SABATES EYE CENTERS

The most trusted name in eye care.™

ROUTINE VS. MEDICAL EYE EXAM?

What You Need To Know Before Your Exam

- **Know the difference between Routine and Medical eye exams to maximize your insurance benefit.**

- **Please clarify the type of exam you need when scheduling to avoid the confusion.**

- **A Routine Eye Exam**
  - Assesses the basic general health of your eyes and may include dilation
  - Provides a prescription for new glasses or contact lenses (please identify if contact lens prescription is also needed)
  - No medical eye conditions will be evaluated at this exam
  - Filed as a routine eye exam with your vision service plan

- **A Medical Eye Exam**
  - Thorough dilated exam to address medical eye conditions
  - Examples: Cataract, Glaucoma, Diabetic Retinopathy, Macular Degeneration
  - This type of exam is a detailed medical exam to determine, assess, and recommend any treatment necessary and may include additional testing
  - Filed to your insurance under your medical coverage

WE APPRECIATE YOUR UNDERSTANDING
IF YOU HAVE ANY QUESTIONS, PLEASE CALL 913-261-2020

SABATES EYE CENTERS

Sabates Eye Centers
P.O. Box 26425
Kansas City, MO 64196-6425
(913) 261-2020

Type of Visit: ☐ Routine ☐ Medical Contact Lens Wearer? ☐ Yes ☐ No

PATIENT INFORMATION				
Name (Last, First, Middle Initial)		Date of Birth	Social Security #	
Local Address		Home Phone	Medical Record #	Sex
City, State, Zip		Secondary/Billing Address (If Applicable)		
Work Phone	Cell Phone		City, State, Zip	
E-Mail Address		Primary Employer		
Primary Care Physician		Local Address		
Referring Physician		City, State, Zip		

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)			
Name (Last, First, Middle Initial)	Social Security #	Date of Birth	Sex
Local Address	Name of Nearest Friend or Relative That Does Not Live with Patient		
City, State, Zip	Local Address		
Home Phone	City, State, Zip		
Relationship to Patient	Home Phone		

PRIMARY INSURANCE			
Name of Insurance Company	Policy # / ID #		
Name of Insured	Group #		
Address of Insurance Company	Co-Pay Amount		
City, State, Zip	Insured Social Security #	Insured Date of Birth	
Relationship to Patient	Effective Date	Expiration Date	

SECONDARY INSURANCE		
Name of Insurance Company	Policy # / ID #	
Name of Insured	Group #	
Address of Insurance Company	Co-Pay Amount	
City, State, Zip	Insured Social Security #	Insured Date of Birth
Relationship to Patient	Effective Date	Expiration Date

SIGNATURE OF PATIENT / GUARDIAN **DATE**

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IS THIS A WORK RELATED INJURY? _____ Yes _____ No

If you answered yes, please notify the receptionist immediately.

Pharmacy Name _____

Pharmacy Address _____

_____

_____

Pharmacy Phone Number _____

MEDICATIONS: Please list all medications you are currently taking and include dosages.

_____

_____

_____

_____

_____

_____

ALLERGIES: Please list

_____

_____

_____

The following authorization permits us to provide appropriate information to your insurance company, Medicare, other physicians, and others who are legally entitled. Please read carefully.

LIFETIME AUTHORIZATION

I authorize reports of my evaluations, treatments and any follow-up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers that I have or will identify to you. I also authorize release of all pertinent medical information to any hospital or outpatient facility or clinic. Photography may be used in the evaluation and management of my condition. I consent to the taking of such photographs, if necessary, and to their possible use in medical meetings, books, journals or other aspects of medical education. If provided, I authorize the use of E-mail as a means of contact.

I UNDERSTAND THAT I AM FULLY AND LEGALLY RESPONSIBLE FOR PAYMENT OF THE ACCOUNT WHICH INCLUDES ALL OUTSTANDING BALANCES NOT COVERED BY MEDICARE AND/OR INSURANCE COMPANIES.

(I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies indicated, or to my employer if this is a worker's compensation claim, any information, including retirement dates, needed for this or a related insurance or Medicare claim.) I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to a party who accepts assignment.

_____

PATIENT'S NAME (Please Print) **PATIENT'S SIGNATURE** **DATE**

MR# _____

SABATES EYE CENTERS

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At Sabates Eye Centers we are dedicated to providing the best eye care to you and your family. As part of this goal, we are focused on meeting Meaningful Use objectives to improve clinical quality and patient outcomes. "Meaningful Use" is a government program to ensure that healthcare professionals are utilizing their Electronic Medical Record (EMR) system efficiently to improve healthcare quality and patient safety. A core objective in Meaningful Use is to document patient demographics including: "preferred language", "gender", "race", "ethnicity", and "date of birth". The Race, Language and Ethnicity categories below are defined by the Federal Office of Management and Budget and the United States Census Bureau.

