

What to Expect During Your Visit

How Long is My Appointment?

Ophthalmology appointments typically take longer than a routine doctor's visit. **Your child's appointment may last two or two and half hours.** During the appointment, your child will receive a comprehensive eye exam, and will most likely have his or her eyes dilated with eye drops.

Initial Evaluation

The ophthalmologist will need to know about your child's general health. Be sure to tell staff about your child's:

- Medical problems
- Surgical procedures
- Allergies
- Medications that your child is taking

If your child has been previously treated with glasses or contact lenses, please have these ready. Also, bring the names and addresses of all physicians who may be treating your child; that way, the ophthalmologist can quickly share any important findings with your child's other doctors.

Eye Examination

We encourage you to stay with your child through the entire examination. We can examine infants and small children while they sit on a parent's lap. Older children are encouraged to sit in the exam chair by themselves.

Your child's ophthalmologist will carefully observe each eye as your child tracks lights or toys. This can give an estimate of a child's visual function. Children who talk but cannot read or count may be asked to identify pictures of common objects. Cooperative and verbal older children will have their vision tested using a computerized eye chart.

We may use lights to determine if your child's eyes are straight or turned. The alignment of the eyes can also be checked by covering one eye and then the other. If the eyes move back and forth during this procedure, they are not aligned properly. Prisms can be used to measure the amount of misalignment.

Your child will likely be given eye drops. These might sting slightly for a few seconds and will make their vision blurry for 4-6 hours. The eye drops are used to dilate the pupils, which gives the ophthalmologist a better view of the structures inside the eye, such as the retina, optic nerve, and blood vessels. **The drops may be given one or more times and take about 30 to 45 minutes to become fully effective.**

These eye drops also cause a temporary weakness of the eyes' focusing muscles. This allows the ophthalmologist to determine if your child has a focusing or refractive error that requires glasses. Refractive errors include:

- Nearsightedness (myopia)
- Farsightedness (hyperopia)
- Distorted vision (astigmatism)

Some children may require a little extra time than others, and some parents may have more questions for the doctor about their child's eye diagnoses. We appreciate your patience, and please know that we will give you and your child the same care and attention.

DATE: _____



ACCT #: _____

PATIENT DEMOGRAPHIC INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)				DATE OF BIRTH	
GENDER	ADDRESS		CITY	STATE	ZIP
HOME PHONE		WORK PHONE	CELL PHONE		
SOCIAL SECURITY #		EMAIL ADDRESS			
REFERRING PHYSICIAN			PRIMARY CARE PHYSICIAN		
SPOUSE NAME			DATE OF BIRTH	SSN	
ARE YOU (the patient) OF HISPANIC OR LATINO DESCENT? Y N			RACE: white black hispanic asian other		
EMERGENCY CONTACT			RELATIONSHIP	PHONE#	
MAY WE CONTACT YOU AT THE PHONE NUMBER, ADDRESS AND/OR EMAIL ADDRESS GIVEN ABOVE? Y N					
IF NOT HOW MAY WE CONTACT YOU? _____					
EMPLOYER INFORMATION					
EMPLOYER'S NAME			BUSINESS PHONE		
SPOUSE'S EMPLOYER			BUSINESS PHONE		
IF PATIENT IS A CHILD, PLEASE COMPLETE					
NAME OF PARENT WITH WHOM CHILD RESIDES			DOB	SSN	
ADDRESS		CITY	STATE	ZIP	
HOME PHONE	EMPLOYER'S NAME		WORK PHONE		
OTHER PARENT		DATE OF BIRTH	SSN		
ADDRESS		CITY	STATE	ZIP	
HOME PHONE	EMPLOYER'S NAME		WORK PHONE		
IF A PARENT IS UNABLE TO ATTEND A CHILD'S APPOINTMENT WHO MAY ACCOMPANY THE PATIENT					
NAME		PHONE #	SSN		
NAME		PHONE #	SSN		
INSURANCE INFORMATION					
DO YOU HAVE MEDICAID INSURANCE? Y N					
PRIMARY INSURANCE			DO YOU HAVE A SECONDARY INSURANCE? Y N		
INSURANCE COMPANY			INSURANCE COMPANY		
ID#	GROUP#	ID#	GROUP#		
GUARANTOR OF INSURANCE			GUARANTOR OF INSURED		
DATE OF BIRTH	SSN	DATE OF BIRTH	SSN		
RELATIONSHIP TO INSURED			RELATIONSHIP TO INSURED		

PLEASE READ AND SIGN BACK OF FORM

Revised Date 09/23/13

**BILLING AND PAYMENT AUTHORIZATION
AUTHORIZATION FOR THE EYE CENTER SURGEONS & ASSOCIATES, LLC**

By signing below, I authorize The Eye Center to request payment, made directly to The Eye Center and file an insurance claim based on insurance information I provide to include Medicare, Medicare Supplement Plans, and Medicaid Plans. I agree to provide the most updated insurance information with allowing a copy of the card to be on file. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company and its agents, any information needed to determine benefits or the benefits payable for related services.

By signing below, I understand the following:

Each patient is responsible for obtaining a referral if one is required by your insurance carrier. It is the patient's responsibility to ensure that The Eye Center is a participating provider with their insurance carrier. If The Eye Center is a participating provider we will file the claim for your office visit or surgery, please allow 45 days for payment in full. If you do not have insurance, do not have a referral for the service date or we are not a participating provider with your insurance, payment is expected at the time services are rendered. Co-payments and non-covered fees, such as refraction fees (up to \$35.00) are the responsibility of the patient and are due at the time of service. Patients may be subject to a \$10.00 fee for co-payments not paid the same date of service. Any accounts subject to collections due to non-payment will accrue a 15% fee added to remaining balance.

SIGNATURE **X** _____ DATE **X** _____

RESTRICTIONS TO THE USE AND/OR DISCLOSURE OF PERSONAL PROTECTED HEALTH INFORMATION

If you choose to restrict the use and/or disclosure of your protected health information you can list the restriction(s) below:

This authorization permits The Eye Center to send the protected health information ONLY to this address or fax number. Any other address or fax number is not permitted by this authorization.

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on the authorization or, if applicable, during contestability period. In order for the revocation of the authorization to be effective.

The Eye Center must receive that revocation in writing. This revocation must include:

- The patient's name, address and date of birth
- The effective date of the authorization, and the recipients of the protected health information according to this authorization
- The patient's desire to revoke the authorization
- The date of the revocation, and the patient's signature

The Eye Center will accept written revocations of the authorization via U.S. Mail or Facsimile at 256-533-3213. ALL revocations must be sent to The Eye Center to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit The Eye Center a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnostics, treatment, and a plan for future care or treatment. This information, often referred to as your medical record serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which your or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to:

ensures its accuracy, better understand who, what, when, where, and why others may access your health information, and make informed decisions when authorizing disclosures to others.

PLEASE BE ADVISED PHONE CALLS MADE TO AND FROM THE EYE CENTER MAY BE MONITORED FOR QUALITY ASSURANCE