EYECARE NOW
URGENT EYE CARE CLINIC

Sahab Astani, OD

Welcome to EyeCare Now!

To help expedite your visit with us, please read and complete the attached forms, and bring them with you to your appointment.

Please remember to include a list of the medications you are currently taking or alternatively, you may bring them with you to your visit. If you have any concerns about answering any of the questions, we will be happy to assist you when you arrive at our office.

Thank you for selecting us to provide your urgent eye care needs.

Information Regarding Dilation Drops

Dilating drops are used to dilate (enlarge) the pupils of the eye to allow the doctors to get a better view of the inside of your eye.

Dilating drops frequently blur vision. The dilation time varies from person to person and may make bright lights bothersome.

It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

Please read and sign below:

I hereby authorize EyeCare Now (ECN) physicians or their assistants as may be designated to administer dilating eye drops. I understand that the eye drops are necessary to diagnosis my condition.

X _____ _____

Patient (or person authorized to sign for patient) *Date*

X _____ _____

Witness *Date*

MAIN OFFICE
1851 South Kelly Ave, Suite B Edmond, OK 73013
(405) EYE–CARE (405) 393–2273 www.EyecareNowOK.com

EyeCare Now Policies

OFFICE HOURS

Our office is open Monday through Friday from 8:00 am until 5:00 pm, excluding holidays. In the event of a medical emergency, please go to the Emergency Room! Prescription refills are not considered an emergency.

APPOINTMENTS

On every visit please bring with you a list of any medication you are currently taking, including over-the-counter supplements or vitamins. We make every effort to schedule patients at the earliest possible opening. Should you need to cancel or reschedule, we ask that you give us at least 24-hour notice so that we can move another patient to that time slot.

We may assess a $15 fee for appointments not canceled within 24 hours, and we may charge a $30 fee for a "no show" (missed appointment with no notice). Your insurance will not pay for these charges and you may be required to pay any such fees prior to being seen at your next appointment

PRESCRIPTION REFILLS

Good medical care requires that a physician review a patient's chart prior to refilling or amending a prescription. For this reason, we require our patients to request refills at least 48 hours in advance ofthe need. We ask that you contact your pharmacy with your request, and allow the pharmacist to contact our office. Please check directly with the pharmacy to see if your refill has been approved— and remember to allow 48 hours! If you called on Friday or a holiday, you may check with your pharmacy on the next business day after 4 pm.

PAYMENT POLICY

- Residual balances, co-payments and deductibles are due at the time of service.
- Our returned check fee is $25. We participate with the Oklahoma County DA in the collectionof returned checks.
- Patients with no health insurance will be required to pay $300 at the first appointment. This amount is NOT payment in full. Additional diagnostic tests or treatment will result in additional charges. If payment in full for the additional charges cannot be made at the time of service for the "private pay" patient, he or she is asked to call our billing office at 877-443-4995 to make suitable payment arrangements. A monthly payment is required to keep the account current.

FORMS

Disability policies are private policies owned by the patient. We charge $30 for a single disability form and $15 each for additional forms when provided at the same time to be completed. Without exception the money must be prepaid at the time the form is left with our office. FMLA forms are not disability forms, and require more time and detail to be completed. Our charge for completing the FMLA form is $50. We may require up to 10 days to complete any forms. Patients may come by to retrieve their form/s, or they may provide our office with a stamped, self-addressed envelope and they will be forwarded as indicated.

MEDICAL RECORDS

Complete medical records can be requested once for no fee. Each consecutive request will have a processing fee of $1.00 for the first page and $0.50 for every subsequent page. The total medical record fee is capped at $25.00.

Signature *Date*

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Patient Data Sheet

Name:_____
Address:_____City:_____State:_____Zip:_____
Date of Birth:_____Age:_____Marital Status: M S D W Sex: M F
Home Phone:_____Work Phone:_____Cell Phone: _____
SS#_____E-mail:_____
Employer:_____Job Title: _____
Employer Address:_____City:_____State:_____Zip: _____

Responsible Party / Insurance Policy Holder
(if different from patient information)

Name:_____Relationship to patient:_____Address: _____
City:_____State:_____Zip:_____
SS#:_____Date of Birth:_____/____/____Phone#:_____
Employer:_____Employer phone: _____

Insurance Information

Primary Insurance:_____ID #:_____Group #: _____
Secondary Insurance:_____ID#:_____Group #:_____
Insurance Address:_____Phone#: _____

Pharmacy Info	Primary Care Physician Info	Eye Doctor Info
Name:_____	Name:_____	Name:_____
Address: _____	Phone:_____	City:_____

Emergency Contact Information

Name:_____Relationship:_____Phone: _____

Authorization/Notice of Privacy for Disclosure of Protected Health Information

You may speak with the following person(s) about my medical services and private information contained in my files/ reports:
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

Power of Attorney

Name:_____Phone:_____
Legal documentation must be provided in order for Power of Attorney to be placed in patient's chart.

