LASER VISION CENTER

NORTHEAST OHIO EYE SURGEONS

- Please complete the enclosed patient information form and bring it with you to your appointment. When you check in, give the form to the receptionist and have your insurance cards available to be copied. Although your insurance may not cover your surgery, it may cover un-related future visits to our office.

- The pre-surgical evaluation requires at least 2 hours to complete. **Your eyes will be dilated. We suggest a driver.**

- Contact lens patients: *All soft contact lens wear will need to be discontinued for two weeks prior to your appointment and four weeks for rigid gas permeable lenses to assure candidacy.* (For a simple screening visit, it is ok to wear your contact lenses to the visit.) Please bring your back-up glasses with you to your initial consultation so that we may measure that prescription as well.

- At Northeast Ohio Eye Surgeons, we pride ourselves in being a blade-free, custom guided facility with experienced surgeons and staff. Please let us know of any questions you may have throughout the process.

Northeast Ohio Eye Surgeons
4277 Allen Road
Stow, Ohio 44224

Phone: 330-929-8607

Welcome to The Laser Vision Center at Northeast Ohio Eye Surgeons. Our goal is to provide personalized surgery and personalized care for each individual. Our team of experienced technicians and doctors are here to guide you through this life-altering experience. We know there are many choices for laser vision correction and we thank you for choosing us.

We look forward to meeting you!!

Lawrence E. Lohman, M.D., F.A.C.S.

Marc F. Jones, M.D., F.A.C.S.

Elizabeth Muckley, O.D., F.A.A.O.

William R. Rudy, O.D

Katie L. Greiner, O.D., F.A.A.O.

Katherine R. Hastings, O.D.

Marcella E. Pipitone, O.D.

Kelly Schreiner, Director of Elective Surgery

LASER VISION CENTER

NORTHEAST OHIO
EYE SURGEONS

Refractive Surgery Information Survey

The information below is needed to help us get to know you (and your eyes) better. Please take some time to answer the following questions:

Patient Name:_____ Date:_____

Preferred Nickname:_____

Profession (please include common work tasks pertaining to your eye health and safety):

_____

Hobbies:_____

What brought you to the decision to explore refractive surgery?_____

_____

How did you hear about Northeast Ohio Eye Surgeons?

____ Optometrist (Please list name of eye doctor:_____

____ Friend (Please list name of friend:_____

____Website (Please list site: _____

____Mailer/Ad

____Other (Please explain:_____

Do you have any questions/concerns you would like answered before we begin today?

_____

_____

_____

How soon are you wanting refractive surgery?_____

Have you had a consultation elsewhere? Please provide any relevant information reagarding this visit:

_____

Thank you for considering Northeast Ohio Eye Surgeons for your refractive surgery.

We look forward to working with you! –Doctors and Staff

Patient Information Sheet

Name _____ Birthdate ___ / ___ / ___ Sex _____SSNo. _____

Last First

Address _____

Street City State, Zip

Home Phone _____Day Phone_____ Email Address:_____

Marital Status _____ Primary Care Doctor _____ Optometrist_____

Pharmacy of Choice _____City/Street _____

Responsible Party Information (required if patient is less than 18)

Name _____ Birthdate ___ / ___ / ___ Sex _____ SSNo. _____

Last First

Address _____

Street City State, Zip

Home Phone _____Day Phone_____ Email Address:_____

Relationship to Patient _____ Martial Status _____

Other Responsible Party _____ Home / Cell Number _____

Insurance Information

Primary Insurance:_____Policy Number _____

Name of Subscriber_____Subscriber's Date of Birth_____

Relationship to Patient_____ Copay Amt _____

Secondary Insurance:_____Policy Number _____

Name of Subscriber _____Subscriber's Date of Birth_____

Relationship to Patient_____ Copay Amt _____

Release of Information

If any family or friends should call our office about your healthcare or appointments we can not disclose any information unless you've listed them below. Please list the person(s) whom you give Northeast Ohio Eye Surgeons permission to discuss your medical care.

