

DATE: _____

Dear _____

Welcome to our practice. We are delighted to be part of your health care team. Our records indicate that you have an eye appointment scheduled with

- Steven Unterman, M.D.**
- Joseph Parelman, M.D.**
- Annette Manion, O.D.**

on _____ at our _____ location.

We have enclosed a health questionnaire and a map to our office. Please complete the health questionnaire and bring it with you to your appointment.

It is very important to bring all of the following information with you as well.

1. **Your insurance card and referral if required by your insurance plan.
(Please call your primary care physician if a referral is needed
PRIOR to your appointment with us.)**
2. **Photo ID**
3. **A list of all the medications you are currently taking**
4. **Payment for any applicable co-pay, co-insurance and/or
refraction charge**

**If you need to make payment arrangements, please call our
Business Office at 913 384-3087.**

If you have questions at any time, please feel free to call us. We look forward to seeing you soon.

Sincerely,

The Staff and Physicians of Mid-America Eye Center

www.midamericaeye.com

REFRACTIONS

You may see a charge for 92015 Refraction on your statement and may wonder why this was charged separately from your eye examination or office visit charge.

Q. What is a refraction?

A. A refraction is a test to determine whether you would benefit from spectacles . Your refractive error may not be great enough for you to require a spectacle prescription, but this cannot be determined without performing the refraction. If you have a medical problem, a refraction may be performed to see how the problem has affected your vision.

Q. Are there different levels of refractions?

A. There are 3 different levels of refractions depending on how complicated the refraction is.

The lowest level is usually a quick check. Often times the patient is not given a spectacle prescription.

A mid level refraction is the most common and is the one usually performed during a routine eye examination.

The higher level refraction is sometimes necessary after certain surgical procedures and with certain eye diseases. It is typically more complicated and takes longer to perform.

Q. Will my insurance pay for a refraction?

A. Most insurances will not pay for refractions. If you have vision coverage a refraction is almost always covered, although it may not apply during a medical eye exam.

Medicare considers a refraction part of routine care making it a non-covered charge. Medicare will not pay for a refraction for any reason and considers this portion of an eye examination the patient's responsibility.

MID-AMERICA EYE CENTER, PA Patient Information Sheet

Date:	Acct #:	How were you referred to our office?			
Patient Name:				Sex: Male Female	
Mailing Address:		City:	State:	Zip:	
Home/Cell Phone:		Birthdate:	SS #:		
e-mail address:		Parents name if minor:			
Is Child Covered under Parents Insurance?			Is there any Secondary Insurance?		

Employer Information

Employer:		Employer Phone:			
Employer Address:		City:	State:	Zip:	

Policy Holder

Name:		Address:			
SS #:	Birthdate:	Employer:			
Employer Address:			Phone:		
*In Case of Emergency Contact/Relationship:			Home/Cell Phone:		

Primary Care Physician _____

Is this Injury a result of:
 Work Related _____
 Motor Vehicle Accident _____
 Accident (Other) _____

Primary Insurance Co.:			Secondary Insurance Co.:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		
Policyholder:	DOB		Policyholder:	DOB	
Policy #:			Policy #:		
ID #:	Social Sec #		ID #:	Social Sec #	

I hereby authorize Mid America Eye as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Mid America Eye and authorize them to submit claims on my behalf for any bills or services furnished to me during the next 12-month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

Date

Signature



Joseph J. Parelman, M.D.
 Steven R. Unterman, M.D.
 Annette S. Manion, O.D.
 913 384-1441
 800 628-4258

Medical History Questionnaire

Name: _____

Date: _____ Age: _____ Date of Birth: _____

Do you presently have any problems in the following areas? If "yes," please give an explanation:

