Longmeadow Optical, LTD

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Welcome To Our Office / Patient Information

Name:_____ _____ _____
Last **First** **MI**
MailingAddress:_____**City:**_____
State:_____ **Zip Code:** _____ **Email Address:** _____
Home Phone: _____ **Work Phone:** _____ **Cell:** _____
Date of Birth: _____ **SSN:** _____ **Age:** _____ **Ethnicity:** _____
Employer: _____ **Occupation:** _____

How were you referred to us: _____

Longmeadow Optical participates in a number of insurance plans, and we will be happy to submit your claim to companies which we are a contracted, in network provider. Billing to Out-of Network and Secondary Insurances are the responsibility of the patient, and you are expected to pay any outstanding balances not paid or not billable to your Primary In-Network insurance.

Some insurances do not cover the entire costs of some procedures. They may apply an amount to your annual deductible or may deny a claim. While we do what we can to make you aware of and collect costs upfront, patients are billed and expected to pay any amounts not covered by insurances, including deductibles, copays, and charges exceeding a given allowance.

If you have insurance that you would like us to bill, please provide the staff with a copy of your insurance cards or supply the information below:

Medical Insurance: _____ **Identification#:** _____ **Group#:** _____
Subscriber Name: _____ **Relationship: Self / Spouse / Child / Other Dependent**
Subscriber's Date of Birth: _____ **Subscriber's SSN:** _____

Vision Insurance: _____ **Identification#:** _____ **Group#:** _____
Subscriber Name: _____ **Relationship: Self / Spouse / Child / Other Dependent**
Subscriber's Date of Birth: _____ **Subscriber's SSN:** _____

At Longmeadow Optical, we are also happy to supply you with glasses and contact lenses. As with medical claims, we will submit claims to your insurance companies for material costs. Any amounts not covered are the patient responsibility. We require a 50% deposit upfront on the patient balance for all glasses orders. Glasses must be picked up within 90 days of completion or the deposit will be forfeited. It is the responsibility of the patient to provide us with up-to-date contact information.

Any balances owed for medical or material charges must be paid within six months. Outstanding balances will then be turned over to collections. You will be responsible for collection costs and/or attorney fees.

Return Policy and Exchanges

Our staff at Longmeadow Optical are here to make the most of your eyeglass experience. Your satisfaction is guaranteed. If, for any reason, you are dissatisfied with your order, please stop in to see one of our Opticians. We will make sure the order is made accurately to your prescription. If necessary, an Rx Check will be scheduled with your doctor. (If you see a doctor outside of our practice, you should set up an appointment to see him or her.)

You have 90 days from date of pick up to make any exchange at full retail value. After the 90 days, additional charges or decreased exchange value will be assessed. Returns without exchange will be offered after a customary restocking fee and will only be for office credit to be used towards medical copays, deductibles, or future orders.

If you have any questions, please bring them up with our front office on the date of service.

Signature: _____ **Date:** _____
(under 18, must be signed by a parent or legal guardian)

LONGMEADOW OPTICAL
7420 HAYWARD RD SUITE 202
FREDERICK, MD 21702

Communication Authorization

PATIENT NAME_____DATE OF BIRTH_____

I, _____ GIVE LONGMEADOW OPTICAL PERMISSION TO DISCUSS THE FOLLOWING:

____ DIAGNOSIS, PROGNOSIS, AND TREATMENT INFORMATION
____TEST RESULTS
____SCHEDULING INFORMATION
____NOTICE OF GLASSES OR CONTACT LENS ORDERS RECEIVED
____BILLING INFORMATION
____OTHER (PLEASE SPECIFY)_____

WITH THE FOLLOWING PEOPLE:
_____RELATIONSHIP_____PHONE #:_____

_____RELATIONSHIP_____PHONE #:_____

I ALSO AUTHORIZE LONGMEADOW OPTICAL TO:

____LEAVE MESSAGES ON MY HOME ANSWERING MACHINE
____LEAVE MESSAGES ON MY CELL PHONE
____LEAVE MESSAGES ON MY WORK ANSWERING MACHINE/VOICEMAIL
____LEAVE MESSAGES WITH MY FAMILY MEMBERS OR OTHERS RESIDING IN MY HOUSEHOLD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION/HIPPA

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU CONSENT TO OUR USING AND DISCLOSING YOUR PROTECTED HEALTH INFORMATION IN ORDER TO TREAT YOU, TO COLLECT PAYMENT, AND TO CARE FOR YOUR HEALTH.

