking any prescribed medications? Yes or No?

Name:	Dosage/Strength:	Directions:	AM or PM

Are you taking any over the counter medications/supplements/vitamins? Yes or No?

Name:	Dosage/Strength:	Directions:	AM or PM:

Visual Disability Inventory
Price Vision Group
9002 N Meridian St. Suite 100

Right Eye **Left Eye**

Patient Name _____ MRN _____

1. My vision decreases my quality of life and I need improved eyesight?	☐ **Yes** ☐ **No**

Do you have difficulty, even with glasses, with the following activities?

2. Reading Small print such as labels on medicine bottles, a telephone book or food labels?	**If yes, how much difficulty do you currently have?**
☐ **Yes** ☐ **No** ☐ **N/A**	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
3. Reading a newspaper or book?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
☐ **Yes** ☐ **No** ☐ **N/A**	
4. Seeing steps, stairs or curbs?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
☐ **Yes** ☐ **No** ☐ **N/A**	
5. Reading traffic, street or store signs?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
☐ **Yes** ☐ **No** ☐ **N/A**	
6. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
☐ **Yes** ☐ **No** ☐ **N/A**	
7. Writing checks or filling out forms?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
☐ **Yes** ☐ **No** ☐ **N/A**	
8. Playing games such as bingo, dominos, card games or mahjong?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
☐ **Yes** ☐ **No** ☐ **N/A**	
9. Watching television?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
☐ **Yes** ☐ **No** ☐ **N/A**	

Do you have any of the following problems?

10. Double vision?	☐ **Yes**	☐ **No**
11. See different image sizes from each eye?	☐ **Yes**	☐ **No**
12. Daytime glare from sun while driving?	☐ **Yes**	☐ **No**
13. Nighttime glare from from lights while driving?	☐ **Yes**	☐ **No**

Signature _____ Date _____

Corneal Consultants of Indiana, P.C., d/b/a Price Vision Group
9002 N. Meridian St, #100 · Indianapolis, IN 46260
Phone: (317) 844-5530 · Fax: (317) 844-5590

EMAIL COMMUNICATION CONSENT FORM

PATIENT:

_____ _____
Name of Patient/Previous Names Birth Date

_____ _____
Street Address City, State, Zip Code Current Email Address

For the ease of our patients, our office would like to offer the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with the practice via email without understanding and accepting these risks. This consent authorizes Price Vision Group and its affiliated health care providers (all referenced here as "PVG") to communicate with me using open internet email channels. The specific email address that I am currently using is noted above. However, this consent allows PVG to communicate with me using any email address that I provide to PVG, and/or any email address that I send communications to PVG.

I authorize PVG to notify me of appointments by email appointment reminders. In addition, I authorize PVG to share information about its programs and services offered in the community, including programs or services specific to me, using email communications. I may also receive patient surveys, promotional offers or information about PVG charities and fundraising programs.

I understand that I can "opt out" of the use of email as a means of communication by sending an email to PVG at pvgclinic@pricevisiongroup.net or by calling (800)317-3937. I understand that some messages already scheduled for delivery may be sent after I opt out, and I authorize PVG up to ten business days to fully process my opt-out request.

The risks include, but are not limited to, the following:
- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient read the email.
- Emails can introduce viruses, generally damage, or disrupt the computer.
- Email can be used as evidence in court.

Conditions of using email
Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however; we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, and communication. Consent to use email includes agreement with the following conditions:
- Emails to or from the patient concerning treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access the medical record/email (e.g. billing staff).
- Our office may forward emails internally to those involved, as necessary, for healthcare operations and other handling. Our employees will not forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although our office will endeavor to read and respond promptly to all emails from the patient, it is not guarantee that any particular email will be read and responded to within any particular period of time. The patient should not use email for medical emergencies or other time- sensitive matters.
- If the patient's email invites a response from the provider and a response is not received within a reasonable time period, it is the patient's responsibility to follow up.

I have read and understand the risks of using email and agree that email messages may include protected health information about me or the patient named below (if I am signing as the patient's representative).

PATIENT SIGNATURE: _____ DATE: _____
(If signed by other than patient, state relationship and authority to do so.)

PVGEMAILRELEASE Rev 8.12.2024

CORNEAL
CONSULTANTS
OF INDIANA

Price Vision Group

www.pricevisiongroup.com

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

- ☐ Appointment Date / Times
- ☐ Diagnosis Exam Results
- ☐ Medications
- ☐ Lab Test / Results
- ☐ Summary of Medical Record
- ☐ Care Plan
- ☐ Other (specify): _____

Indicate Confidential Information

- ☐ Mental Health
- ☐ HIV Information
- ☐ Alcohol / Drug Information

Patient Name: _____ Date of Birth _____/_____/_____

Information to be given to: Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (PLEASE CHECK ONE):

_____ (specify expiration date or event)

NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Price Vision Group the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature:_____ Date: _____

Relationship to Patient (if signed by person representative of patient): _____