<u>EYES</u>	Yes	No	Explanation of Problem
Loss of Vision	___	___	_____
Blurred Vision	___	___	_____
Distorted Vision (Halos)	___	___	_____
Loss of Side Vision	___	___	_____
Double Vision	___	___	_____
Dryness	___	___	_____
Mucous Discharge	___	___	_____
Redness	___	___	_____
Sandy or Gritty Feeling	___	___	_____
Itching	___	___	_____
Burning	___	___	_____
Foreign Body Sensation	___	___	_____
Excess Tearing/Watering	___	___	_____
Occasional Tearing	___	___	_____
Eye Pain or Soreness	___	___	_____
Chronic Infection of Lids	___	___	_____
Sties, Chalazion	___	___	_____
Fluctuating Vision	___	___	_____
<u>Ears, Nose, Mouth, Throat</u>			
Sinus Congestion	___	___	_____
Dry Throat/Mouth	___	___	_____

please continue to the following page

	Yes	No	Explanation of Problem
<u>Cancer</u>	_____	_____	_____
<u>Cardiovascular</u>	_____	_____	_____
Heart	_____	_____	_____
High Blood Pressure	_____	_____	_____
<u>Respiratory</u>	_____	_____	_____
Lungs/Breathing	_____	_____	_____
<u>Gastrointestinal</u>	_____	_____	_____
Stomach/Intestines	_____	_____	_____
<u>Genitourinary</u>	_____	_____	_____
Kidney/Bladder	_____	_____	_____
<u>Musculoskeletal</u>	_____	_____	_____
Muscle or Joint Pain	_____	_____	_____
<u>Neurological</u>	_____	_____	_____
<u>Psychiatric</u>	_____	_____	_____
<u>Endocrine - Diabetes</u>	_____	_____	_____
<u>Allergic</u>	_____	_____	_____
Seasonal Allergies	_____	_____	_____
Hay Fever Symptoms	_____	_____	_____

List all major illnesses and injuries you have had in the past: _____

List any surgeries you have had in the past: _____

<u>Family History</u>	Yes	No	Relationship to You
Blindness	_____	_____	_____
Cataract	_____	_____	_____
Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Retinal Detachment	_____	_____	_____
Diabetes	_____	_____	_____
Heart Problems	_____	_____	_____
Cancer	_____	_____	_____

Social History

Current Occupation: _____

Do you drive? Yes ___ No ___

Do you have visual difficulty when driving? Yes ___ No ___

Do you have a problem with night vision? Yes ___ No ___

Have you ever tried to wear contacts? Yes ___ No ___

Do you currently wear glasses? Yes ___ No ___

If "yes," how long have you had the current pair? _____

Do you smoke? Yes ___ No ___ If "yes," how many packs a day? _____

Have you ever had a blood transfusion? Yes ___ No ___

Do you drink alcohol? Yes ___ No ___ If yes, how many glasses per day? _____

What are your hobbies or special interests? _____

To Be Completed by Physician and Staff

Medications and Dosages

Allergies

HX Reviewed: _____ No Changes: _____ Additions as Noted: _____

Doctor's Signature: _____ Date: _____

MID-AMERICA EYE CENTER, P.A.
Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (please print)

Medicare Number (if applicable)

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Mid-America Eye Center for services furnished me by Mid-America Eye Center. I authorized any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Mid-America Eye Center accepts the charge determination of the Medicare carrier and 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.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claims forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Mid-America Eye Center, if possible, or otherwise to me.

3. OTHER INSURANCE: I understand that Mid-America Eye Center, maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. Mid-America Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Mid-America Eye Center if I belong to a plan that does not appear on the above mentioned list. ***Some insurance plans require that a referral must be obtained from a primary care physician. The patient must acquire this referral prior to any office visit or surgery. This is a patient responsibility, and the patient will be held responsible for any and all balances due from failure to obtain a referral.***

4. NON-COVERED SERVICES: I understand that Mid-America Eye Center's contracts with health care plans (i.e., HMOs, PPOs, Missouri and Kansas Medicaid) relate only to items and services, which are "covered" by the health care service plans. Accordingly, the undersigned accepts full responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. **Refraction (92015) is not a covered service and is the patient's responsibility.** The undersigned agrees to cooperate with Mid-America Eye Center to obtain necessary health care service plan authorizations.

5. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Mid-America Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Mid-America Eye Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mid-America Eye Center. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

6. OWNERSHIP: The following physicians own interest in Physician's Surgery Center: Dr. Joseph J. Parelman, MD and Steven R. Unterman, MD.

Beneficiary Signature or Authorized Party

Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Notice to Patient:

Mid-America Eye Center is required to provide you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of Mid-America Eye Center's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency it was not possible to obtain an acknowledgment.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

Employee signature

Date