Drs. Miller & Flynn, Optometrists
2757 Laurel St.
Columbia, SC 29204

Patient Information:

Last Name_____ **First Name**_____ **MI**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Home Phone_____ **Work**_____ **Cell**_____
Date of Birth_____ **Email**_____
Insurance Carrier_____ **SSN**_____ **Occupation**_____
Date of last Exam_____ **Referred by**_____ **Driver's License #** _____
Pharmacy Name & Location _____
Name of family doctor & location: _____**Last date of visit:**_____
Gender: Male ☐ **Female** ☐ **Language: English** ☐ **Other:**_____
Ethnicity: Caucasian/White ☐ **African American/ Black** ☐ **Native Hawaiian or Pacific Islander** ☐ **Asian** ☐
Hispanic or Latino ☐ **American Indian or Alaskan Native** ☐ **Other** ☐ **Unknown** ☐ ***DECLINE TO ANSWER*** ☐

Spouse/Guardian/Insurance Holder Information:

Last Name_____ **First Name**_____ **MI**_____
Address_____ **City**_____ **State**_____ **Zip**_____
SSN_____ **Date of Birth**_____ **Cell**_____

Medical History: **Please circle if you have or have had any of the following issues:**

Gastrointestinal:…….**Y N** **Nervous system:**…….**Y N** **Mental:**……**Y N**
Urinary:……..**Y N** **Ear/Nose/throat:**……**Y N** **Endocrine:**…… **Y N**
Cardiovascular:……. **Y N** **Musculoskeletal:**……..**Y N** **Blood/Lymph:**…… **Y N**
Respiratory:……**Y N** **Skin:**……..**Y N** **High Blood Pressure:. Y N**
Diabetes:…….. **Y N** **If yes, what type:**_____ **Date of diagnosis**_____
Allergies:…… **Y N** **If yes, what are you allergic to:**_____
Do you use tobacco products.... Y N **Alcohol?..... Y N** **Other Substances?.... Y N**
Have you had any operations…..Y N If yes, What kind?_____ **When**_____
Other:_____
Current Medications or Type:_____
_____

Ocular History: **Please circle if you have or have had any of the following issues:**

Glaucoma:……**Y N** **Macular Degeneration…. Y N** **Cataracts**…….. **Y N**
Keratoconus:……..**Y N** **Dry Eyes**…… **Y N** **Allergic conjunctivitis**…… **Y N**
Have you ever had any eye injuries?…… **Y N** **Have you ever had any eye operations?**……**Y N**
Do you wear Glasses?……**Y N** **Do you wear Contacts?**……**Y N** **What type:**_____

Family Medical History: **Please circle if your immediate family has had any of the following issues:**

Diabetes:…….. **Y N** **High Blood Pressure:. Y N** **Macular Degeneration Y N**
Glaucoma:……**Y N** **Cataracts**…… **Y N** **Other:**_____

Please alert our office if you are nursing, pregnant, or may become pregnant!

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Thank you for choosing Drs. Miller & Flynn for your eye care experience. We strive to provide the best and most comprehensive eye care experience possible. Our office prides itself in delivering patient satisfaction. We hope that we are able to achieve this result with you. As a token of our appreciation for any referral to our practice, we offer a **$10 credit** to your account for **any future** visit. **Patient Initial**

Your exam today may include a **refraction**, the portion of the exam which calculates your glasses or contact lens prescription. Your medical insurance does not pay for the **refraction**, regardless of your diagnosis. If you have vision insurance, it may cover the refraction. If your insurance does not cover the **refraction**, then you will be responsible to pay the $15 along with your co-pay. How an examination is filed will be determined based on the diagnosis that drives the examination. That diagnosis will determine if the patient encounter is a medical encounter which will be filed with the medical insurance versus a refractive encounter which will be filed with the vision insurance. If you have any questions, please ask someone in our office. **Patient Initial** _____

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both, and our practice accepts both:

1. **Vision Care Plans** (such as VSP and Eyemed)
2. **Medical Insurance** (such as Blue Cross/Blue Shield and Medicare)

- Vision Care Plans only cover routine vision exams along with eyeglasses and contacts lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that may affect your eyes. Your doctor will determine if these conditions apply to you, but some are determined by your health history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out of pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advance authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, you are responsible for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract. Non-covered services may include refraction, and contact lens fitting/evaluation. Refraction is $15, Contact Lens Evaluation starts at $60, . The Contact Lens Evaluation fee consists of the evaluation for contact lenses and two follow up visits in a three-month period. If a patient does not return in the three-month period, or change to a different contact lens after three months, then they may accrue a new contact lens evaluation charge. Once a patient's Contact Lens prescription has been finalized, it will be electronically uploaded into the patient's personal health information portal to be accessed by the patient at their convenience. **Patient Initial** _____

Payment is expected at time of treatment. Any deductibles, co-payments and non-covered services must be paid at time of visit. We accept MasterCard, Visa, Amex, and Discover. We will be glad to help you fill out any insurance forms that your plan may require.

The Following are our professional and service fees:

Refraction…….. $20
Contact Lens and Evaluation & Fitting…… $70
Driver's License Renewal Form…….$10

Payment Policy:

Payment for professional services is required at the time the service is rendered. If ophthalmic materials are prescribed, a deposit is required before the glasses or contact lenses will be ordered from the lab and the balance is to be **paid in full** at the time of dispensing. If insurance will be used to pay for services, you will be responsible for any payment not paid by the insurance company. **Patient Initial** _____

Private Insurance:

I authorize Drs. Miller & Flynn, Optometrists to release any medical information to my insurance company and to accept assignment of benefits.

Signature: _____ Date: _____

Medicare Insurance:

I, _____, hereby authorize Drs. Miller and Flynn, Optometrists to accept assignment of benefits for payment of medical services furnished by Dr. Flynn, be made either to me or on my behalf.

Signature: _____ Date: _____

Consent For Release of Information, Consent to treat, and Responsibility for Payment:

I authorize Drs. Miller & Flynn, Optometrists to submit an eye examination or professional services claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

I consent to the use and disclosure by Drs. Miller & Flynn, Optometrists of any information (e.g. health information) concerning my eye examination and products, to any third party and/or agent, including, but not limited to, my employer, health plan or plan sponsor, as needed for my treatment, the payment of my eye examination claims, and related customer communications regarding health care services provided by Drs. Miller & Flynn, Optometrists.

I understand that this consent for release of information is voluntary and I may revoke my consent at any time by contacting Drs. Miller & Flynn, Optometrists in writing, except for any disclosure already taken in reliance of my consent to release of information. I understand that I may request Drs. Miller & Flynn, Optometrists to restrict the use and disclosure of my information; however Drs. Miller & Flynn, Optometrists is not required to agree to my request.

I understand that Drs. Miller & Flynn, Optometrists abides by federal guidelines in both the privacy and security of my personal health information(HIPPA). This notice serves to inform me that my rights are publicly displayed in the office of Drs. Miller & Flynn, Optometrists and that I may ask any questions or request further information if I so choose.

I have read and agree to the Privacy Act (HIPPA), Advance Beneficiary Notice (ABN) and our insurance policies. I voluntarily consent to all diagnostic evaluation and medical treatment as may be necessary in their professional judgement during the course of my examination.

Signature:_____Date:_____