GILMER EYE CARE CENTER

Dr. Jadie Roberts O.D.
Dr. Shiloh Roberts O.D.

101 Simpson St
Gilmer, Texas 75644
(903) 843-5400 work (903) 843-5101 fax

Dear Patient:

Welcome to Gilmer Eye Care Center. Please read the following information to prepare for your visit.

- **Have the enclosed papers filled out completely prior to your arrival to our office. Your appointment may be delayed if these papers are not completed before you arrive.**

- Bring a list of all your medications
- Bring your insurance card(s) with you.
- **If your insurance provider requires a referral authorization number or form**, **it is your responsibility to insure the referral is sent prior to your appointment or bring this information with you and present it to the front office upon arrival.**
- If this required information is not available, full payment will be expected, or your appointment may have to be rescheduled. If you are unsure, call the phone number listed on your insurance card or contact your primary care physician prior to your appointment.
- Bring your driver's license or photo I.D.
- Bring your latest glasses or if you wear contact lenses, please bring your boxes with you.
- Please be prepared to pay your co-payment, the percentage that your insurance does not cover, or the balance in full, depending on your insurance arrangements.
- Patients who do not have insurance may call our office to discuss our payment policy prior to the visit as we do require payment in full at the time of service.

If you are unable to keep your appointment, kindly give a 24 hour notice.

Thank you,

Gilmer Eye Care Center

WELCOME TO

gilmer EYE CARE CENTER

FOR PEOPLE WHO SEE THE DIFFERENCE

DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____ WORK _____ CELL _____

SOCIAL SECURITY NO. ___ – ___ – _____ DATE OF BIRTH _____

OCCUPATION _____

EMPLOYER _____

GENDER M ☐ F ☐ EMAIL ADDRESS _____ TEXTING OK ☐ Y ☐ N

EMERGENCY CONTACT / TELEPHONE NUMBER _____

NAME OF PARENT OR SPOUSE _____

PERSON RESPONSIBLE FOR PAYMENT _____

METHOD OF PAYMENT: ☐ INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ CHECK ☐ CASH ☐ CREDIT CARD

HAVE WE SEEN ANY OTHER FAMILY MEMBERS: ☐ YES ☐ NO

IF YES, WHOM _____

HOW DID YOU HEAR ABOUT OUR OFFICE:

☐ MAIL OUTS ☐ NEWSPAPER ☐ TELEPHONE BOOK ☐ FAMILY / FRIEND ☐ LOCATION

– MEDICAL INFORMATION –

WHAT IS YOUR GENERAL HEALTH? _____

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS? *(PLEASE CHECK ALL THAT APPLY)*

EYES	☐ YES	☐ NO	**NERVOUS**	☐ YES	☐ NO	**MENTAL**	☐ YES	☐ NO
GASTROINTESTINAL	☐ YES	☐ NO	**GENITOURINARY**	☐ YES	☐ NO	**ENDOCRINE (GLANDS)**	☐ YES	☐ NO
EAR / NOSE / THROAT	☐ YES	☐ NO	**MUSCULOSKELETAL**	☐ YES	☐ NO	**BLOOD / LYMPH**	☐ YES	☐ NO
CARDIOVASCULAR	☐ YES	☐ NO	**INTEGUMENTARY (SKIN)**	☐ YES	☐ NO	**ALLERGIC / IMMUNOLOGIC**	☐ YES	☐ NO
RESPIRATORY	☐ YES	☐ NO						

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN _____

_____

_____

_____

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OVER PLEASE →

– MEDICAL INFORMATION CONTINUED –

PLEASE ANSWER ALL THAT APPLY:

