Eugene Eye Clinic, LLC

John D. Polansky, M.D. & Jason P. Gross, M.D.
2460 Willamette Street, Eugene, OR 97405
Phone (541) 683-3744 Fax (541) 683-6672
www.eugeneeyedoctors.com

Welcome to the Eugene Eye Clinic

_____ is scheduled for an appointment on

_____ with Dr. Polansky / Dr. Gross. Please arrive at _____ to check in.

The office is located on the corner of 24th Place and Willamette Street. Patients may park in our private lot on either side of the building. <u>The office suite is located on the lower level and can be accessed via the stairs or ramp</u>.

- Please complete all the included forms and bring with you to your appointment to help expedite the registration process.

- Please remember to bring your insurance cards and photo identification. By providing your correct insurance information, your benefits can be verified and billed correctly. Please refer to the enclosed "Medical vs. Vision Waiver" for explanation of different exam options.

- Your eyes may or may not be dilated, depending on your specific needs. Most patients are able to drive themselves after dilation, while others may need a driver to accompany them.

- Please allow 1½ - 2 hours for your initial exam.

- Bring your most recent pair of eyeglasses and a list of your current medications.

- **If you wear contact lenses, wear them to your appointment. Your lenses must be worn for at least 2 hours prior to your appointment. Please bring your contact lens RX information, i.e. written RX or packaging.**

- Co-payments and fees for non-covered services are collected at time of check-in. Our office accepts cash, check and Visa/American Express/MasterCard/Discover.

The Spectacle Shop is conveniently located in our office for your eyewear needs.
The Spectacle Shop is open Mon.-Fri. 9:00-1:00 and 2:00-5:00.
Their telephone number is (541) 683-3746.

EUGENE EYE CLINIC, LLC
JOHN D. POLANSKY MD AND JASON P. GROSS MD

MEDICAL VS. VISION BENEFITS WAIVER

WHY DO I NEED TO CHOOSE BETWEEN A MEDICAL EYE EXAM AND A VISION EYE EXAM?

There is significant confusion regarding insurance coverage for eye exams. Some vision plans only cover "Routine" vision exams while others will cover your exam only if you have a medical eye condition or disease. Our staff will ask whether you are here for a medical eye exam or a "Routine" vision exam. We can do our best to educate you on your benefits, but we do not want to choose your exam for you. Also, we cannot re-file your claim with a different benefit once the initial claim has been filed.

VISION EXAM

A "Routine" Vision exam is for people who do not have medical eye disease(s) or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contacts) or any potential indicators of eye disease. A Routine vision exam allows you to update your glasses and/or contact lens prescription and screen the health of your eyes. For this type of visit, vision insurance is billed. If our doctors find anything medical during your vision exam, the discussion and possible further testing may be needed at an additional visit to address the medical findings. In that case, your medical insurance would be billed for that next visit. If you are concerned about medical conditions, you should choose to bill your medical insurance.

MEDICAL EXAM

A comprehensive "Medical" eye exam is for the diagnosis and treatment of disease(s) and/or condition(s) of the eye performed by a physician. This exam evaluates the reason for the symptoms and assesses any treatment needed. Some conditions evaluated with a medical exam include dry eyes, allergies, red eyes, cataracts, glaucoma, diabetic retinopathy, macular degeneration and other sight-threatening diseases. In most cases your eyes will be dilated so the doctor can get a good view of the inside and back of your eye. For this type of visit, medical insurance is billed.

WHAT IF I HAVE BOTH MEDICAL AND VISION INSURANCE?

Some insurance plans allow us to bill both types of insurance to utilize your benefits in the way that best suits your situation. If you have medical problems related to your eyes, you should use your medical benefits. However, if you need your prescription, then the refraction portion of your exam may be billed to your vision benefit by checking both Medical & Vision options listed below.

Most patients will have a refraction done during either type of exam. A refraction is a diagnostic test used to determine your best corrected vision. For some medical conditions, a refraction is needed even when eyeglasses aren't prescribed. The majority of insurance company's do not cover this procedure. If your insurance doesn't cover your refraction you will be asked to pay the fee of $50.