NOTICE OF PRIVACY PRACTICES: A COPY OF OUR NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO YOU AT OUR OFFICE AS WELL AS ON THE WEB AT WWW.LONGMEADOWOPTICAL.COM. UPON SIGNING THIS CONSENT, YOU ARE ACKNOWLEDGING THAT YOU HAVE CAREFULLY READ OUR NOTICE OF PRIVACY PRACTICES.
IF OUR PRIVACY POLICY IS REVISED, WE WILL ASK YOU TO ACKNOWLEDGE THE UPDATES AND TO SIGN THIS CONSENT AGAIN.

CHANGING YOUR PERMISSIONS: YOU ARE RESPONSIBLE TO FILE A NEW COMMUNICATION AUTHORIZATION IN THE EVENT YOUR HOUSEHOLD SITUATION CHANGES AND/OR YOUR DESIRED PERMISSION CHANGES.

RIGHT TO REVOKE: YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. TO DO SO, GIVE WRITTEN NOTICE OF YOUR REVOCATION TO OUR OFFICE AT THE ADDRESS LISTED ABOVE. IF REVOCATION WILL INTERFERE WITH YOUR TREATMENT IN ANY WAY, WE MAY DECLINE TO SEE YOU FOR FURTHER TREATMENT.

PATIENT/PARENT/GUARDIAN'S SIGNATURE_____DATE_____

LONGMEADOW OPTICAL, LTD.

PATIENT NAME:_____BIRTHDATE_____ GENERAL MEDICAL HISTORY:
CHECK ALL THAT APPLY

NAME OF MEDICAL DOCTOR:_____

DIABETES (WHEN DIAGNOSED_____)	____	ASTHMA	____
HIGH BLOOD PRESSURE	____	EMPHYSEMA	____
HEART DISEASE	____	MIGRAINES	____
CAROTID ARTERY DISEASE	____	CANCER	____
THYROID: HYPO OR HYPER?	____	LUPUS	____
IRRITABLE BOWEL SYNDROME	____	HIV+	____
ARTHRITIS: RHEUMATOID OR OSTEO?	____	SINUS	____
BLEEDING DISORDER	____	HEPATITIS	____
HIGH CHOLESTEROL	____	PREGNANT	____
KIDNEY DISEASE	____	LYME DISEASE	____
ACNE ROSACEA	____	DEPRESSION	____
SJOGREN'S SYNDROME	____	ANXIETY	____
MULTIPLE SCLEROSIS	____		

OTHER CONDITIONS NOT MENTIONED: _____
_____

LIST ANY OPERATIONS AND HOSPITALIZATIONS WITH APPROXIMATE DATES: _____
_____

MEDICATIONS: (INCLUDE PRESCRIPTION MEDICINES, EYE DROPS, VITAMINS, HERBALS, AND OVER THE COUNTER MEDICINES) _____
_____
_____

ALLERGIES TO:

MEDICATIONS	YES	NO	_____
EYE DROPS	YES	NO	_____
OTHER (ENVIRONMENTAL)	YES	NO	_____

EYE HISTORY: (CHECK ALL THAT APPLY)

GLAUCOMA	____	CATARACTS	____
LAZY EYE	____	AMBLYOPIA	____
RETINAL DISEASE	____	RETINAL DETACHMENT	____
ALLERGIES	____	DRY EYE	____

DATE OF LAST EXAM: _____

DO YOU WEAR GLASSES?	YES	NO (FOR DISTANCE, NEAR, OR BOTH?)_____
DO YOU WEAR CONTACT LENSES?	YES	NO (SOFT OR RIGID GAS PERMEABLE?)_____

