Patient Name: _____

Appointment Date: _____ Time: _____

Physician: _____

Des Peres
12990 Manchester Rd
Des Peres, MO 63131

St. Charles
3513 Harry S. Truman Blvd
St. Charles, MO 63301

Sullivan
965 Mattox Dr
Sullivan, MO 63080

Phone: 314-966-5000 **Fax: 314-909-6666**

Welcome to Ophthalmology Associates

Our team is dedicated to providing you and your family with the best possible medical treatment. Together, we can reach your health goals.

Patients are seen by appointment only. While we will work to honor your scheduled appointment time, please understand that medical emergencies occur. We ask for your patience during those times.

What to bring to your first appointment:

- Completed forms (enclosed)
- Insurance cards
- Insurance Co-Pay, if applicable
- Photo ID
- Medication List
- Glasses and/or contact lenses
- Insurance Referral from your Primary Care Doctor if applicable

Precautions Following Dilation:

- It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend not driving or operating dangerous machinery immediately after dilation. If you are uncomfortable driving, we recommend that you arrange to have someone drive you home.

Other Considerations:

- For patients coming for a cataract evaluation, it is required to be out of contact lenses 10 days prior to visit.
- If you cannot keep an appointment, we ask that a 24-hour notice be given to the office at a minimum.

Learn more about our surgical services at www.youreyedoc.com

Thank you,

The Doctors and Staff of Ophthalmology Associates

Des Peres Location – Located in the Eye Surgery and Laser Center Building
12990 Manchester Rd. Suite 200
Des Peres, MO 63131

From 270 North

Take exit 9 to Manchester West. Use the second lane from the right and keep left at the fork. Continue on Manchester in the left lane. Take the "Manchester Rd East" exit. Merge into the far-right lane. Take a right turn after "Aloha Pools and Spas" to enter the parking lot for St. Louis Eye Survey and Laser Center Building.

From 270 South

Use the right lane to take exit 9 for Manchester. Keep right at the fork to merge onto Manchester West. Merge into the far-left lane. Take the "Manchester Rd East" exit. Merge into the far-right lane. Take a right turn after "Aloha Pools and Spas" to enter the parking lot for St. Louis Eye Survey and Laser Center Building.

If you pass the building

Stay in the far-right lane and take the exit for "Des Peres Rd/Manchester Rd West." Turn left on Des Peres Rd. Take a left at the second stop light onto Manchester West. Merge into the far-left lane. Take the "Manchester Rd East" exit. Merge into the far-right lane. Take a right turn after "Aloha Pools and Spas" to enter the parking lot for St. Louis Eye Survey and Laser Center Building.

St. Charles Office
3513 Harry S. Truman Blvd.
St. Charles, MO 63301

From I-70 West

Take exit 225 Cave Springs/Truman Rd. Keep right at the fork on the ramp. Merge onto Truman Rd and move into the left lane. Continue 0.5 miles down the road and the office is on the left.

From I-70 East

Take exit 225 Cave Spring/Truman Rd. Keep left at the ramp. Take a left on Truman Rd. Continue 0.5 miles down the road and the office is on the left.

Sullivan Office – Missouri Baptist Hospital
965 Maddox Dr.
Sullivan, MO 63080

From I-44

Take exit 225 from I-44 and turn on to Missouri D. Turn on Old Rte 66 towards Cracker Barrel. Follow Old Rte 66 to Missouri D. After about a mile, turn right onto Sappington Bridge Rd. Turn right onto Maddox. Turn right into the parking lot and look for Specialty Clinic Building B.

