East Carolina Retina
CONSULTANTS

Welcome Letter
Dr. Peter Van Houten & Associates
2501A Stantonsburg Rd office 252.758.2402
Greenville, NC 27834 toll free 800.849.8459
EastCarolinaRetina.com fax 252.758.2762

Date:_____

Patient: _____,

You are scheduled to see Dr. Van Houten on _____, at _____. Please call our office **at least 24 hours** prior to this appointment if you foresee that you will be unable to make it on this day and time to avoid our **$50.00 cancellation fee**. Our schedule fills up quickly, so please do not delay calling us if you need to change your appointment date and/or time. You will find the following forms that you need to read and fill out prior to your appointment:

1) Registration Sheet & Patient Disclosures **(Complete front & back)**
2) Medical History Form **(Complete front & back)**
3) Notice to Patients – Read only & keep for your records
4) Financial Policy – Read only & keep for your records

Please complete these forms in their entirety and bring them along with your most updated insurance card(s), your insurance co-payment if required or money to pay for your services, and a photo ID. **Our office no longer offers monthly payment arrangements. If you need to discuss financial arrangements, you must call prior to your appointment as we expect <u>your portion</u> of the bill to be paid in full at the time of service.**

You also will need someone to drive you to your appointment as your eyes will be dilated, as your eye problem may require tests or procedures to be performed that afterwards may make it difficult for you to see to drive**. Your visit will be lengthy so it is important to make arrangements to be with us for several hours.** We advise you not to make any other appointments on the day of your appointment due to the unpredictability of your wait time. **If you are diabetic, we recommend that you bring a snack.**

We hope receiving this information prior to your appointment will assist you in making arrangements for your appointment and will allow us to better serve you. Please call our office if you have any questions prior to your appointment at (800) 849-8459, then press "0" and your call will be routed appropriately.

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Information Sheet
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Please read this important information prior to your visit

CHECK LIST: Please be sure to bring the following to your appointment:

1. All of your precription medications.
2. Your most recent eye glasses or contact lenses.
3. A list of all physicians currently treating you along with their addresses and phone numbers.
4. Medical insurance cards.
5. Diabetic patients may want to bring a snack as the length of your visit may be lengthly.
6. Legal papers indicating you are a Power of Attorney/Guardian for a patient.

Thing you need to know prior to you visit:

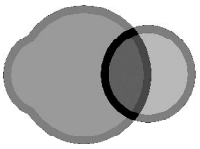
Be prepared to pay any copays, co-insurances, deductibles and noncovered charges at the time service is rendered. We accept MasterCard, Visa, Discover, CareCredit, Cashiers Checks, Personal Checks or Cash.

If your insurance plan requires an authorization, YOU are responsible for getting it to us from your Primary Care Provider prior to your visit, otherwise we may not be able to see you.

Because your eyes will be dilated, we strongly recommend that you arrange to have someone drive you to and from your visit with us.

If you are arranging transportation to our office, please make sure you check-in at our front desk before your driver leaves you. We sometimes have to cancel or rearrange appointments due to emergency cases.

We ask that you limit the number of people accompanying you to your appointment as seating is limited. Medical procedures, cost, and payment options may be discussed, if you are not comfartable having these matters discussed with this person, please ask them to remain in the reception area.



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Patient Registration – Minors

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Patient's Name:_____ Birth Date:_____

SSN:_____ Age:_____ Sex: (M) (F)

Race: African American ___ Asian___ Caucasion___ Hispanic___ Other ___

Mother's Name:_____ Date of Birth:_____ SSN:_____

Father's Name: _____ Date of Birth:_____ SSN:_____

Address :_____

City:_____ State:_____ Zip:_____

Phone:(Home)_____(Cell)_____(e-Mail)_____

Mother's Employer:_____ Phone: _____

Address:_____City, State, Zip:_____

Father's Employer:_____ Phone: _____

Address:_____City, State, Zip:_____

Emergency Contact:_____ Relationship:_____

Phone:(Home)_____ (Work)_____(Cell)_____

Referring Physician:_____ Phone:_____City:_____

Primary Physician:_____ Phone:_____City:_____

Current Pharmacy:_____ __ Phone:_____City:_____

PRIMARY Insurance Plan:_____ Policy #:_____

Policy Holder's Name:_____ DOB:_____

SECONDARY Insurance Plan:_____ Policy #:_____

Policy Holder's Name:_____ DOB:_____

I, the Patient or the legal representative of the Patient, hereby authorize the release of any information to my insurance carriers and my referring physicians. I also authorize the payment of medical benefits directly to East Carolina Retina Consultants, PLLC and I understand that I am responsible for any amount not covered by my insurance.