Please use the lists below when indicating your Race, Language and Ethnicity:

RACE

☐ - American Indian or Alaska Native	☐ - Native Hawaiian or Pacific Islander
☐ - Asian	☐ – White/Caucasian
☐ - Black or African American	☐ - Other

PREFERRED LANGUAGE

☐ - English	☐ - Spanish	☐ - Other

ETHNICITY

☐ - Non-Hispanic or Latino ethnicity	☐ - Hispanic or Latino ethnicity

Participation in this questionnaire is voluntary, you are not obligated to provide this information if you do not wish.

☐ – I do not wish to participate

Sabates Eye Centers understands that this is personal and sensitive information. We want to assure you that this information will only be used as part of the Meaningful Use objectives.

Patient Initials: _____

SABATES EYE CENTERS

Corporate Office
11261 Nall Ave.
Leawood, KS 66211
Phone: 913-261-2020
Fax: 913-261-2090

PERSONAL REPRESENTATIVE DESIGNATION FORM

Patient Name:_____ Our MR#: _____

This form allows you to give Sabates Eye Centers permission to discuss your Protected Health Information with a person(s) you appoint as your Personal Representative.

You are not required to name a Personal Representative, **but if you do not**, we will not disclose your Protected Health Information to someone who may call on your behalf. Your Personal Representative may be anyone of your choosing such as a spouse, parent, child or friend. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

You may revoke this designation of a Personal Representative at any time by giving written notice to the Privacy Official.

- ☐ **I decline** to name a Personal Representative. Please check box, sign and date this form.***
- ☐ Restricted Access. All requests approved by patient only. ***

1.) Personal Representative **To Confirm Personal Representative**

Full Name:_____ Relationship: _____

Contact Phone:_____ Date of Birth: _____

Any limitations on issues your personal representative may discuss:	Yes	No
If yes, please specify (example: Medical, financial, etc.):		

2.) Personal Representative **To Confirm Personal Representative**

Full Name:_____ Relationship: _____

Contact Phone:_____ Date of Birth: _____

Any limitations on issues your personal representative may discuss:	Yes	No
If yes, please specify (example: Medical, financial, etc.):		

3.) Personal Representative **To Confirm Personal Representative**

Full Name:_____ Relationship: _____

Contact Phone:_____ Date of Birth: _____

Printed Patient Name: _____ Date of Birth: _____ Date: _____

_____ _____

Signed Patient/Legal Representative* *Relationship to Patient

Please return this completed form to: Sabates Eye Centers Privacy Official 11261 Nall Ave. Leawood, KS 66211
If you have any questions about this Personal Representative Designation form, please call the Privacy Official at (913) 261-2020.

SABATES EYE CENTERS

FINANCIAL POLICY

Thank you for selecting Sabates Eye Centers for your eye care needs. The following information outlines financial responsibilities related to payment for your professional services.

You, the patient, are ultimately responsible for all charges associated with your care. Sabates Eye Centers participates with a variety of insurance plans. We refer to "in network" as the insurance companies that we have a contract agreement with. Please be aware, you incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check your insurance company for coverage and participation detail.

Please understand the fee for a refraction could be a non-covered service. If so, patient must accept full financial responsibility for the cost of this diagnostic service.

We will submit insurance claims on your behalf to your primary insurance and one secondary insurance carrier. However, your insurance is a contract between you and your insurer, and it is your responsibility to know and understand the requirements of your insurance plan. We are not responsible if you do not follow the specific terms of your insurance agreement and if we do not receive payment from them, you will be responsible.

For each visit, it is your responsibility to:

- Bring your insurance cards, for both vision and medical coverage, and picture ID.
- Be prepared to pay for your co-pay and non-covered services.
- Obtain any referrals that your insurance requires.
- Provide a valid physical address. Post office boxes may be used as mailing addresses only.

Failure to provide any of the above may require you to pay in full or reschedule your visit.

If there is a remaining balance due after your insurance carrier pays, you will be billed. If that balance is not paid within 60 days, we send outstanding balances to an outside collection agency without further notice. Payment arrangements can be made, but it is your responsibility to contact the Billing Office before it is turned over to an outside agency.

We accept cash, check, VISA, MasterCard, Discover and American Express.

If the patient is a minor (17 years and younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at the time of service, required referrals, insurance, and picture ID cards.

If you have any questions or need assistance, please do not hesitate to contact our Billing Office at (913) 261-2080, option 2, Toll Free at (800) 742-0020], Monday-Friday, 8:00 am to 5:00 pm CST.

Your signature below indicates that you have read and agree to this Financial Policy.

_____ _____

Patient or Guardian's Signature Date

Listed below are websites for information regarding financing options for healthcare services.
We do not endorse any of these financing options.

www.creditcare.com https://retailservices.wellsfargo.com/pl/2169081312