Name_____Phone_____

Name_____Phone_____

Emergency Contact Name _____ Phone_____

Name: Date:	Birthdate:
Occupation:	Family Physician:

Systemic or General Health History Form
Please review the following complete lists and indicate conditions or surgeries that apply

General Medical History:

☐ **NONE of the Following Conditions**

ENDROCRINE:
☐ Diabetes**
☐ Year Diagnosed:_____
☐ Diet Controlled
☐ Pills (No Insulin)
☐ Insulin
☐ Thyroid Disease**
☐ HyperThroidism
☐ Grave's Disease
☐ Goiter
☐ Hypo-Thryroidism
☐ Hashimoto's
☐ Liver Disease
☐ Gall Bladder Disorder
☐ Pituitary Problem**
☐ Pituitary Tumor**
☐ _____

CARDIOVASCULAR:
☐ A-Fib
☐ Arrhythmias (Irregular Heart)
☐ Carotid (Neck) Artery Blockage
☐ Congestive Heart Failure (CHF)
☐ Coronary (Heart) Blockage
☐ Heart Attack (MI)
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Sickle-Cell Anemia**
☐ Bleeding /Clotting Disorder
☐ Stroke**
☐ With Vision changes
☐ Without Vision changes
☐ TIA (mini-stroke)
☐ Temporal Arteritis**
☐ _____

NEUROLOGICAL:
☐ Bell's (or Facial) Palsy**
☐ Chiari malformation **
(Arnold-Chiari)
☐ Headaches—Chronic
☐ Headaches—Cluster
☐ Headaches—Migraines
☐ "Ocular Migraines" **
(Visual Distortion without Headache)
☐ Multiple Sclerosis (MS)**
☐ Neurologic Problem
☐ Parkinson's Disease**
☐ Epilepsy

☐ _____

General Medical History Cont'd:

ENT– Ear-Nose-Throat:
☐ Allergies—Seasonal Hayfever
☐ Hearing Impaired
☐ Acoustic Neuroma **
☐ Meniere's Disease**
☐ Dizziness or Vertigo
☐ Sinus Congestion
☐ _____

LUNG-BREATHING-PULMONARY:
☐ Breathing Problems
☐ Asthma
☐ Emphysema—COPD **
☐ Sleep Apnea
☐ Bronchitis—Chronic
☐ Lung Cancer**
☐ Lupus (SLE)**
☐ Sarcoidosis**
☐ _____

SKIN—MUSCULAR SKELETAL-AUTOIMMUNE:
☐ Acne Rosacea**
☐ ALS ("Lou Gehrig's")**
☐ Basal Cell Carcinoma
☐ Behcet's Syndrome**
☐ Connective Tissue Disorder
☐ Dermatitis-Eczema-Psoriasis
☐ Fibromyalgia
☐ Arthritis—Osteo-arthritis
☐ Rheumatoid Arthritis**
☐ HLA-B27 + **
☐ Marfan's Disease**
☐ Osteoporosis
☐ Paget's Disease**
☐ Polio
☐ Reiter's (Reactive Arth) Syndrome**
☐ Scleroderma**
☐ Sjogren's Syndrome**
☐ Skin Cancer
☐ _____

RENAL-URINARY-REPRODUCTIVE:
☐ Prostate Problems
☐ Renal Failure**
☐ Dialysis

☐ **PREGNANT or NURSING**

DIGESTIVE TRACT:
☐ Irritable Bowel Syndrome
☐ Crohn's Disease**
☐ Ulcerative Colitis**
☐ Colon Cancer
☐ _____

General Medical History Cont'd:

COGNITIVE-EMOTIONAL-DEVELOP:
☐ Autism
☐ Asperger's
☐ Pervasive Dev Disorder (PDD)
☐ Anxiety
☐ Bipolar
☐ Depression
☐ Developmental Delay
☐ Downs Syndrome
☐ Intellectual Disability (MRDD)
☐ Learning Disorder
☐ Mild
☐ Moderate-Severe
☐ Psychiatric Disorder
☐ Schizophrenia
☐ _____

List Any Health Issues that might be important:
_____
_____
_____
_____

Infectious Conditions:

☐ **NONE of the Following Conditions**

☐ Chlamydia**
☐ Chicken Pox
☐ Histoplasmosis **
☐ Hepatitis: **
☐ Type A
☐ Type B
☐ Type C
☐ Uncertain
☐ Herpes Simplex
☐ Above the Waist **
☐ Cold Sores
☐ Eye
☐ Below the Waist
☐ HIV Positive **
☐ AIDS **
☐ Measles
☐ German Measles**
☐ Meningitis
☐ Mumps
☐ Rheumatic Fever**
☐ Scarlet Fever**
☐ Sexually-Transmitted Disease
☐ Syphillis**
☐ Toxoplasmosis**
☐ Tuberculosis**
☐ _____