DIABETES: ☐ YES ☐ NO TYPE _____ DATE OF DIAGNOSIS _____

MEDICATION ALLERGY: ☐ YES ☐ NO WHAT MEDICATION? _____ WHAT HAPPENS? _____

OTHER HEALTH PROBLEMS _____

CURRENT MEDICATIONS _____

HAVE YOU EVER HAD ANY OPERATIONS? ☐ YES ☐ NO KIND? _____

DO YOU USE CIGARETTES / TOBACCO? _____ ALCOHOL? _____ OTHER SUBSTANCE (S)? _____

NAME OF FAMILY DOCTOR _____ DATE OF LAST VISIT _____

DATE OF LAST TETANUS SHOT _____

– FAMILY HISTORY –

HIGH BLOOD PRESSURE? ☐ YES ☐ NO RELATION _____

MACULAR DEGENERATION? ☐ YES ☐ NO RELATION _____

DIABETES? ☐ YES ☐ NO RELATION _____

RETINAL DETACHMENT? ☐ YES ☐ NO RELATION _____

GLAUCOMA? ☐ YES ☐ NO RELATION _____

OTHER EYE CONDITION? ☐ YES ☐ NO RELATION _____

IF YES WHAT KIND _____

– PERSONAL EYE INFORMATION –

DATE OF LAST EYE EXAM _____ DILATED ? _____

HAVE YOU HAD ANY EYE OPERATIONS? ☐ YES ☐ NO

IF YES, TYPE _____ DATE _____

HAVE YOU HAD AN EYE INJURY? ☐ YES ☐ NO

IF YES, KIND _____ DATE _____

DO YOU HAVE GLAUCOMA? ☐ YES ☐ NO

DO YOU HAVE CATARACTS? ☐ YES ☐ NO

DO YOU HAVE OTHER EYE PROBLEMS? ☐ YES ☐ NO

DO YOU HAVE DRY EYES? ☐ YES ☐ NO

DO YOU HAVE BLURRED VISION? ☐ YES ☐ NO

DO YOU HAVE MACULAR DEGENERATION ☐ YES ☐ NO

IF YES, WHAT KIND _____

DO YOU WEAR GLASSES? ☐ YES ☐ NO

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

IF YES, WHAT TYPE _____

ADDITIONAL INFORMATION _____

PATIENT'S SIGNATURE _____ **DOCTOR'S INITIALS** _____

Kilgore-Gilmer Eye Care Centers, P.A.

J.T. Roberts, O.D. Jadie Roberts, O.D. Shiloh Roberts, O.D.

FINANCIAL POLICIES

Disclosure:
Office personnel have been instructed to inform patients of our payment policy when appointments are scheduled. We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding payment, you may discuss them with the Billing Manager or the Office Manager.

Estimates:
We invite you to discuss charges with our office freely. How much you will be charged will, of course, depend upon the services provided. Office personnel will, however, try to give you the best estimate based upon consultation with clinical staff prior to the services provided.

Benefit Verification and Disclaimer:
Our office personnel will call to verify primary insurance on all carriers, with the exception of Medicare, for all new patients. We will report to you what we are told by your primary carrier, and will collect from you at the time of service accordingly. However, we do not guarantee benefits. In the event your insurance pays differently from what they have told us, you will be responsible for all unpaid portions up to the allowable amount of each service performed.

Billing:
We accept assignment on all insurance carriers, and will prepare and send claims to primary and secondary payers for you. Once your carrier(s) have responded, any unpaid portion (after managed care discounts) will be released to the patient's responsibility and will be due upon receipt. In the event your health plan determines a service to be "not covered" or pre-existing, you will be responsible for the complete charge which will be released to patient responsibility on your monthly statement.

HMO's and PPO's:
We are affiliated with certain HMO and PPO plans. If you are a member of one of these plans in which we participate as a network provider, you will be required to pay the co-payment, deductible, and co-insurance at the time of each visit, as well as payment for any non-covered services, in accordance with the rules of your plan. Flat fee co-payments will be collected at check-in or check-out. Co-payments that are a percentage of the bill and non-covered services will be collected at check-out. If we are not a participating provider, your plan will pay "out-of-network", and will be treated as an indemnity plan. This means co-payment, co-insurance and deductibles will be due at the time of service.

Medicare:
Medicare co-payments and deductible for office visits are due at time of service unless you have a supplemental policy. Not all supplemental policies to Medicare will cover the Medicare deductible and/or may have their own deductibles or co-payment. In these cases, there will be a patient balance due from you, which will be billed to you once your supplement processes the claim. There is a $30.00 refraction fee due at time of visit. This is not covered by Medicare.

