Riverside Eye Clinic
RiversideEyeClinic.com

Welcome to the Riverside Eye Clinic. Please read the following notifications so you will be familiar with the policies of our practice.

Medical Insurance is different from Vision Insurance. Dr. Gilmer is a Medical Doctor/Ophthalmologist (not an Optometrist) and we accept medical insurance, not vision plan insurance. We apologize but unfortunately medical insurance companies do not usually cover refraction fees. If you would like a prescription for new Eye Glasses, the fee is **$40.00.**

Dilation - Please note that we may need to dilate your eyes during your examination so that the ophthalmologist can get a better view of the inside of your eyes. Dilation of your pupils may blur your vision and make you more sensitive to light for several hours after your exam. If your vision is affected by the dilation then we recommend you make arrangements to not drive yourself until your vision has returned to normal. It is not possible to predict how long the effect of dilation will last or how much your vision will be affected. We recommend that you wear sunglasses when your eyes are dilated. Please ask the check-out staff for a complimentary disposable pair if you do not have yours with you.

Pharmacy Prescriptions - You may be given a prescription for medications in conjunction with your care. It is important that you check with your pharmacist and/or primary care physician regarding potential interactions between your medicines.

Medical Examinations and Treatment vs Vision Plan (Routine) Examinations - Dr. Gilmer is a Medical Doctor. Therefore, we bill medical insurances, not vision plans. The appointment is considered a **"medical eye exam"** as opposed to "vision exam." When sending a claim to the patient's insurance company, our records will indicate that the patient was seen for a medical reason and has received a medical diagnosis. Also, we cannot change the diagnosis on a claim in order to receive payment. All diagnosis much be documented in the patient's chart at the date of service in order to be included on a claim.

Co-Pays, Deductibles and Non Covered Services - I acknowledge that I am financially responsible for co-pays, deductibles and not-covered services and that those fees will be collected at time of service.

Insurance Referrals/Authorizations - It is always the responsibility of the patient to ensure that they have a valid referral/authorization for services rendered at each visit

Please Keep Your Insurance Information of File with Us Up to Date - Insurance Companies have time limits on how long a provider can take to file a claim. If a claim is not sent in a timely manner, it will be denied.

Insurance Assignment and Release - I certify that I have insurance coverage with the company(ies) I have provided and I assign to Riverside Eye Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions. Riverside Eye Clinic may use my health care information and may disclose such information to the above-mentioned Insurance company(ies) and their agents for the purpose of coordinating care, obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will remain in effect for as long as I am a patient at the Riverside Eye Clinic.

Medicare/Medigap Authorization - I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to Riverside Eye Clinic for any services furnished to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

HIPPA Protected Health Information Acknowledgment - Riverside Eye Clinic follows HIPAA guidelines in regard to your PHI (Protected Health Information). Copies of our Notice of Privacy Practices are available at the Front Desk.

By signing below, you acknowledge that you have read and agree to adhere to the Riverside Eye Clinic Policies contained within these two pages.

_____ _____ _____ _____

Patient/Designated Representative Signature Today's Date Print Name Here DOB

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Name: Date: Date of Birth:

1. Reason for Visit:

3. Do you wear contact lenses?

4. Your Eye History (for example, cataract surgery, glaucoma, macular degeneration, etc):

5. Your Family Eye History (mom, dad, siblings, etc):

6. Your Medical History (do you have high blood pressure, diabetes, or ANY other medical problem?):

7. Your Family Medical History (mom, dad, siblings, etc):

8. Tobacco Use, Past or Present:
9. Alcohol Use, Past or Present:

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Name: Date: Date of Birth:

Home Phone:

Cell Phone:

Email address:

Would you like to be emailed login instructions so that you can view your Riverside Eye Clinic medical records online? _____ YES _____ NO

Ethnicity: Race:

Who is your primary care doctor:

Are you allergic to any medicine, food or anything (include the reaction for each item)?

Please list any eye drops you are using, prescription or over the counter:

Please list any medicines you are taking, prescription or over the counter:

Authorization to discuss patient management/care: _____ Yes _____ No

NAME: _____ RELATION: _____

NAME: _____ RELATION: _____

Signature of Patient or Legal Representative: _____ Date: _____

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Medical Records Release Authorization

Date:

Patient name: Date of Birth:

Records requested from the following physician:

Information to be released from Date (or Range of Dates):

Chart Notes: _____
Diagnostic Testing: _____
Consultation Reports: _____
Pathology Reports: _____
Other: _____

Intended use of PHI: Continuity of Care

This PHI will be used by: William Gilmer, MD

Records are to be sent to Riverside Eye Clinic at address or fax # listed above. This Authorization will expire 12 months from date of signature below. I authorize the release of the protected patient information as checked above to the Riverside Eye Clinic. I understand this authorization is voluntary and is not intended to alter the patient's ability to receive medical care from any health care provider. I understand the medical record may (if applicable) include information related to treatment of drug/alcohol abuse, mental health impairment, sickle cell anemia and/or HIV/AIDS. I understand this authorization can be revoked at any time provided the revocation is provided to the Riverside Eye Clinic in written form.

Signature of Patient or Legal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____