TRI STATE OPHTHALMOLOGY

PATIENT INFORMATION	
Patient Name:	
Home Phone:	
Mobile Phone:	
Email:	
Address:	
Date of Birth:	
Age:	
Social Security #:	
Ethnicity:	
Race:	
Gender:	
Language:	
Patient Employer:	
Employer Phone:	
SPOUSE INFORMATION	
Full Name:	
Mobile Phone #	
Social Security #:	
Date of Birth:	
Employer:	
Employer Phone:	
GUARANTOR INFORMATION (If patient is under 18)	
Guarantor Name:	
Relationship to patient:	
Social Security #:	
Date of Birth:	
Address: (if different from patient)	
Home Phone:	
Mobile Phone:	
Employer:	
Employer Phone:	

TRI STATE OPHTHALMOLOGY

COVERAGE INFORMATION	
Primary Insurance:	
Subscriber:	
Relationship to Subscriber:	
Policy #	
Secondary Insurance:	
Subscriber:	
Relationship to Subscriber:	
Policy#	

EMERGENCY CONTACT INFORMATION	
Name:	
Relationship:	
Home Phone:	
Mobile Phone:	

PRIVACY	
Please list any individuals you authorize to discuss medical or financial records and information as well as pick up prescriptions, records, samples of medications, etc... in the event you are unable:	
Name:	
Relationship:	
Phone	
Name:	
Relationship:	
Phone:	

I have reviewed my information to verify it is correct.

X_____ _____

Patient Signature (or authorized person /relationship) **Date**

TRI STATE OPHTHALMOLOGY

AUTHORIZATION TO SUBMIT CHARGES

I request until further notice, that payment of benefits be made on my behalf to Tri-State Ophthalmology Associates for any services furnished to me. I also authorize the release of any medical information necessary to process these charges.

x_____ _____

Patient Signature (or authorized person / relationship) **Date**

MEDICARE ELIGIBLE PATIENTS

Do you or your spouse work and have insurance coverage through that job? ☐ YES ☐ NO	You ☐ Spouse ☐ Both	**If Yes**, are there fewer than 20 employees? ☐ YES ☐ NO

I request authorized "Medicare Supplement" benefits be made on my behalf for any services furnished to me. I also authorize the release of any medical information needed for determination of benefits.

x_____ _____

Patient Signature (or authorized person / relationship) ***Date***

NOTICE OF NON-COVERAGE

The "Refraction" is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. The refraction may also be performed for diagnostic reasons. For example: If your vision has changed, a refraction may be completed to see if the change is due to a medical reason.

Most insurance companies (including Medicare) **DO NOT** pay for this service (Refraction) and it is a separate charge from the office visit.

By signing below, you are agreeing to have the refraction performed, if needed, and to pay the refraction fee of $35.00 which will be due at check out.

x_____ _____

Patient Signature (or authorized person / relationship) **Date**

NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under the federal and state laws and outlining my rights regarding my health information.

x_____ _____

Patient Signature (or authorized person / relationship) **Date**

*****I wish to place the following restrictions on disclosure of my health information******

_____

TRI STATE OPHTHALMOLOGY

ACKNOWLEDGEMENT OF NON-PARTICIPATION WITH INSURANCE CARRIER

I have been informed that Tri-State Ophthalmology Associates and physicians are not contracted with ANY vision plans. These plans include:

* *Block Vision*
* *EyeMed*
* *Superior Vision through Caresource and Avesis Vision*
* *March Vision*
* *VSP*
*

I have also been informed that they are not contracted with the following medical plans:

* *Aetna Better Health of WV*
* *Aetna Coventry Medicare HMO of West Virginia*
* *Aetna Better Health of Kentucky*
* *Anthem Medicaid of Kentucky*
* *Anthem HMO for University of Kentucky*
* *Carelink*
* *Passport Health*
* *The Health Plan of West Virginia*
* *West Virginia Chip*
* *West Virginia Family Health*
* *Unicare of West Virginia*

If Medicare is primary, I understand I will be responsible for the Medicare deductible and coinsurance amounts.

x_____ _____

Patient Signature (or authorized person / relationship) **Date**

MEDICAL V/S VISION EXAM

Insurance coverage for eye examinations vary Some plans only cover "routine vision" exams - others will only cover "medical" eye exam.

VISION EXAMS: *These are routine examination for people who do not have eye disease or symptoms of eye disease. Your eyes will be examined for any needed correction (glasses) or any potential indicators of eye disease. If your provider finds anything abnormal, further testing of a medical nature may be needed at another visit. In that case, your medical insurance will be billed.* ***We do not bill vision plans.***

MEDICAL EXAM: *This is a medically necessary comprehensive examination for the diagnosis and treatment of disease and conditions of the eye or medical conditions which can affect the eyes. Some conditions evaluated during a medical eye exam include: Cataracts, glaucoma, diabetic retinopathy, macular degeneration and other potentially sight-threatening eye diseases.*

x_____ _____

Patient Signature (or authorized person / relationship) **Date**

JOHN C. GROSS, M.D.
CARTER H. GUSSLER, M.D.
JOSH C. GROSS, M.D
JOSHUA L. DANIEL, O.D.

TRI STATE OPHTHALMOLOGY

2841 LEXINGTON AVENUE
ASHLAND, KY 41101
PHONE: (606) 324-2451
FAX: (606) 324-7123

Name: _____ Date of Birth: _____

Pharmacy: _____ Pharmacy Location: _____

Primacy Care Physician: _____

Allergies: (*please include all medication and food allergies and the reaction(s)* _____

_____

LIST ALL CURRENT MEDICATIONS, *INCLUDING PRESCRIPTION & OTC*

	Name of Medication *(example: Coreg)*	Dosage *(example: 6.25mg)*	Route & How Often You Take This Medication *(example: by mouth twice a day)*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Please use the back of this page if necessary. Please fill out this form completely.