Medicaid:
Medicaid recipients are required to show proof of current coverage every time they obtain service. Medicaid has requirements you have to meet in order to be able to get glasses. Be sure to check with our staff to make sure you qualify for these benefits.

CHIPS:
The CHIPS co-pay is due at the time of service.

Indemnity Insurance:
Co-payments, co-insurance and deductibles are due at the time of service.

Non-covered:
If we have reason to believe that your services will not be covered by your insurance plan, we will ask you to sign a waiver to such effect. If you opt for the services to be provided, you will be required to pay for such services at our standard fee, and at the time the services are rendered.

No Insurance:
If you do not have insurance, all charges are due and pay able at the time of service.

Referral Authorizations:
Some managed care plans require you to obtain a referral number prior to you initial visit, and require you update your referral number periodically if you are continuing to be treated in our clinic. It is your responsibility to obtain the referral number through your primary care physician prior to your initial visit, and for any subsequent office visits. Your insurance company may refuse to pay for services performed without a valid referral number. You will then be held responsible for these charges. We will see that referrals are renewed or extended during the course of any on-going treatment. However, should you interrupt your treatment and then restart, it will be your responsibility to verify that a valid referral is still in effect, and if not, obtain a new one. If you change your primary care physician, or change insurance, it will be your responsibility to obtain a new referral in accordance with your policy changes.

Outstanding Balances:
Outstanding (past due) balances with be billed on your monthly statement. Outstanding (past due) balances are due and will be asked for at the time of any appointment or encounter. Prescriptions will not be released to a patient with an outstanding balance. Any account that goes past 120 days without a payment will automatically be turned over to the collection agency.

Changes of Address/Name/Phone number:
It is very important that your medical record reflects current information. You may call our office regarding any changes. You will be asked at every office visit to verify and/or make changes to your personal information.

Change of Insurance Carrier, Insurance Plan, or Primary Care Physician:
Notification of changes in insurance carrier, insurance plan, or primary care physician is your responsibility. Failure to do so may result in unpaid claims. Upon receipt of your updated information we will re-file the claims for the affected dates of service. However, if notification is received past the filing deadline, you will be held responsible for the charges.
***PLEASE NOTE: Some plans have a filing deadline of less than 45 days. ***

Form of Payment:
We accept MasterCard, Visa, American Express and Discover for your convenience. If you are an established patient and you feel that you cannot pay the entire amount of your charges at the time of your visit, please make arrangements to speak with our Billing Manager prior to your visit, so that a payment plan can be discussed. We will try to work with you as much as possible.

Care Credit:
We accept Care Credit for your convenience. We have only two options available: 6 months no interest with a $200.00 minimum purchase or 12 months no interest with a $750.00 minimum purchase. No other payment options are available. This is for patients that do not have insurance.

Product Ordering:
We require 50% of total payment before any product is ordered. This includes frames, lenses and contact lenses. The remaining balance must be paid before dispensing.

Cancellation Policy:
Should you need to cancel or reschedule your appointment, we require 24 hour notice. If we do not receive 24 hour notice, we reserve the right to charge $25.00 for each missed appointment.

Divorced Parents:
Payment is the responsibility of the parent who brings the child into the office for treatment. This will be enforced regardless of the terms outlined in the Divorce Decree. The divorced parties and the courts should decide matters of payment for children where there is joint custody, and this should be worked out between the parents in such a way as to not place us in the middle.

These policies do not constitute a contract, and can be changed at any time without notice by Kilgore-Gilmer Eye Care Centers, P.A. Thank you for your cooperation and understanding about the above policies.

We are looking forward to working with you.

1100 Stone Rd Suite 2020
Kilgore, TX 75662
(903) 983-2020
(903) 983-4000 fax

101 Simpson St
Gilmer, TX 75644
(903) 843-5400
(903) 843-5101 fax

Gilmer Eye Care Center

Dear Patient,

The federal government published regulations designed to protect the privacy of your health information. This law is called Health Information Portability and Accountability Act of 1996 or HIPPA and is referred to as the "privacy rule". It was passed to ensure that health information is treated in a confidential manner. It protects health information that is maintained by physicians, hospitals, other health care providers and health plans.

