Allied Eye
Dennis Matzkin, M.D.

Dear_____,

Welcome to Allied Eye. We are honored that you chose us for your eye care needs. We want your visit to be as smooth as possible, so here are some things you need to know to ensure all your needs are met.

Q: Is there anything I need to bring to my appointment?

A: These are "must haves" when you come to your appointment. Please bring the following:

-your driver's license or other photo ID
-your medical AND vision insurance cards (if you have vision insurance)
-your current glasses
-your contact lens box (if you wear contacts)
-a list of your medications and dosages
-a method of payment

Q: Who may come with me to my appointment?

A: If you need to bring someone with you to your appointment, please bring only one family member or friend due to space limitations. Only the patient may go into the exam room and testing area, unless there are special needs (help walking, hearing, translation etc.).

Q. I need my phone so people can get ahold of me. Is that okay?

A. Cell phones may be on silent and off vibration mode. Texting and browsing is acceptable but no cell phone conversations are permitted in the office as a courtesy to the doctor, staff and other patients.

Q. How long will I be in the office?

A. Your medical visit may last for ***up to two hours***. Beyond that, you may need to come back for comprehensive testing on one of our dedicated testing days or for a follow up with Dr. Matzkin.

Q. Will I have my eyes dilated?

A. If you are a new patient for a "medical" exam, it is likely that your pupils will be dilated. In some situations, it may not be safe to dilate your pupils. If your visit is a "routine vision" exam for glasses or contacts, it is likely you will not be dilated. Dr. Matzkin may recommend that you return for a comprehensive exam following your exam.

Q. How much will I have to pay on my visit?

A. Every insurance plan is different and payment will depend on your personal insurance benefits. Please be familiar with your individual plan. Our policy is to collect copayments, deductibles and coinsurance at the time of your visit.

7405 Shallowford Rd., Ste. 420 Chattanooga TN. 37421 PH. 423 855-8522 Fax 423 855- 8533

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Authorization for Verbal Communication and/or to Leave Voice Mail Messages Regarding My Personal Health Information and Permission to Invite Me to Participate in the Patient Portal

This does not authorize release of copies of medical records without a separate signed Authorization to Release Medical Records by patient or guardian.

Patient Information

Name- Last, First, MI _____ **Date of Birth:** _____

****Information to be disclosed: verbal communication only regarding patient's care-no copies of medical records provided**

Please provide your current telephone numbers

Home Phone _____ Cell Phone _____ TEXT? Y☐ N☐

Emergency Contact Name _____ Phone_____

Your Protected Health Information Designees

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. test results, prescription information, etc.). This person (designee) will also be able to call the office on your behalf. Please print the name and relationship to you/patient of each designee below:

Designee Name: _____ Relationship to Patient: _____

Designee Name: _____ Relationship to Patient: _____

_____ Check here if you ***do not want*** your health care information discussed with anyone other than yourself.

Information for Patient Portal

Please list an email address that we can send you an invite to participate in our patient portal. The Portal allows you the ability to communicate with Allied Eye in regards to: appointment requests, billing, demographic and insurance changes, and much more!

Email Address: _____

Your Current Health Care Providers

(Please list the Doctors you are currently seeing (i.e. Primary Care, Cardiologist, rheumatologist, oncologist etc.....)

Primary Care Physician: _____ **Referring Physician:** _____

How did you hear about Allied Eye: _____

Your signature ***below*** confirms your approval of these updated HIPPA communication preferences. You may Change your selections at any time, but must do so in writing by completing an updated form.

Signature: _____ **Date:** _____

Notifications and Releases

Appointment Policy

No shows and cancellations with less than 2 business days' notice are a significant problem for our small practice. Many practices overbook on purpose so that no-shows and last minute cancellations won't limit access for other patients as well as cause financial hardship for the practice.

In our office please schedule an appointment by calling, (423) 855-8522 and pressing option 2. If you need to reschedule an appointment and have multiple appointments booked, it is important that you tell this to the receptionist. Some doctor appointments are meant to occur after testing or after a procedure so the sequence of your scheduled appointments matter and may need to be adjusted.

We will attempt to confirm your appointment beginning ten days prior to your scheduled visit. If you do not respond to the automated calls and emails, then we will attempt to reach you personally two days prior to your visit. Our software tracks whether or not you press cancel or confirm on our automated system.