Patient Information

Date: _____

Patient Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Date of Birth: _____ **Social Security No.** _____

Cell Phone: _____ Home Phone: _____ Work Phone:_____

Preferred E-Mail Address: _____

Please complete the following information to meet requirements set forth by the Affordable Care Act:

Marital Status: ☐ Married ☐ Single ☐ Widow ☐Divorced **Birth Sex:** ☐ Male ☐Female

Primary Language: _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (please circle one): White Black/African American Asian Hispanic or Latino American Indian Alaskan Hawaiian/Pacific Islander Greek Multi-racial

Primary Care Physician _____ Phone _____

Pharmacy _____ **Phone** _____

Pharmacy Address _____

Referring Physician _____ Phone _____

How did you hear about us? ☐Clarkson Eyecare ☐Existing ☐Family/Friend

☒Independent OD ☐Medical Doctor ☐Insurance ☐KEZK_____ ☐KFTK_____

Person Responsible _____ Relationship _____

Address (if different than above) _____ City_____

State _____ Zip _____ Phone _____ Social Security No. _____

Insurance Information: *You must provide us with your current insurance card(s).*

Primary Insurance _____ ID#_____

Group # _____ Policy Holder _____

Date of Birth _____ Social Security No. _____ Relationship to Patient _____

Secondary Insurance _____ ID#_____

Group # _____ Policy Holder _____

Date of Birth _____ Social Security No. _____ Relationship to Patient _____

To be signed for the following years' visits only. *I have reviewed the above information and it has remained the same:*

Signature _____ *Date* _____

We accept assignment on Part B Medicare patients. You will be expected to pay your deductible and 20% coinsurance. We will only file to one secondary policy.

Medicare Authorization

I understand that my signature requests 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 HICFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of medical information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Name: _____ Date:_____/_____/_____

Signature: _____ Medicare Policy # :_____

Financial Contract Agreement

We are committed to your successful treatment. Please note that payment of your account is considered a part of your treatment.

- All co-pays are due on the day of service (we accept Checks, MasterCard, Visa, Discover).
- **If you do not have your current insurance card at the time of service you will be treated as a "self pay" patient.**
- All "self pay" patients to pay this visit fee in full at the time of service.
- All patients covered under an HMO plan must have a valid referral at the time of their visit.
- **All delinquent accounts, 90 days past due, may be placed in collections, you may be responsible for all additional charges incurred to collect this account, including court costs and legal fees.**
- We do not get involved with litigation, disputed workman's' compensation cases, divorce decrees, or auto accidents; you will be 100% responsible for full payment at time of service or within 90 days of service with prior arrangements.
- The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of account.

Telephone Consumer Protection Act (TCPA) I agree that Ophthalmology Associates, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

We accept assignment of benefits for insurance plans that we are contracted with. The balance is your responsibility. Please be aware that some or all of the services provided may be noncovered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. You are responsible for verifying the benefits of your policy.

If you have no insurance coverage and need financial help, our Business Office will be happy to work out an agreeable payment plan.

I understand and agree to this Financial Contract Agreement as stated above:

Signature: _____ **Date:**_____

Release of Information/Assignment of Benefits/Consent to Treat

I authorize the use of this form on all of my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this insurance authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on dispute claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider.

Signature: _____ **Date:**_____

Receipt of Notice of Privacy Practices/Written Acknowledgement Form
I have received a copy of Ophthalmology Associates. Notice of Privacy Practices dated 5/2024

Signature _____ **Date** _____

The above authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.

HEALTH HISTORY FORM

NAME:_____ **DOB:**_____ **DATE:**_____

Describe in your own words why you are seeing us? List any vision or eye problems you are having:

_____

_____

MEDICAL HISTORY-Have you been diagnosed with any of the following?

☐Asthma
☐Anxiety/depression
☐Cancer_____
☐COPD
☐DM, type__,yrs.__
☐Head/spinal injury
☐Heart disease
☐Hepatitis
☐HBP
☐High cholesterol
☐Migraines
☐Multiple sclerosis
☐Pregnant-currently
☐Rheumatoid arthritis
☐Seizures or fainting
☐Stroke
☐Thyroid disease
☐Other

SURGICAL HISTORY-(Include date and type of each procedure).