Please Bill Today's Visit to My _____**Medical Insurance** _____**Vision Insurance**

Patient Signature: _____ Date: _____

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The Spectacle Shop
(541) 683-3746

To Our Valued Contact Lens Wearers,

Dr. Polansky, and Dr. Gross' desire is to exceed the standards set for safe and healthy contact lens wear. For our patients an Annual Contact Lens Evaluation ***is needed to meet these standards.***

A prescription for contact lenses is good for 12 months from your last exam. An ***Annual Contact Lens Evaluation*** is needed to continue to prescribe contact lenses. The fee for this service is $75. Should a change in contact lens material be warranted, additional fee will apply. This evaluation will be performed at your complete vision exam and is a separate charge from the exam itself. If you are only in need of a new contact lens prescription an ***Annual Contact Lens Evaluation*** will need to be done in order to renew your contact lens prescription.

All contact lens services are to be paid for at the time of service. All contact lenses and contact lens services are charged through **The Spectacle Shop**. Please call your insurance carrier directly if you have questions about coverage for contact lenses and contact lens services. If you have questions regarding charges for contact lens services please call **The Spectacle Shop at (541) 683-3746**, Monday through Friday 9 a.m. - 5 p.m.

Thank you for continuing to trust us with your vision needs.

Sincerely,

Dr. Polansky, Dr. Gross, and Staff

PATIENT REGISTRATION FORM

Eugene Eye Clinic, LLC
2460 Willamette Street
Eugene, OR 97405

Jason P. Gross, M.D.
John D. Polansky, M.D.

PATIENT INFORMATION

Today's Date: _____

Name: _____
(Last) (First) (MI)

Address: _____ City: _____ St.: _____ Zip: _____

Email Address: _____Social Security No.: _____

Date of Birth: _____ Preferred Method of Contact: Phone Call / Text / Email

Home phone no.: _____ Cell phone no.: _____ Work phone no.: _____

Sex: M / F Marital Status: S / M / D / W / DP Patient Employer: _____

Emergency Contact Person: _____Relationship: _____

Home#: _____ Cell#: _____ Work#: _____

How did you hear about our office? _____

Who is your Primary Care Physician? _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Subscriber name: _____

Relation to patient: _____ Subscriber's DOB: ___ _____

Secondary Insurance Co: _____ Subscriber name: _____

Relation to patient: _____ Subscriber's DOB: _____ _____

Legal Guardian or Power of Attorney Information

Name: _____

Relationship: _____

Date of Birth: _____

Phone #: _____

Signature: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____
Date of Birth: _____ Date of last eye exam: _____
Primary Care Physician: _____ Your Occupation: _____
List any medications you currently take, prescription AND over the counter: _____
_____
_____

Do you have any allergies to any medications? YES / NO
If YES, list the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart disease, asthma, etc.) or injuries (concussions, etc):
_____
_____

List any EYE surgeries you have had: _____

Are you ***CURRENTLY*** experiencing any of the following?
Please circle all that apply.

CARDIOVASCULAR: High blood pressure/Heart disease/Other: Y/N_____
RESPIRATORY: Congestion/Wheezing/Asthma/Other: Y/N_____
GENITAL, KIDNEY, BLADDER: Painful urination/Frequent urination/Other: Y/N_____
ENDOCRINE: Diabetes/Hyperthyroid/Other: Y/N_____
NEUROLOGICAL: Numbness/Headaches/Seizures/Paralysis/Other: Y/N_____
MUSCLES, BONES, JOINTS: Joint pain/Stiffness/Cramps/Swelling/Arthritis/Other: Y/N_____
GASTROINTESTINAL : Stomach upset/Diarrhea/Ulcers/Constipation/Hernia/Other: Y/N_____
CONSTITUTIONAL: Fever/Heat stroke/Weight loss/Weight gain/Unusually tired/Other: Y/N_____
EYES: Poor vision/Eye pain/Tearing/Redness/Other: Y/N_____
EARS, NOSE, THROAT: Hard of hearing/Earache/Stuffy nose/Cough/Dry mouth/Other: Y/N_____
BLOOD / LYMPH: Bleeding/Anemia/Other: Y/N_____
ALLERGIC / IMMUNOLOGIC: Sneezing/Swelling/Redness/Itching/Hives/Lupus/Other: Y/N_____
SKIN: Pimples/Warts/Growths/Rash/Other: Y/N_____
PSYCHIATRIC: Anxiety/Depression/Insomnia/Other: Y/N_____
FEMALES: Are you pregnant? Y / N Are you nursing? Y / N