If you cancel twice within the 48 hour time period, you will receive a letter from our office notifying you that this has occurred twice. Should you late-cancel or no-show for a third time within the 48 period, you will be dismissed from our practice as your care is our responsibility. We cannot care for you if you do not keep your appointments.

Initial _____

Financial Policy

We collect co-pays, co-insurance, deductibles and non-covered services at the time of your visit. We have found that doing so reduces the burden on our billing department and protect patients from accruing balances that can impede us from providing care. Please be prepared to pay at the time of service.

All surgery payments need to be collected two weeks prior to a scheduled surgery date to cover our costs and reserve the time at the surgery center. If you are in need of surgery, our surgery scheduler will inform you of your payment due date.

Initial _____

Cell Phones

Cell phones are a distraction to our staff and doctor. Please turn off your phone and take calls outside if necessary.

Initial _____

Tardiness/Last Minute Cancellations

If you are running late for your appointment or have to miss it at the last minute, please call us. We start to worry about you when you have confirmed and then do not make it in on time.

Initial _____

Patient Dismissal

Allied Eye will dismiss patients that:

- cancel within the 48 hour window three times
- do not show up for an appointment three times
- cause disruption by their behavior, including but not limited to in-office cell phone use

Initial _____

Please read this document outlining certain responsibilities applying to you, the patient (or person acting on behalf of the patient), and to us, the care providers. By initialing a statement, you indicate that you have read it and are in agreement with it.

GENERAL CONSENT FOR TREATMENT: The undersigned hereby gives permission for the physician to examine, provide treatments for, and perform diagnostic studies as necessary on herself/himself or on the minor for whom she/he is responsible. If more invasive procedures are deemed necessary, the risks and benefits will be explained to the undersigned, and a more detailed consent form will be provided. **Initial** _____

PRIVACY POLICY: Allied Eye, in compliance with federal regulations, keeps confidential records for ten years after a patient's last visit, and will only share information with other providers who are participating in the care of the patient, the patient's insurance company to document the procedures and costs, those concerned with medical management issues, and who are listed as authorized designees by the patient on the reverse of this form. **Initial** _____

MEDICARE BENEFITS: The undersigned certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct, and authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. Furthermore, the undersigned requests that payment of authorized benefits be made on the patient's behalf, and assigns the benefits payable for physician services to the physician or organization furnishing the services, or authorizes such physician or organization to submit claims to Medicare for payment to the patient. **Initial** _____

FINANICIAL POLICY/ASSIGNMENT OF BENEFITS: As a courtesy and convenience to patients, Allied Eye accepts assignments from most commercial insurance programs and Medicare, and will file the primary insurance claim. Once the primary claim has been paid, they will file the secondary insurance claim if the information has been provided. Insurance coverage is a contract between the patient and the insurance company; therefore, the patient carries final responsibility for the payment of services rendered. **Initial** _____

PATIENT PAYMENTS: Any co-payments, deductibles or coinsurance required by an insurance company must be paid at the time of service. **Initial** _____

PAYMENT GUARANTEE: The patient, or person acting on behalf of the patient as guardian, agent, representative, or guarantor, agrees, in consideration of services rendered, to pay the amount owed to Allied Eye which, if the insurance company denies coverage, disallows a service, or otherwise does not settle the claim, may include the costs of a collection agency, attorney, and court, as well as other related fees. **Initial** _____

FINANCE CHARGE: Prompt settlement is encouraged. Finance charges will be imposed on each item appearing on the account not paid within 60 days of having been added, computed at the rate of 1% per month on the overdue balance. Allowing bills to fall in arrears gives permission for the checking of credit and employment history and the provision on request of information regarding the patient's credit experience. **Initial** _____

I, the undersigned, hereby confirm that I have read this document and understand it, and that I have been given the opportunity to ask any questions. Furthermore, I certify that I am the patient, or the general agent or representative of the patient, duly authorized to accept and fulfill the terms of this document.

_____	_____	_____
Signature of Patient	Printed name of patient	Date
_____	_____	_____
Patient's Guardian/Power of Attorney	Relationship to patient	Witness

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REFRACTION FEE

Date: _____

Patient Name: _____ DOB: _____

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. There are some eye conditions which require the doctor to make the refraction measurements, even if you don't end up changing your eye glasses. It is NOT a covered service by Medicare and many other health insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $51.00 and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that my deductible, co-insurance or co-payment is also due at this time.

Patient signature: _____

Print Name: _____