LIST ALL PAST EYE INJURIES AND EYE SURGERIES WITH APPROXIMATE DATES:
_____
_____

FAMILY HISTORY:	RELATION TO PATIENT (LIST ANY OTHER EYE OR MEDICAL CONDITIONS IN YOUR FAMILY)		
GLAUCOMA	YES	NO	_____ _____
MACULAR DEGENERATION	YES	NO	_____ _____
RETINAL DETACHMENT	YES	NO	_____ _____
BLINDNESS	YES	NO	_____ _____

SOCIAL HISTORY:

SMOKE?	NEVER	FORMER, QUIT _____ YEARS AGO	CURRENT (HOW MUCH) _____
DRINK ALCOHOL?	NEVER	<1 DRINK/DAY	>1 DRINK/DAY (HOW MUCH)_____

PATIENT'S SIGNATURE_____DATE_____

Important Information on the Coding and Billing of your Comprehensive Eye Exam

Thank you for coming to Longmeadow Optical for your eye exam! The Eye Care/Medical Industry is under the regulation of numerous and often-changing laws dictating the coding and reporting of each visit. The purpose of these laws is to ensure visits are of high quality. While we pride ourselves in meeting all of these quality control measures, it also means we have to be very specific with the nature of each visit and code that visit specifically and accurately.

Though you may have come in today for a "routine eye exam," if something is discovered and/or addressed in your exam, the exam may turn into a medical visit and thus be coded accordingly. Below is how a typical eye exam works.

Patient undergoes an eye exam, which includes:
- A health, medication and vision history
- A refraction to determine your best corrected vision and glasses prescription
- An examination of the front and back of the eye with dilation where indicated

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Based on the results of the exam, the doctor determines if your vision changes are routine or medical in nature. The doctor may order additional testing, refer you to another doctor or specialist, or advise other treatments as needed.

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Routine Coding:
(Billed to Vision Plan if available: VSP, EyeMed or as preventative to medical insurance)

If the doctor determines your vision changes are caused by normal refractive error (nearsightedness, farsightedness, astigmatism), your exam will be coded as a routine Comprehensive Eye Exam.

Medical Coding:
(Billed to Medical Insurance)

If the doctor determines your vision changes are caused by a medical condition and/or addresses a medical concern you have raised, your exam will be coded as a medical Comprehensive Eye Exam (i.e. cataract, glaucoma, diabetic retinopathy, macular degeneration, dry eye, flashes/floaters, double vision, etc.)

Once the visit is coded, your insurance company will then use those codes to determine how the visit will be processed. The patient is responsible for any unpaid deductibles, copays, coinsurance, and non-covered services* (i.e. refraction, fundus photography, topography, etc.) *Copays are due at the time of treatment.*

*We will send a statement of uncovered charges; payment is due within 30 days of receipt. Any payments not received within 30 days may be subject to a $5 late fee. Balances not paid within 120 days may be forwarded to collections and may be assessed 8% simple interest per year.

Please sign below to confirm you understand your Comprehensive Eye Exam today may be billed "routine" or "medical" determined by the results of the exam. By signing below, I confirm I have reviewed both my medical insurance and vision plan and understand how each applies to my insurance benefits. I understand I am responsible for any unpaid deductibles, copays, coinsurance, and non-covered services.

Printed Name _____ Date _____

Signature _____

Any concerns or inquires please call our billing office at (517)709-3313

Longmeadow Optical

By choosing Longmeadow Optical, you have entrusted us to care for your eyes. We take this responsibility very seriously and pride ourselves on providing our patients with the best possible standard of care.

Because of this, we can now offer the *Optomap* retinal scan as part of your pre-test work-up. This retinal scan allows us to capture an image of the back part of the eye to better evaluate for diseases like diabetes, high blood pressure, glaucoma, macular degeneration, retinal tears or detachments, and certain types of cancers. These problems can threaten vision without warning or symptoms. The image then becomes a good baseline we can compare in the future to detect changes. When the *Optomap* retinal scan is taken, you may not need to be dilated unless Dr. Gill or Dr. Chen says otherwise. It isn't covered by insurance and costs $39. The doctor will review the images with you during your exam.

_____ I would like the *Optomap* retinal scan

_____ I have additional questions and would like to speak with the doctor