_____

_____

Heart Defibrillator? ☐ Yes ☐ No **Pacemaker? ☐ Yes ☐ No** **Heart Stent? ☐Yes ☐No**

EYE HISTORY- Have you been diagnosed with any of the following? If so, date?

☐Blepharitis_____ ☐Dry eye syndrome_____ ☐Thyroid eye disease_____
☐Cataract_____ ☐Glaucoma_____ ☐Other_____
☐Corneal disease_____ ☐Macular DGen_____ ☐Other_____
☐Diabetic retinopathy_____ ☐Ocular allergies_____ ☐Other_____

Previous Eye Surgery? ☐No ☐Yes If yes, what and when:_____

Previous Eye Injury? ☐No ☐Yes If yes, what and when:_____

MEDICATIONS- (including eye drops) include the dosage, Attach list if possible
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, health plan, and other healthcare providers: Int._____

_____

_____

ALLERGIES to MEDICATIONS:name/reaction-_____

SOCIAL HISTORY

Use of Alcohol? ☐Never ☐Rarely ☐Occasional ☐Daily ☐Moderate

Use of Tobacco?☐Never ☐Former smoker/quit date_____ ☐Current Packs/Day_____

Use of Drugs? ☐Never ☐Type/Frequency_____

FAMILY HISTORY-Has any of your **blood relatives** had any of the following? Note which relative.

☐Autoimmune disease_____ ☐Diabetes_____ ☐Stroke_____
☐Cataract_____ ☐Glaucoma_____ ☐Thyroid_____
☐Corneal disease_____ ☐Heart Disease_____ ☐Other_____
☐Cancer_____ ☐Macular DGen_____

Patient Signature: _____ **Date:** _____

MEDICAL EXAMS ● REFRACTIONS ● PRESCRIPTION RELEASE

The type of care you need will be billed to your medical insurance.

1. Medical insurance covers medical eye exams relating to any health issues affecting our eyes.
2. We do not accept vision insurance.

What is Refraction?
The refraction is the testing completed to obtain an eyeglass prescription, or to determine if eyeglasses are needed. Majority of medical insurance companies do not cover refractions because it is considered routine. **Refractions will be billed to the patient with the fee of $50.00**. In addition, exam charges (including co-payments) is payable at the time of service. If you have questions or concerns regarding the need for a refraction, please address them with the technician at the beginning of your exam.

I understand that my eye doctor is required by the Federal Trade Commission to provide me with a copy of my eyeglass prescription at the conclusion of my exam process, whether or not I desire it or ask for it.

Once a final prescription has been determined, I will receive either a digital/paper copy. If possible, a digital copy will be available in the patient portal. I acknowledge that I have previously accessed the patient portal, or if that is not the case, then I understand that I can register for the patient portal. I understand that refraction is a **non-covered** service. I accept full financial responsibility for the cost of this service in addition to any co-payments or deductible.

_____ _____
Patient/Legal Representative Signature Date

PERMISSION TO RELEASE HEALTH INFORMATION/EMERGENCY CONTACT

I understand the person(s) I list to authorize to disclose information to those involved in my care, will be listed as my emergency contact. If this information is to change, the front office will need to be notified.
I wish to be contacted in the following manner (check all that apply)

☐ Home Phone ( )_____ ☐ Leave message with Detailed Information
☐ Leave message with Call Back Number Only

☐ Cell Phone ( )_____ ☐ Leave message with Detailed Information
☐ Leave message with Call Back Number Only
☐ Send text message

☐ Work Phone ( )_____ ☐ Leave message with Detailed Information
☐ Leave message with Call Back Number Only

Written Correspondence
☐ O.K. to mail to my home address ☐ O.K. to fax to: ( )_____

To whom may we talk to about your medical and billing information?

☐ Spouse_____
☐ Parent _____
☐ Child _____
☐ Other _____

_____ _____
Patient/Legal Representative Signature Date

Please complete the Back Side of this Form as well...