Name:	Date:	Birthdate:
Preferred Pharmacy:	Street:	City:

Ocular (Eye) History Form

Please review the following complete lists and indicate conditions or surgeries that apply

Past Eye History:

☐ **NONE of the Following Conditions**

☐ Cataract
☐ Cataract Surgery :
  ☐ Right Eye:
    Date : _____
    Surgeon:_____
  ☐ Left Eye:
    Date : _____
    Surgeon:_____

☐ Glaucoma
☐ Glaucoma : Borderline or Suspect
☐ Glaucoma Laser
☐ Glaucoma Surgery
☐ "Narrow Angle"

☐ Macular Degeneration
  ☐ Dry Form
  ☐ Wet Form
    ☐ Laser Treatment
    ☐ Injections
    ☐ Not Sure
☐ Diabetic Retinopathy
  ☐ Laser Treament
  ☐ Injections
  ☐ Not Sure
☐ Amblyopia—"Lazy Eye"
    ☐ Patched as a Child
    ☐ Not Patched
    ☐ Surgery as Child
☐ Turned Eye (Strabismus)
    ☐ Crossed Eye
    ☐ "Wall-eyed"
    ☐ Surgery
☐ Duane's Syndrome

Lids/Face:

☐ Bell's Palsy
☐ Blocked Tear Duct
☐ Blepharospasm
    ☐ Facial Spasm
☐ Ectropion—Lid turning outward
☐ Entropion—Lid turning inward
☐ Eye lid Surgery
☐ Dry Eye Syndrome
☐ Cranial Nerve Palsy
☐ Orbital Fracture

Misc

☐ Double Vision
☐ Iritis
☐ Uveitis

Past Eye History Cont'd:

Cornea:

☐ Corneal Scar
☐ Corneal Ulcer
☐ Corneal Dystrophy ☐ Fuch's
☐ Herpes Simplex (Cold Sore) in eye
☐ Pterygium
☐ Shingles on Face
☐ Keratoconus (or Pellucid Degen)
☐ Other Eye Surgeries _____
_____
_____

Retina/Optic Nerve:

☐ Floaters
☐ "Stroke In Eye"
  ☐ Broken Blood Vessel IN Eye
  ☐ Blood Clot in Eye
☐ Macular or Retinal Wrinkling
☐ Nystagmus
☐ Optic Atrophy
    (Optic Nerve Damage)
☐ Optic Neuritis
☐ Histoplasmosis in Eye
☐ Pseudotumor Cerebri
    (Intracranial Hypertension)
☐ Retinal Detachment or Tear
  ☐ Laser Treatment
  ☐ Buckle Procedure
☐ Retinal Problem—Unknown

History of Head or Eye Trauma:

☐ **No Significant Traumas**

☐ Assault to Head
☐ Blunt Trauma to eye
☐ Chemical Injury to eye
☐ Foreign Body in eye
☐ Severe Head Trauma
☐ Motor Vehicle Accident
☐ Sharp Object to eye

Have you EVER taken the following medications:

☐ Flomax or Tamsulosin

Are you CURRENTLY taking any of the following medications (Please Circle):

☐ Aspirin ☐ Coumadin
☐ Plaquenil ☐ Plavix
☐ Prednisone ☐ Warfarin

Non-Eye Major Surgeries:

☐ **NONE of the Following Surgeries**

☐ Aortic Valve Replacement
☐ Amputation—Limb
    ☐ Arm
    ☐ Leg
☐ Angioplasty
☐ Back Surgery
☐ Bladder Surgery
☐ Brain Surgery**
☐ Carotid Endarterectomy
☐ Coronary Artery Bypass—CABG
☐ Colostomy
☐ Gallbladder Surgery
☐ Gastric Bypass (Weight Loss)
☐ Gastro-Intestinal (GI) Surgery
☐ Heart Stents
☐ Hip Replacement
☐ Hysterectomy
☐ Knee Surgery
☐ Mastectomy
☐ Mitral Valve Replacement
☐ Organ Transplant
    ☐ Kidney
    ☐ Liver
    ☐ Other:_____
☐ Pacemaker Implant
☐ Parathyroidectomy
☐ Pituitary Surgery**
☐ Thyroidectomy