Required Authorizations

Authorize Payment / Release of Information: I hereby authorize payments directly to ECN of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract. I also agree to the ECN Cash/Insurance Payment Policy which authorizes release of information necessary to file insurance claim or filing a payment for review.

_____ _____
Patient Signature (or parent of minor) *Date*

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Eye Care Now, PLLC (ECN) may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eye Care Now, PLLC reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Name of Privacy Officer: Saurabh Singh
Address: 1851 South Kelly Ave, Suite B

Name of Practice: Eye Care Now, PLLC
State, Zip: Edmond, Oklahoma, 73013

Telephone/Text

With my consent, Eye Care Now, PLLC may call my home or another designated location and leave a message (on voice mail, answering machine, in person, or by automated text message) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail

With my consent, Eye Care Now, PLLC may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email

With my consent, Eye Care Now, PLLC may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Eye Care Now, PLLC restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Eye Care Now, PLLC.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Eye Care Now, PLLC may decline to provide treatment to me.

I have received a Notice of Privacy Practices from ECN.

X _____

Print Patient's Name

X _____ _____

*Signature of Patient *or Legal Guardian* *Date*

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Cash Payment Policy
General Insurance Payment Policy

The goal of EyeCare Now (ECN) is to provide our patients with exceptional care. For us to maintain this high standard of care, we require co-payments, coinsurance amounts and insurance deductibles to be paid at the time services are rendered.

Your appointment today may be for an initial consultation; however, it may be medically necessary to perform additional testing. If you have questions about the cost, please ask any member of our staff, as you or your insurance company will be charged for services rendered.

If we do not participate with your insurance and they have not paid our claim within 60 days, the balance will be due in full from you. If you are unable to pay in full, we ask that you make payment arrangements to get the bill resolved as quickly as possible.

If our office is participating with your insurance, we will abide by the terms of our contract, but services not covered or deemed patient responsibility are due from you, and again, we ask that you resolve the balance as soon as possible.

Our office works diligently to identify programs of financial assistance to help our patients obtain needed medications. If you wish to know more about these resources, please ask any member of our staff. We accept VISA, MasterCard, Discover and American Express, as well as Care Credit.

Note:
We are happy to file any insurance on your behalf, but please be aware that we do not participate in all plans. If you are uncertain if our office participates in your plan, you should call the customer service number and ask them directly. Many companies are now offering multiple plans, and some have a closed network. We are not able to confirm or deny our participation with any certainty.

By signing below I acknowledge that I have read and understood the information presented.

X _____ _____

Signature of Patient *Date*

If I am not the patient, but instead signing on behalf of the patient, I certify that I am legally authorized to sign on the patient's behalf and to bind the patient to the above terms and conditions. I agree that the patient and I are jointly and severally responsible for complying with the above terms and conditions, including any and all payment obligations.

X _____ _____

Signature of Patient Representative *Date*

X _____

Relationship of Representative to Patient

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Review of Systems

Name: _____

Date of Birth: _____

List any previous and/or current eye-problems & procedures (cataract, laser, lazy eye, trauma, etc.)
Please specify which eye & include approximate procedure dates

OCULAR HISTORY:

_____

_____

Include any prescription or over-the-counter (artificial tears, vitamins, etc.)
Please note which eye & frequency

OCULAR MEDS:

_____

Check Box if You Have Had Any of the Following:

- ☐ Flu Vaccination *in past year*
- ☐ Pneumonia Vaccination *in past 5 years*
- ☐ AIDS / HIV
- ☐ Arthritis / RA
- ☐ Asthma / COPD
- ☐ Blood Clots
- ☐ High Cholesterol
- ☐ Drug Dependency
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Lupus
- ☐ Migraines
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Thyroid Conditions
- ☐ Tuberculosis
- ☐ History of Plaquenil Use
  Dates: _____
- ☐ Kidney Disease / Kidney Stones
  Start of Dialysis: _____
- ☐ Cancer
  Type: _____
  Date Diagnosed: _____
- ☐ Diabetes _____
  Type I or II:
  Date Onset: _____
  Any Complications: _____
  Last Known A1C: _____
- ☐ Stroke
  Date: _____
- ☐ Other: _____

All Previous Surgeries & Dates:

_____

_____

Current Medications:

Include any prescription and/or over-the-counter

Medication	Dose	Frequency	Medication	Dose	Frequency

Drug Allergies: ☐ NONE _____

Family History:

	Relationship to patient		Relationship to patient
☐ Unknown Family History		☐ Retinal Detachment	
☐ Diabetes		☐ Macular Degeneration	
☐ Glaucoma		☐ Cancer	

Social History:

Fall Risk: ◯ No Falls in Past Year ◯ 1+ Falls in Past Year ◯ 2+ Falls in Past Year with Injury

History of Smoking: ◯ Never ◯ Former ◯ Current Light Tobacco User ◯ Current Heavy Tobacco User