



GREGORY J. JOHNSON, M.D., M.B.A., F.A.A.O.

AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

I authorize the use and/or disclosure of my protected health information to Intracoastal Eye Physicians. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

YES/ NO: May we discuss details regarding your care, test results, billing information, or appointment information with someone else other than you? If yes, **name specifically any family, friends, and/or others authorized** to which we may release your protected health information either in writing or verbally:

Name	Relationship	Phone number
_____	_____	_____
_____	_____	_____

YES/NO: May Intracoastal Eye leave medical information regarding my care (i.e. lab results, medications) or appointments on an answering machine? If yes, please do so on this number: (_____)_____.

I acknowledge that I have been made aware of Intracoastal Eye Physicians' **Notice of Privacy Practices** and a copy is available at my request. I have had full opportunity to read and consider the contents of the Intracoastal Eye Physicians Notice of Privacy Practices.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Intracoastal Eye Physicians Privacy Officer, 6740 Rock Spring Road, Suite 100 Wilmington, North Carolina 28405
Phone: (910) 777-8254 Fax: (910) 769-1246 Email: rjohnson@intracoastaleye.com



What is a Refraction?

A **Refraction** is the process of determining the need for eyeglasses or a change in one's prescription. A refraction is necessary to write a prescription for glasses or contact lenses, and to help diagnose medical conditions affecting your eyes.

Most Medical Insurance plans, including Medicare, do **NOT** pay for refractions. The refraction fee is a separate charge from the eye examination fee. Our office fee for a refraction is \$40.00 and is collected at the time of service in addition to any co-payment your plan may require.

If you wish to forego the refraction, please inform us BEFORE the test is performed.

Signature _____ Date _____

Intracoastal Eye Financial Policy

INITIAL

_____ You will be responsible for any co-pays, deductibles, coinsurances, and any non-covered services or screening that your insurance does not pay.

_____ It is your responsibility to know your plan and plan benefits. Intracoastal Eye will submit your claim for services to your insurance company on your behalf.

_____ If your insurance company requires an authorization, you will be responsible for getting one prior to your visit. If no authorization is in place, you accept full financial responsibility.

_____ Statements are mailed out monthly for outstanding balances. Financial arrangements can be made with our office manager if needed.

_____ If your account balance becomes past due it will be sent to an outside collection agency and you will be responsible for any additional fees incurred.

_____ The adult parent or guardian accompanying a minor is responsible for payment of the minor patient's account regardless of the name listed as the insurance policy holder.

_____ Intracoastal Eye accepts cash, check, Mastercard, Visa, American Express, and Discover.

Signature _____ Date _____

INTRACOASTAL EYE PHYSICIANS HISTORY AND INTAKE FORM

Name : _____ DOB: _____ MR#: _____

PAST MEDICAL HISTORY (please mark all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid reflux/heartburn | <input type="checkbox"/> Heart problems (heart attack, stents, atrial fibrillation, valve problems, pacemaker or defibrillator) | <input type="checkbox"/> Neurologic (nerve) disorder/seizures |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Hepatitis or other liver disease | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Bone/joint disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatologic disorder |
| <input type="checkbox"/> Cancer (type and treatment) | <input type="checkbox"/> HIV | <input type="checkbox"/> Sinus/nasal surgery/infections/allergies |
| <input type="checkbox"/> Chronic pain or migraines | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Skin cancer (type and treatment) |
| <input type="checkbox"/> Depression/anxiety/mood disorder | | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Diabetes (insulin dependent?) | | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Lung disease (COPD/emphysema, asthma) | | |

Please provide details/other conditions:

PAST SURGICAL HISTORY (please mark all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Problems with anesthesia/sedation | <input type="checkbox"/> Any type of heart surgery/procedure (stents, bypass, valve surgery, transplant) | <input type="checkbox"/> Any type of surgical implant/stent/plates? |
| <input type="checkbox"/> Prolonged bleeding in you/family member | <input type="checkbox"/> Procedure on arteries/blood vessels | <input type="checkbox"/> Neck or back surgery |
| <input type="checkbox"/> Heal slowly | <input type="checkbox"/> Joint replacement (hip, knee, shoulder) | <input type="checkbox"/> Facial/nose/sinus surgery or injury |
| <input type="checkbox"/> Keloid (form bad scars) or heal poorly | | <input type="checkbox"/> Spleen removed |
| <input type="checkbox"/> Allergy to LATEX or BETADINE | | |
| <input type="checkbox"/> Please provide details/dates of any hospitalization(s) in the last 5 years: | | |