☐ Cancer**
    Primary Type/Location:

_____

List any other surgeries that involve: Heart/Blood Vessels/Brain/Major Nerves/Glands of the body:

_____
_____
_____
_____
_____
_____

Name: Date:	Birthdate:

Family Eye History
Please indicate conditions that apply and the affected family member

☐ **NONE of the Following Conditions**

☐ Glaucoma

_____

☐ Macular Degeneration

_____

☐ Keratoconus

_____

☐ Retinal Tear or Detachment

_____

☐ Blindness

_____

How many alcoholic drinks do you consume per day?

_____

Alcohol Use

Please check all that apply:

Tobacco Use

☐ Current every day smoker
☐ Current some days smoker
☐ Former Smoker
☐ Never Smoker
☐ Unknown if ever smoked
☐ Smokeless Tobacco

Recreational Drug Use

Do you use recreational drugs?

☐ Yes ☐ No

If Yes, what/how much _____

_____

Medications
Please list all current medications with dosage

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Allergies
Please list all allergies and associated reactions

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For Office Use Only
~~Medical History Recorded by (Date):~~

_____
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_____

Signature on File and Assignment of Benefits

_____

Patient Name (print)

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Northeast Ohio Eye Surgeons, for services furnished me by Northeast Ohio Eye Surgeons. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorized 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. Northeast Ohio Eye Surgeons 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.

2. **MediGap:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature 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 Northeast Ohio Eye Surgeons, if possible or otherwise to me.

3. **Release of Information:** Northeast Ohio Eye Surgeons may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Northeast Ohio Eye Surgeons for reimbursement for services rendered (2) any health care provider for continued patient care. Northeast Ohio Eye Surgeons may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **Other Insurance:** I understand that Northeast Ohio Eye Surgeons maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Northeast Ohio Eye Surgeons 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 Northeast Ohio Eye Surgeons if I belong to a plan that does not appear on the above mentioned list.

5. **Non-Covered Services:** I understand that Northeast Ohio Eye Surgeon's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial 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 test not authorized by the health care service plan. The undersigned agrees to cooperate with Northeast Ohio Eye Surgeons to obtain necessary health care service plan authorizations.

_____ _____

Patient Signature or Authorized Party Date

NORTHEAST OHIO
EYE SURGEONS

Patient Financial Policy Statement

Welcome to Northeast Ohio Eye Surgeons and thank you for choosing us to be your eye care provider. Your clear understanding of our financial and practice policies is important to our relationship with you. We are committed to exceeding the expectations for quality eye care through qualified trained staff and doctors.

For your convenience: insurance claim forms will be prepared and sent to your insurance company(s) on your behalf for exams and procedures performed by the doctors at Northeast Ohio Eye Surgeons. A statement for your deductible, co-insurance and/or any non-covered charges will be sent to you as we receive an explanation of payment from your carrier. Balances are due upon receipt of the statement. Please be aware that the balance on your acccount is your responsibility whether or not your insurance company pays the claim. Accounts with unpaid balances may be forwarded to a collection agency. Personal checks that are returned for non-sufficient funds are subject to administrative fees.

Each office visit billed is based upon clinical information, not based on coverage by insurance companies. We follow our patients for vision and medical diagnosis, please be sure to let us know if you are here for an annual/biannual eye exam. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance company is considered insurance fraud and will not be done by our office. All patients are required to complete our patient information form and health history questionnaire.

Co-pays are required at the time of service. We try our best to collect the correct co-pay amount from you at the time of service as required. To help with correct co-pay and insurance billing it is imporant that you keep the office up to date with your insurance information. If an office copayment is not paid at the time of your visit a service fee will be charged per practice policy.

Please be advised that the contract between you and your insurance company is a separate contract from the relationship between you and our practice. It is your responsibility to be knowledgeable of your insurance coverage/benefits/eligibility and to alert us should your insurance or copay change. If proof of coverage cannot be provided at each visit you will be responsible for payment in full at the time of service.