I, the Patient or the legal representative of the Patient, agree to provide payment in full for any insurance co-payments/co-insurances/deductibles I am liable for per my health insurance coverage or any office charges, if self pay, via cash, check, credit card, and/or CareCredit on the date services are rendered. In the event my balance becomes delinquent more than 60 days it is the policy of East Carolina Retina Consultants to begin an external collection process and if my account becomes delinquent more than 120 days that it will be turned over to a collection agency and may affect my credit rating.

Signature:_____ **Date:**_____

Printed Name of Parent/Guardian/Power of Attorney :_____

Chart#:_____

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I acknowledge receipt of a Notice of Privacy given to me and/or my legal representative. I give my permission to East Carolina Retina Consultants, PLLC to use and disclose my Private Health Information in accordance with it.

Notice: Be aware that anyone who accompanies you during your examination will hear your Private Health Information. By allowing this individual(s) to accompany you during your examination, you are giving us permission to disclose your Private Health Information to them. Images, sounds, and conversations may be recorded.

I give the following individual(s) permission to receive my PHI (Private Health Information) today and anytime in the future. These individuals have my permission to call and inquire about my Private Health Information both verbally and written, unless I notify you in writing.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Name of Patient (Print) Medical Record #

_____ _____
Patient Signature Date

For patients represented by a Medical Power of Attorney or Guardian, these individuals must present legal documentaiton showing his/her authority to receive private health information related to the patient and to make medical decision for the patient. Legal documents must be copied and retained in the chart along with a copy of the representative's identification.

_____ _____
Name of Power of Attorney, Parent, or Guardian NC Driver's License #

_____ _____
Signature of Power of Attorney, Parent, or Guardian Date

Witness:_____ _____
ECRC Employee Date

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Medical History Form

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Please check current or past medical conditions that apply to you or an immediate family member (Mother, Father, Sibling or Grandparent of the patient: A Blood Relative).

	PATIENT		FAMILY MEMBER		RELATIVE WITH DIAGNOSIS
	YES	NO	YES	NO	
Blindness					
Eye Trauma					
Glaucoma					
Retinal Detachment					
Cancer: **Type** _____					
Chest Pain					
Congestive Heart Failure					
Coronary Artery Disease					
Diabetes (Sugar)					
Elevated Cholesterol					
Fibromyalgia					
Hardening of the Arteries					
Hearing Problems					
Heart Attack					
Heart Murmur					
Hepatitis					
High Blood Pressure:					
If YES how long? _____					
Kidney Stones					
Stroke or Mini stroke					
Thyroid Disease					
Arthritis / Gout					
Asthma / Bronchitis					
Crossed eyes / Lazy eye					
Emphysema / COPD					
Headaches / Migraines					
HIV / AIDS					
Lyme's Disease / Tick Bite					
Mental Illness / Depression					
Prostate / Kidney Disease					
Seizure / Epilepsy					
Sickle Cell Disease / Trait					
Stomach Ulcers / Irritable Bowel					
Tuberculosis / Sarcoidosis					
Any other diseases that run in your family:					

If YES Please Circle ⇓

PATIENT NAME: _____ DATE: _____

CHART # _____

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Have you had an Eye Surgery or Laser before? ☐ YES ☐ NO

If YES, which eye was operated on? ☐ LT ☐ RT ☐ BOTH

If YES, why were you operated on? _____

List Other Surgeries or None:_____

_____

List Medication Allergies or None:_____

_____

List All Medications You Are Currently Taking (Eye Drops, Herbs and Vitamins)

Name	Dose (mg)	How Often

Are you diabetic? ☐ YES**, How Long?** _____ ☐ NO

If YES, **What** was your last Hemoglobin A1C (3 mo avg. blood sugar?) _____

When was your last Hemoglobin A1C checked? _____

Do you check your own blood sugar? ☐ YES ☐ NO **How often?**_____

What was your Blood Sugar this morning? _____

What do you primarily drink during the day? _____

Do You Drink Alcohol? ☐ YES ☐ NO **What & How Often?**_____

Do you Smoke or have you ever? ☐ YES **Yr Started:**____ **Yr Quit:**____ ☐ NO

What tobacco do you use? __cigarettes __pipe __cigars __chewing tobacco __snuff

Please describe your current eye problems:_____

_____

Please write any questions you want to ask the Doctor:_____

_____

Patient Signature:_____ **Date:**_____

Chart #_____

Revised 1/30/13

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Financial Policies

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Co-payments, co-insurances, deductibles and self pay charges are expected on the day your services are provided.