Please provide details/other conditions:

OCULAR HISTORY AND SURGERY (please mark all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Dry eye syndrome | <input type="checkbox"/> Prior eyelid surgery or injury |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Eye muscle surgery/crossed eyes | <input type="checkbox"/> History of Bell's palsy or stroke affecting facial muscles |
| <input type="checkbox"/> Cataract/cataract surgery | <input type="checkbox"/> Glaucoma/glaucoma surgery | <input type="checkbox"/> Prior tear duct, sinus or nose surgery |
| <input type="checkbox"/> Corneal disease/surgery | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Prior eye socket surgery or injury |
| <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Retinal disease/surgery | <input type="checkbox"/> Prior facial surgery or injury |
| <input type="checkbox"/> Drooping eyelids | <input type="checkbox"/> Any type of eye laser surgery? | |
| <input type="checkbox"/> Family History (please list eye and other diseases that run in your family) | | |

Please provide details/other conditions:

MEDICATIONS (please list all current medications, supplements, vitamins, and pain relievers along with the strength and how often you take them)

1- _____	2- _____
3- _____	4- _____
5- _____	6- _____
7- _____	8- _____
9- _____	10- _____
11- _____	12- _____
13- _____	14- _____

ALLERGIES (please include all medication and other allergies and the reaction you have had)

1- _____	2- _____
3- _____	4- _____
5- _____	6- _____

TOBACCO HISTORY (please respond to each section)

Smoking/Tobacco:

- | | |
|--|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Smokes _____ packs per day |
| <input type="checkbox"/> Quit _____ (year) after _____ years | <input type="checkbox"/> Other tobacco usage: _____ |

REVIEW OF SYSTEMS (please mark active problems below and explain to our staff)

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Kidneys, urinary, or gender organ problems |
| <input type="checkbox"/> General (fever, weight loss, fatigue) | <input type="checkbox"/> Muscle, bone, or joints |
| <input type="checkbox"/> Eyes (not already included above) | <input type="checkbox"/> Endocrine (diabetes, thyroid) |
| <input type="checkbox"/> Ear/nose/throat (infections, drainage) | <input type="checkbox"/> Allergies/immune system |
| <input type="checkbox"/> Heart or blood vessels (chest pain) | <input type="checkbox"/> Blood (anemia, bleeding, clotting) |
| <input type="checkbox"/> Lungs (shortness of breath, cough) | <input type="checkbox"/> Skin (rash, rosacea, psoriasis) |
| <input type="checkbox"/> Digestion (reflux, vomiting, diarrhea) | <input type="checkbox"/> Psychiatric (depression, anxiety, mood) |
| <input type="checkbox"/> Nerve system (headaches, numbness) | |

Please provide details:



Intracoastal Eye Contact Lens Agreement

Thank you for entrusting Intracoastal Eye with your contact lens needs. We offer the latest contact lenses for a wide variety of visual conditions, including nearsightedness, farsightedness, astigmatism, and age-related decline in near vision. We also specialize in complex contact lens fittings, including keratoconus and other anterior segment diseases. Dr. Johnson and our staff are dedicated to your eye health and an enjoyable, comfortable contact lens experience.

In addition to a refraction (determining your glasses prescription), an annual **Contact Lens Evaluation** is necessary to ensure that your vision is optimized, the contact lenses fit properly, and that the contact lenses are not adversely affecting the health of your eyes. Most insurance companies do not cover charges related to contact lenses.

Our **Contact Lens Evaluation** fees are as follows, payable at the time of service:

- Soft Spherical\$60
- Toric (astigmatism)\$80
- Monovision\$90
- Multifocal\$90
- Rigid Gas Permeable\$120
- Specialty (keratoconus, aniridia, hybrid, etc.)\$160

If you have **never worn contact lenses before**, you will be scheduled for a training session with a contact lens technician. During this session, patients are taught how to safely insert, remove, clean, and care for contact lenses. The **Contact Lens Training Session** fee is \$90 in addition to the Contact Lens Evaluation fee.

All Contact Lens Services include 90 days of follow up for any necessary adjustments.

Patient signature _____

Date_____