Dear Patient,

Thank you for making an appointment with

☐ Dr. Brownlow ☐ Dr. Charkoudian ☐ Dr. Bray ☐ Dr. Wann

Your appointment has been scheduled for:

MONDAY / TUESDAY / WEDNESDAY / THURSDAY / FRIDAY

_____/_____/_____ at _____ AM / PM in our_____ office.

Please plan on arriving at least 15 minutes before your appointment time so we may have time to enter your information into the computer and provide our technicians with time to review your history with you before your appointment. This is necessary so the doctor will have enough time for a complete and thorough exam. **Please make sure to thoroughly complete all forms provided and bring a list of all medications you are taking with you to your appointment.**

At this visit, your eyes will be dilated and special testing may need to be performed. **Please plan to be with us for at least two (2) hours the day of your appointment.** Please make transportation arrangements if you are uncomfortable driving after having your eyes dilated. We will provide disposable sunglasses for your comfort, if needed.

Please bring all medical insurance cards and identification with you so that we can verify your benefits. Many insurance plans require co-payment or deductible be paid at the time of service. **If your insurance is one that requires a co-payment or if you have a deductible, please plan on paying this upon checking out.** Should you have any questions or concerns about our office policy on this matter, please call our office to speak with someone in our billing department.

We look forward to welcoming you as a patient of Cape Fear Retinal Associates!

CAPE FEAR RETINAL ASSOCIATES, PC
(910) 332-3560

MAIN	SUPPLY	ANNEX	WHITEVILLE	KENANSVILLE
1104 MEDICAL CENTER DR WILMINGTON, NC 28401	10 DOCTORS CIRCLE, STE 1 SUPPLY, NC 28462	1098 MEDICAL CENTER DR WILMINGTON, NC 28401	2183 JAMES B. WHITE HWY N. WHITEVILLE, NC 28472	402 NORTH MAIN STREET KENANSVILLE, NC 28349

CAPE FEAR retina

Patient Information

Last Name First MI			Birth Date / /	Age	Sex
Mailing Address City State Zip					
Home Phone	Work Phone	Mobile Phone	Social Security #		
Email Address		Employer			
Marital Status: (circle one): S M W D Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language: _____ Race: _____		Occupation: _____ Spouse's name:			
Next of Kin/Emergency Contact Name		Relationship	Phone #		
REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____					
INDIVIDUAL RESPONSIBLE FOR PAYMENT (IF DIFFERENT THAN PATIENT)					
Last Name First MI			Birth Date / /		
Street Address City State Zip					
Home Phone	Work Phone	Mobile Phone	Social Security #		
SEE COPY OF INSURANCE CARD/S ON FILE					

Patient History Information

Name:	Date:	Date of Birth:

Family Doctor:	Eye Doctor:	Referring Doctor:(if applicable)

When was your last eye exam? _____
Have you had your flu shot? _____ Date of last Pneumonia vaccine?_____

Please answer the following questions about your medical status and history.

Have you ever been treated for any of the following medical conditions? Please check the box and circle all that apply. Explain further in the space provided if necessary.

☐ Mental Health (depression, anxiety, schizophrenic, bipolar) _____
☐ Arthritis (rheumatoid, osteo-degenerative) _____
☐ Heart Disease (heart attack, angina, arrhythmia, heart failure, heart valve disease, bypass surgery) _____
☐ Blood Diseases (anemia, leukemia, clotting problems) _____
☐ Lung Disease (asthma, emphysema, COPD, chronic bronchitis) _____
☐ Cancer (list type or location & date) _____
☐ Diabetes (type, how controlled & when diagnosed) _____**Last A1C**_____
☐ Genito-Urinary Disease (kidney disease, dialysis, kidney stones) _____
☐ Ear, nose, Throat (hearing loss, sinus disease) _____
☐ Thyroid Disease (hypo, hyper, Graves disease) _____
☐ High Blood Pressure _____
☐ Gastrointestinal Disease (ulcers, esophageal reflux, intestinal or liver disease) _____
☐ Neurological Problems (stroke, mini strokes, seizures, paralysis) _____
☐ Skin Diseases (eczema, psoriasis, acne rosacea) _____
☐ Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis) _____

Other Problems _____

Previous Surgery (date/reason)_____

_____

ALLERGIES:

Please list any allergies and reactions you have (including medications, food, or other):

_____

_____

_____

Social History

☐**Yes** ☐**No** Do you smoke?

☐**Yes** ☐**No** Do you drink alcohol? If yes, how much? _____

Females: Are you pregnant? ☐ **Yes** ☐ **No** Breast feeding? ☐ **Yes** ☐ **No**

Eye Disease

Have you ever had any eye disease? If yes, please explain and include the year diagnosed.

☐**Yes** ☐**No** Cataract_____

☐**Yes** ☐**No** Corneal Disease or Transplant _____

☐**Yes** ☐**No** Diabetic Eye Disease _____

☐**Yes** ☐**No** Glaucoma _____

☐**Yes** ☐**No** Lazy Eye (Amblyopia) _____

☐**Yes** ☐**No** Macular Degeneration _____

☐**Yes** ☐**No** Muscle Disorder (Crossed Eye) _____

☐**Yes** ☐**No** Retinal Detachment or Hole _____

☐**Yes** ☐**No** Injury _____

☐**Yes** ☐**No** Surgery or Laser _____

Other_____

Comments _____

Review of Systems Do you currently have any of the following problems? Check all that apply.