Workers Compensation or automobile accident claims will be billed directly to the carrier. Payment of any disputed or denied claims will be your responsibility. A service charge for filling out forms or FMLA papers may be charged per practice policy.

Medicare recipients and Medicare HMO recipients: Medicare and related Senior Health Plans do not cover routine vision testing and refractions. Refraction is the test that is done to see if vision can be improved with glasses. Refraction is an out of pocket expense with payment due at the time of service.

Appointment Utilization: We kindly request at least 24 hours notice when cancelling or rescheduling your appointment. Missed appointment times could be used to treat other patients in need of care. No Show/missed appointments may be charged a service charge per practice policy. Please help us provide the best care for you and our other patients by keeping your scheduled appointment. Additionally, to prevent delays in care please do not use a cellphone/text when a care provider is with you.

Patient Signature_____ Date:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The purpose of this Notice is to provide you with information regarding our privacy practices, including the ways in which we may use or disclose your health information. The Notice also describes your rights and our obligations concerning such uses and disclosures.

Uses and Disclosures
Northeast Ohio Eye Surgeons is committed to maintain the privacy and confidentiality of your health information.

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, laboratory results, surgery information, specialized testing, co-management information, etc. will be available in your medical record to all health professionals who may provides treatment now or in the future.

Payment. Your health information may be used to seek payment from your health plan or other sources of payment, including finance companies that you may use for services. For example, your health plan may request dates of service, services rendered, and diagnosis.

Healthcare operations. Your health information may be used for evaluation of the day to day operations of Northeast Ohio Eye Surgeons. For example, your procedure or services may be used for financial reporting.

Family and Friends. With your approval and using our professional judgment, your health information may be disclosed to designated family, friends, and others who are directly involved in your care or the payment of your care. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval.

Law enforcement. Your health information may be disclosed to law enforcement officials, without your permission, to support government audits and inspections and to comply with government reporting.

Public health reporting. Your health information may be disclosed to public health officials as required by law. For example, we are required to report certain infectious diseases to the state's public health department.

Worker's compensation. Your health information may be disclosed, for purposes of payment, if there is a work related illness or injury.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your written authorization. A written revocation of the authorization can be made at any time. This revocation will not affect the previous release of information.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to remind you of upcoming appointments.

Newsletters. Your health information will be used by our staff to send you a newsletter. You may call our office if you do not wish to receive the newsletter.

Your Rights

Restrictions on Use and Disclosure of Individual Health Information. You have the right to request restrictions on some of our uses and disclosures of your health information. These restrictions must be made in writing and signed by you. This office is not required to abide by your restrictions. We retain the right to terminate a restriction if we believe such termination is appropriate. You have the right to terminate, in writing or orally, any restriction by sending such termination notice to the Compliance/Privacy Officer at 2013 State Route 59, Kent, Ohio 44240.

Access to Individual Health Information. You have the right to inspect and copy your health information maintained by this office. All requests for access must be made in writing and signed by you or your representative. There may be a nominal fee per page and for postage, if a mailed copy is requested. You may obtain a request for access form from the Compliance/Privacy Officer at 2013 State Route 59 Kent, Ohio 44240.

Amendments to Individual Health Information. You have the right to request in writing that your health information maintained by this office be amended. In certain cases, we may deny your request for the amendment. All Amendment requests must be made in writing and signed by you or your representative and must state the reason for the amendment. You may obtain an amendment request form from the Compliance/Privacy officer at 2013 State Route 59, Kent, Ohio 44240. If we deny your request, you may submit a statement of disagreement to us. Please contact the Compliance/Privacy Officer for questions about amendments to your health information.

Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures made by us of your health information. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Compliance/Privacy Officer at 2013 State Route 59, Kent, Ohio 44240. There may be a nominal fee for each accounting you request. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Compliance/Privacy Officer at 2013 State Route 59, Kent, Ohio 44240. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing. There will be no retaliation for filing a complaint.

Additional Information

If you have any questions or need additional assistance regarding this Notice, you may contact the Compliance/ Privacy Officer at 2013 Ste Route 59, Kent, Ohio 44240 or by phone (330) 678-0201.

Patient Signature: _____ Date: _____

_____NEOES employee initial here to verify patient received a copy of this Notice.

2/03 kmk; updated 9/08 tlb