Family History
Has any immediate family member had any of the following? If yes, please list whom.
Cataracts: Y/N _____
Macular Degeneration: Y/N _____
Glaucoma: Y/N _____
Diabetes: Y/N _____
Other Eye Diseases: Y/N _____
Other hereditary disease: Y/N _____

Social History
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES / NO
Have you ever had a blood transfusion? YES / NO If Yes, Date of transfusion:_____
Do you drink alcohol? YES / NO If YES, how much? _____ How Often?_____
Do you use tobacco? YES / NO If YES, how much? _____ How many years?_____
Do you use recreational drugs? YES / NO If YES, Please explain: _____

_____ _____
Jason P. Gross, M.D. / John D. Polansky, M.D. Date

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Jason P. Gross, MD
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Eugene, Oregon 97405
541-683-3744

Authorization to Discuss Health Information with **Friends, Family or Caregivers**

Patient name_____Patient DOB_____

_____I authorize Eugene Eye Clinic, LLC to leave a personal voice message or recorded message on the primary phone number I have provided.

Please initial:

_____I do not authorize Eugene Eye Clinic, LLC to discuss my information with anyone other than myself.

OR

I authorize Eugene Eye Clinic, LLC to discuss the areas I have identified below with the individuals listed.

_____ Unlimited access to all information listed below

_____Insurance and Billing information

_____Discuss treatment and diagnosis

Please print:

_____	_____	_____
Name of authorized person	Relationship	Phone Number
_____	_____	_____
Name of authorized person	Relationship	Phone Number
_____	_____	_____
Name of authorized person	Relationship	Phone Number

_____ _____

Patient Signature **Date**

This authorization will remain in effect until revoked or updated by the patient.

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FINANCIAL AGREEMENT

Welcome to Eugene Eye Clinic, LLC. We would like to inform you about our office's financial and privacy policies.

FOR ALL PATIENTS:
By signing below, I acknowledge that I have provided my current insurance information and I authorize the release of any medical information necessary to process claims. I authorize payment of medical benefits directly to Eugene Eye Clinic, LLC for services performed by John D. Polansky, MD, or Jason P. Gross, MD. I acknowledge that Eugene Eye Clinic, LLC will bill my insurance as a courtesy. Any services not covered by my insurance will be my responsibility, including services denied due to lack of referral from my primary care provider. Any balances due are to be paid within 90 days of the statement date. After 90 days any balance due will be turned over to an outside collection agency. While payment in full is preferred, you may discuss payment arrangements with the billing staff. I also request payment of government benefits on my behalf to Eugene Eye Clinic, LLC.

Date: _____ Signature: _____

FOR MEDICARE PATIENTS:
I request that payment of authorized Medicare benefits be made on my behalf to Eugene Eye Clinic, LLC for services furnished me by John D. Polansky, M.D, or Jason P. Gross, M.D. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eugene Eye Clinic, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Date: _____ Signature: _____

HIPAA Privacy Acknowledgment

We are required by law to protect the privacy of your medical information and to provide you with our written Notice of Privacy Practices. Our Notice of Privacy Practices is available for you to review at your convenience in our waiting areas and front desk. Please take a copy for your records. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices. Your patience and cooperation is greatly appreciated.

Date: _____ Signature: _____