June 2021

Patient Information Sheet

General Information:

Last Name ______________________ First Name ____________________ Middle Initial ________

Mailing Address ________________________ City ________________ State _____ Zip ________

Street Address _________________________ City ________________ State _____ Zip ________
(If different from above)

Primary Phone: (____) ____-________ ☐Cell ☐Home Alternate Phone: (____) ____-________ ☐Cell ☐Home

Appointment Reminder Preference: ☐Text ☐Voice ☐No Reminder

Date of Birth: ___/___/____ Sex: ________ Email Address: ______________________________

Social Security Number: _____-_____-_______ Marital Status: ☐Single ☐Married

Family Physician: ________________________ Referred by: ______________________________

Emergency Contact Person: _______________ Phone: (____) ____-______ Relationship: _____________

Employment Information:

Employer: __________________________________ Occupation: ____________________________

Employer Address: ___________________________________ Employer Phone: (_____) _____-__________

Insurance Information:

Insurance Company Name: _____________________________ Subscribers Name: __________________

Relationship to Subscriber: ____________________________ Subscribers Date of Birth: ___/___/___

If Patient is a minor, please complete the following:

Parent/Guardian Name: _______________________________ Relationship: ____________________

Parent/Guardian Address: ____

Parent/Guardian Phone: (_____) ____-__________ Parent/Guardian Date of Birth: _____/_____/______

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IF YOU HAVE INSURANCE, WE WILL NEED TO COPY YOUR INSURANCE CARD.
WE ARE UNABLE TO BILL YOUR INSURANCE WITHOUT A COPY OF YOUR CARD.

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Information regarding DILATING DROPS: Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you may need to wait for your eyes to adjust before driving or arrange for a driver. Adverse reaction, such as acute angle closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. By signing below, I authorize Glacier Eye Clinic to administer dilating eye drops. I understand the eye drops are necessary to diagnose my condition.

RELEASE: I affirm that the information I have given is correct to the best of my knowledge and that I am responsible to inform this office of any changes. I authorize Glacier Eye clinic to administer dilating drops. I understand that I am responsible for all fees regardless of insurance benefits. I authorize the release of any medical information necessary to process my claims. I authorize the payment of medical benefits directly to the physician for services performed.

SIGNATURE: ____ DATE: ____________________

AARON M. ALME, MD MAKENZIE FAI, OD ROGER A. BARTH, MD FRANCES MANGAHAS, OD MARK GOERLITZ-JESSEN, MD JANATHAN OLSEN, OD TYLER OFSTAD, MD, PhD MARIE ROACH, OD MARK C. REMINGTON, MD LUCAS SCHMIDT, OD GUS STEIN, MD
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POLSON CLINIC
103 WHITEWATER PLACE STE. C. POLSON, MT 59860 406-257-2020

COLUMBIA FALLS CLINIC
500 12th AVENUE, STE. #2E, COLUMBIA FALLS, MT 59912 406-257-2020

REFRACTION SERVICES AND FEES

What is a refraction?

A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. A refraction is the part of the examination where the doctor or staff member flips various lenses inside the phoropter and ask questions like "Better 1 or Better 2"? They will keep asking questions until they have helped you achieve the best possible corrected vision.

Why is it necessary?

Refraction is sometime necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vison or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem.

Is it covered by my insurance?

A refraction is NOT a covered service by Medicare, Medicare Advantage, and most other medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service. We charge separately for that portion of the examination since it is not a covered service. You may have coverage for a refraction and/or routine vision care through a separate vision plan distinct from your medical plan. Examples may include, but are not limited to: Eyemed, VSP, Davis Vision, BlueVision, etc. Glacier Eye Clinic is not contracted with ANY vision plans. You will be responsible for payment to Glacier Eye Clinic for a refraction and routine vision care services, and will need to submit your vision plan eligible expenses directly to your vision plan. We can provide you with a copy of your paid itemized statement if your insurance requires you to do so.

What if I do not want the refraction?

You may decline the refraction fee ONLY if you choose not to have the prescription itself, and you will not be charged. Should you want your prescription after today's visit, the below fees will apply.
IMPORTANT: You must still proceed with the testing part of the examination so that the doctor will be able to determine the cause of your decrease in vision.

The cost for a refraction:

- **$60.00 for glasses**
- **$80.00 for glasses & contact lenses**

It is collected at the time of your visit, in addition to any copayment or deductible or balance due from the medical portion of your examination.

IMPORTANT: If you choose to not pay today, you will be billed for this service and are responsible for payment.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a noncovered service. I accept full financial responsibility for the cost of this service.

I have received my glasses and/or contact lens prescription today and agree with the above cost of service.

Signature: ______________________ **Date:** ______________

Glacier Eye Clinic, P.C.

175 Timberwolf Parkway, Kalispell, MT 59901 406-257-2020

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Clinic Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Clinic may disclose and use my protected health information.

Patient Name: ____________________________________ Patients DOB: ____________

Signature: ____ Date: ______________

If signed by the patient's personal representative, indicate:

a. Name of signer and relationship to patient

If acknowledgment not signed, indicate reason not signed and efforts made to have acknowledgment signed:

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AUTHORIZATION TO DISCUSS MY CARE

I, ______________________________ would like to give authorization to this facility to discuss my medical care with the following persons. I understand this authorization will stay in effect until I ask to have it removed in writing.

Individual(s) Name:	Relationship to Patient:
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

Can we Leave a Message?

Home Phone: ______________________ OK to Leave Message Y or N

Cell Phone: _______________________ OK to Leave Message Y or N

Revised 3/2021