☐**Yes** ☐**No** Joint pain (Musculoskeletal)

☐**Yes** ☐**No** Easy bruising (Hematological)

☐**Yes** ☐**No** High blood pressure

☐**Yes** ☐**No** High/low blood sugar

☐**Yes** ☐**No** Abnormal thyroid level

☐**Yes** ☐**No** Shortness of breath, wheezing, coughing (Respiratory)

☐**Yes** ☐**No** Sore throat, ear pain, sinus problems

☐**Yes** ☐**No** Heartburn, abdominal pain, diarrhea, vomiting

☐**Yes** ☐**No** Pain with urination, blood in urine

☐**Yes** ☐**No** Weakness, numbness, headache

☐**Yes** ☐**No** Rashes, excessive dryness

☐**Yes** ☐**No** Depression/anxiety

Family History of Disease

Do you have a family history of any of the following diseases? Please indicate which relative is affected (example- mother, father, sister, brother)

☐**Yes** ☐**No** Cancer _____

☐**Yes** ☐**No** Diabetes _____

☐**Yes** ☐**No** Glaucoma _____

☐**Yes** ☐**No** Heart Disease _____

☐**Yes** ☐**No** Retinal Disease _____

Patient Signature: _____ Date: _____

CAPE FEAR retina

MEDICATION LIST

PLEASE LIST ALL MEDICATIONS YOU TAKE (INCLUDING EYE DROPS, OVER-THE-COUNTER MEDICATIONS, BIRTH CONTROL PILLS AND ASPIRIN)

NAME OF MEDICINE (LIST ALL EYE DROPS FIRST)	DOSAGE (MG, ETC.)	HOW OFTEN (ONCE A DAY, TWICE A DAY, ETC.)

Consent for Purposes of Treatment, Payment and Healthcare Operations

CONSENT FOR TREATMENT:
The undersigned consents to any examination, laboratory procedure, or other medical treatment or service rendered to the patient under the general and special instructions of Robert L. Brownlow Jr., M.D. Leon D. Charkoudian, M.D or Kevin James Bray, MD. The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of the patient's rights and responsibilities.

RELEASE OF INFORMATION:
The undersigned hereby authorizes this medical office to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of this medical office's charges or having the responsibility for reviewing such charges, including but not limited to this medical office or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned must be transferred to another provider/facility. The undersigned acknowledges and consents that medical records, laboratory results, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST OR PAYMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION FOR MEDICARE/MEDICAID PATIENTS:
The undersigned requests payment of authorized Medicaid/Medicare benefits, if any, for any services furnished to the patient by Cape Fear Retinal Associates, P.C., including physician services, and hereby assigns such benefits otherwise payable directly to the patient, to Cape Fear Retinal Associates, P.C., or the physician(s) furnishing such services. The undersigned authorizes Cape Fear Retinal Associates, P.C., or such physicians to submit a claim for such services to Medicare/Medicaid. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare/Medicaid, or its agent, claims processor, or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS:
In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorized Cape Fear Retinal Associates, P.C., or physicians to submit a claim for such services, and benefits are hereby assigned to this medical office for application on the patient's bill. It is agreed that Cape Fear Retinal Associates, P.C. may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information given by or on behalf of the patient in applying for payment from all third party payors is correct.

FINANCIAL AGREEMENT:
The undersigned understands and agrees that the patient and guarantor are financially responsible to Cape Fear Retinal Associates, P.C. for charges for medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient's insurance plan or Medicare/Medicaid. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized as the patient's general agent to execute the above and accept its terms.

I HAVE READ, OR I HAVE HAD EACH OF THE ABOVE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

_____ _____

Signature of Patient or Personal Representative **Date**

Payment Policy

Thank you for choosing Cape Fear Retinal Associates, P.C. as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. **Please be aware that should your account be referred to a collection agency, the percentage charged by the collection agency to our practice will be added to the total amount of your bill.**

8. Missed appointments. Failure to call our office to cancel or reschedule an appointment may result in a fee**.** Please refer to the attached document for our current no-show policy.

9. Copies of Medical Records and Insurance/Disability Forms. Our office will gladly make copies of medical records for you. The fee for this service is $15.00 per set. If you need our office to complete any disability forms or forms for your insurance company or other parties, we will be glad to do so for a fee of $15.00, payable in advance.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE

1. I acknowledge that I have received or have been offered a copy of Cape Fear Retinal Associates, PC's Notice of Privacy Practices, effective April 14, 2003. **_____(Initial)**

2. Is there a family member or friend that you will allow us to leave messages with or release billing or medical information to? If so list their name & telephone number on the line below.

Name: _____ Phone: _____

_____ _____

Signature of Patient or Representative **Date**

_____

Print Name

_____

Relationship of Representative/Authority to act on behalf of the Patient

FOR CAPE FEAR RETINAL ASSOCIATES, P.C. STAFF USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____

_____

***A current Notice of Privacy Practices for Cape Fear Retinal Associates, P.C. is also available at the check-in counter.**

CAPE FEAR retina

No Show Policy

Preserving your vision is our priority. By maintaining regular appointments at Cape Fear Retina, our physicians can best manage your eye care needs, address new or worsening concerns in a timely manner, and optimize your treatment outcomes.

To ensure that each patient is given the highest quality of care, it is very important for each patient to attend their scheduled visit on time. As a courtesy, an optional appointment reminder process is offered to provide phone call, text, or email communications. We appreciate your commitment to arrive on time at your scheduled visit.

We understand that there are times you may need to cancel or reschedule your appointment due to schedule conflicts and emergencies. If you are unable to keep your appointment, please call us as soon as possible to reschedule.

1. After the first "No-Show/Missed" appointment, you may receive a phone call or letter asking you to please reschedule your appointment
2. After the second "No-Show/Missed" appointment, you may receive a phone call or letter asking you to please reschedule your appointment.
3. If you have three consecutive "No-Show/Missed" appointments within a one-year period, you may be dismissed from the practice.

*You will be notified by letter if dismissal occurs. *

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name _____ Date of Birth _____ Date _____

Signature _____