Gilmer Eye Care Center believes very strongly in the principles of confidentiality. We have always taken and will continue to take precautions in our office to safeguard your health information. Our employees receive routine training regarding protected health information and computer security systems have been installed. On the following pages you will find our "Notice of Privacy Practices".

Please review the "Notice of Privacy Practices" that is available to every patient in our lobby or you may request a paper copy, even if you have agreed to accept this notice electronically. You have the right to obtain a paper copy of this notice from us at any time. Please keep this document available for current and future reference. We will also ask that you sign an Acknowledgement Statement that we will keep on file in your chart and will be our record that you received notice.

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for the personal health information we already have, as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

Under HIPPA, you have the rights which are listed in the "Notice". You may exercise any of your rights in writing at any time. Also, we have a full time staff member designated to help you with any questions you might have. The contact person is listed below.

If you believe your privacy rights have been violated, please call the matter to our attention. We will strive to correct any complaints you might have with the utmost haste. You may file a complaint with us by notifying our Privacy Director. You may also complain to the Secretary of Health and Human Services at 200 Independence Avenue, S. W. Room 509F, HHH Building Washington D.C. 20201 (email: orcmail@hhs.gov).

YOU WILL NOT BE RETLIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

The name and address of the person you can contact for further information concerning our privacy practices is:

Becky Steele, Privacy Director
101 Simpson St
Gilmer, TX 75644
903-843-5400
Email: gilmer@eyecarecenters.org

This Notice of Privacy Practices is effective on or after February 14, 2003.

Kilgore – Gilmer Eye Care Centers, P.A.

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review the Kilgore-Gilmer Eye Care Centers' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that Kilgore-Gilmer Eye Care Centers will follow the guidelines set forth in this Notice. I understand that I am entitled to receive a copy of the Notice. I also have been made aware of whom to contact if I have any questions or complaints.

_____ _____

Name of Patient (Printed) Date

_____

Patient Signature

_____ _____

Personal Representative Relationship to Patient

Release of Private Health Information

I understand that I can grant access to my Private Health Information (PHI). I understand that Kilgore-Gilmer Eye Care Centers reserves the right to deny this request dependent upon the circumstances. I also understand that I may make changes and/or additions to this list at any time. I also understand that I can grant permission to leave a message at the phone numbers that I have provided.

☐ I give permission for Kilgore-Gilmer Eye Care Centers' staff to leave messages at the phone numbers that I have provided.

☐ I request the following person/people to have access to my PHI.

Name Relationship

_____

_____

_____

Assignment of Benefit

Initial_____*Primary Insurance_____

Subscriber's Name_____

Subscriber's Date of Birth _____ Policy#/I.D.#_____

Group #_____ Subscriber's relationship to Patient_____

*Secondary Insurance_____

Subscriber's Name_____

Subscriber's Date of Birth_____Policy#/I.D.#_____

Group #_____ Subscriber's relationship to Patient_____

Authorization To Release Information

Initial_____I request that payment of authorized Medicare, Medigap, Medicaid, Private or Commercial Insurance benefits be made on my behalf to Kilgore-Gilmer Eye Care Centers or any Physician of that group. I authorize the Eye Care Centers to release to my insurance company, any information needed to determine these benefits payable for related services.

I will be financially responsible for all charges not covered by my insurance policy.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Financial Policy

Initial_____I have read and understand the Financial Policy for Kilgore-Gilmer Eye Care Centers.

Signature _____Date_____

Refraction Policy

Refraction is a test using a series of lenses to determine your best-corrected vision or your need for corrective lenses. This test is **ALWAYS** performed along with your comprehensive eye examination and can be ordered at various other times if deemed necessary by the doctor.

Refraction is a non-covered service for Medicare and most commercial insurance companies.

Our office fee for refraction is **$30.00** and is collected at the time of the exam, in addition to any deductibles, co-pays and co-insurance.

_____ _____

Patient Signature Date