Danny Lee, M.D.
Board Certified Ophthalmologist

Please complete and bring all enclosed paperwork, a photo I.D., all medical insurance cards and a list of your medications with you to your appointment.

Failure to do so may result in us having to either re-schedule your appointment or collect for the office visit and testing at check in.

Thank you and we look forward to seeing you at your appointment.

Huntsville Office
4601 Whitesburg Dr., Suite 103 Huntsville, AL 35802
256-808-2000

Decatur Office
1238 13th Avenue Decatur, AL 35601
256-686-9000

Appointment Date: ______________________________

Appointment Time: ______________________________

Appointment Location: ___________________________

PATIENT INFORMATION SHEET

Today's Date________________ Referred By: ____________________

Chart # ____________________ Age _____________

Patient's Name ____________________________________ Patient's DOB_______________________

Street Address_____________________________________ City______________________________

State_____________ Zip Code______________ Male_______ Female______

Home Phone________________________________ Cell Phone: ______________________________

Employer __________________________________ Employer Phone _____________________________

Email Address:______________________________Social Security Number________________________

Family Physician: ____________________________ Family Physician Phone:_______________________

Family Physician Address: ____

Primary Insurance Information

Insurance Company______________________

Group #________________________________

Contract #______________________________

Name:__________________________________

Relationship to Patient__________________

DOB________________ Co-Pay____________

Secondary Insurance Information

Insurance Company________________________

Group #__________________________________

Contract #________________________________

Name:____________________________________

Relationship to Patient_____________________

DOB________________ Co-Pay_____________

Emergency Contact:____

Relationship to Patient:_____________ Phone Number:_____________________________________

Release of Medical Information and Assignment Of Benefits

I hereby authorize Laser Eye Center, P.C., Danny K. Lee, M.D. to release information regarding my treatment or examination rendered to me for medical or surgical care to my insurance company(s) or it's representatives. I also authorize payment to be made to the Laser Eye Center, P.C., Danny K. Lee M.D. in the amount due for all medical and/or surgical charges for myself or my eligible dependents. I understand that I am financially responsible for any amounts not covered or paid by my insurance company(s). I authorize Laser Eye Center to obtain my medical records from any necessary hospital, clinic, or doctor's office.

Patient Signature :______________________________ Date:_______________________

Doctor's Signature:_____________________________ **Date:**_______________________

Past/Present Ocular History

Please note any personal or family history(parents, grandparents, siblings, children, living or deceased) for the following conditions.

	Self	Family	Relation	Please Explain
Glaucoma	____	____	____________	____________
Cataracts	____	____	____________	____________
Macular Degeneration	____	____	____________	____________

Other :____

The questions below are for the PATIENT only:

	YES	NO	Please Explain
Cancer	____	____	____________________
Diabetes	____	____	____________________
Endocrine	____	____	____________________
Respiratory	____	____	____________________
Cardiovascular	____	____	____________________
Neurological	____	____	____________________
Gastrointestinal	____	____	____________________
Genitourinary	____	____	____________________
Hematologic	____	____	____________________
Musculoskeletal	____	____	____________________

Additional medical issues: ______________________________

List any medications you take(including over the counter medications and home remedies). **We would be glad to copy your list.**

Name of Medication	**Dosage**	**Frequency**	**See List**

Do you have any allergies to Medications or Food? ___YES ___NO

If YES please explain:______________________________

Are you currently under Hospice Care? ____ Yes ____No

Are you pregnant or nursing? _____Yes _____No

Do you smoke?___Yes___No

If yes how many packs per day?_____________

Do you consume alcohol?__Yes__No

If yes how much/how often?_____________

Pharmacy Information:

Name:______________________________

Phone:______________________________

Location:______________________________

Tech:______________________________ **Date:**______________________________

INFORMATION ABOUT REFRACTIONS AND WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, but they typically do not cover the eye service called "refraction."

WHAT IS A REFRACTION?
Refraction is a testing procedure that measures how much optical (focusing) error and eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front if your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

WHEN DOES INSURANCE NOT PAY FOR A REFRACTION?
Most health insurance was not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs, and most private policies will not pay for refraction. Almost all insurance payers consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

WHEN DOES PRIVATE INSURANCE PAY FOR REFRACTION
Most health insurance will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, refraction will be performed as part of your eye evaluation. Refraction in this instance is necessary to learn your eyes best vision capability at the time of the examination. That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated. It is a necessary part of the exam for both medical and legal purposes. In this case, it is possible that the refraction may be covered by your insurance. However, Medicare typically will not cover refraction under any circumstances.

WHO HAS MADE THIS DISTINCTION FOR INSURANCE COVERAGE?
It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore, if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

WHAT IS OUR POLICY?
At *LASER EYE CENTER*, we are dedicated to providing our patients with the very best medical and surgical eye care in the region. Therefore, a refraction will be performed when medically necessary (typically this includes all new patients, those presenting with decreased vision, and on a yearly basis thereafter). Additionally, we are happy to perform a refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter. Our fee for the refraction is $30 (thirty dollars) and is collected at the time of your visit, in addition of any co-payments or deductible due for the medical portion of your examination.

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. The co-payment and deductible are separate from and not included in the refraction fee.

______________________________ ____________________

PATIENT SIGANTURE **DATE**

Laser Eye Center

Insurance/Financial Agreement

To the extent necessary to determine liability and to obtain reimbursement, I authorize disclosure of my medical record to my insurance carrier. Medigap carriers, and/or such other persons or entities which may be responsible for payment, in whole or in part. I hereby assign all medical benefits and payments to Dr. Danny Lee, M.D. More specifically, in the event I am entitled to any type of medical benefits arising out of policy insurance and benefits, I hereby agree that LEC (Laser Eye Center, P.C.) and/or such physician may retrieve any such payment. I agree that in return for the services provided to the patient by LEC, I will pay my account at the time service is rendered or make financial arrangements satisfactory to LEC for payment. If an account is sent to a collection agency or attorney's office for collection on a past due balance. I agree to pay collection expenses and reasonable attorney's fees as established by a court and not by a jury and any court action. I understand and agree that, if my account is delinquent I may be charged interest at the legal rate. Any benefits, of any type, under any policy insuring the patient, or any other party liable to the patient are hereby assigned to LEC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to LEC; however, it is understood that the undersigned and/or patient is primarily responsible for full payment of my bill.

Signature: ______________________________ **Date:** ______________________

Medicare Assignment/Signature on File/Financial Agreement

I request payment of authorized Medicare benefits be made on my behalf to LEC for services furnished by LEC. I authorize any material information about me to be released to the centers for Medicare and Medicaid services (CMS) and its agents, any information needed to determine these benefits payable for related services. I understand that my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If other health indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. LEC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible for only the deductible, co-insurance and non-covered services. I agree that in return for the services provided to the patient by Laser Eye Center, P.C. (LEC). I will pay my account at the time service is rendered or make financial arrangements satisfactory to LEC or payment. If an account is sent to a collection agency or attorney's office for collection on a past due balance. I agree to pay collection expenses and reasonable attorney's fees as established by a court and not by a jury and any court action. I understand and agree that, if my account is delinquent I may be charged interest at the legal rate. Any benefits, of any type, under any policy insuring the patient, or any other party liable to the patient are hereby assigned to LEC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to LEC; however, it is understood that the undersigned and/or patient is primarily responsible for full payment of my bill.

Signature: ______________________________ **Date:** ______________________