We accept Cash, Checks, Mastercard, Visa, Discover, and CareCredit Accounts.
If your check is returned there will be a **$20** charge to your account.

All patients must complete our registration forms and provide us with a photo ID.

Patients without insurance: If you do not have insurance, you must be prepared to pay for your services on the day of your visit. If you have questions regarding our charges for services you may speak to one of our financial counselors to discuss payment arrangements prior to your appointment, otherwise you must be prepared to pay your bill in full. If you cannot pay your bill in full then we ask that you contact **CareCredit** at **www.carecredit.com** to establish a credit account to pay for your services received at our practice. There are also agencies that may be able to assist you depending on your financial situation.

Patients with insurance: You must present your insurance card(s) and be prepared to pay the co-payment/co-insurance/deductible amount your insurance requires for you to see a Specialist. If you cannot pay your bill in full then we ask that you contact **CareCredit** at **www.carecredit.com** or you may call them at (800) 677-0718 to establish a credit account to pay for your services received at our practice. **Your appointment will be rescheduled if co-payments are not made the day of your appointment, unless your appointment is emergent.** If you have questions, please call and inquire prior to your appointment date.

Medicaid Patients: If you are an enrollee in the Medicaid program you must present your Medicaid Card and be prepared to pay your co-payment of $3.00 the day of your visit **or your appointment will be rescheduled, unless it is of an emergent nature.**

Worker's Compensation Cases: If you are referred to us due to an injury on the job, you must provide us with your employer's workers compensation policy information and a contact name and telephone number for your employer. Failure to provide this information will result in your visit being rescheduled, unless the you agree to pay the full charges yourself for that days visit or unless your eye problem is emergent. Any money received from you will be refunded upon receipt of payment from your employer's Worker's Compensation Insurance Plan.

Third Party Payers: If you are being represented by an attorney as a result of an accident or injury and are expecting reimbursements from a third party, you are still responsible for your bill at the time the services are provided. No arrangements will be made based on prospective third party payments. We will refund money received upon receipt of payment from the third party.

Billing Procedures: As a courtesy, our office will submit your insurance claim on your behalf. Therefore, it is essential that we have complete and accurate information about your insurance carrier. Please remember that your insurance policy is an agreement between you and your insurance company. No insurance company attempts to cover all medical costs. Some pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any balance not paid or covered by your insurance.

Reschedule, Canceled Appointment Charge, & No Show Appointment Charge: A $50.00 charge will be assessed if an appointment is rescheduled or canceled in less than 24 hours from your appointment date and time, or if you do not show for your appointment.

Disability, FMLA and Other Forms: A $25.00 charge will be assessed to you **per form prior** to our office completing ANY DISABILITY, FMLA, or OTHER REQUESTED forms for yourself or a family member. Your forms will be completed in order of receipt not to exceed a month from the date of payment. The patient may pay the Expedited fee of $50.00 to receive their forms within 7 business days of payment.

Medical Reords Fee: A minimum fee of $10.00 will be assessed to you **prior** to our office preparing a copy of your medical records for you. Depending on the number of pages with in your record there may be additional charges over the $10.00 minimum. Any additional charges will need to be paid prior to your records being delivered to you.

Delinquent Accounts: It is our policy to submit unpaid insurance and patient balances to Statewide Collections Company of Charlotte. Statewide Collections will try contact you in regards to your balance over a 2 month period in an effort to collect. If your account is submitted to Statewide Collections you will continue to mail your payment to East Carolina Retina Consultants, 2501-A Stantonsburg Road, Greenville, NC 27834. If payment in full is not received after submitting your account to Statewide Collections or if we do not hear from you regarding payment arrangements your account will be sent to the Bad Debt section of Statewide Collections where your credit rating may be affected. At this point all further negotiations regarding payment must be handled through their office. We will also disconnect our patient relationship with you at this point.

Surgical Coordination & Financial Arrangments: If after consultation with the doctor, your condition requires surgery in the hospital or procedures in the office, you will meet with our Surgical Coordinator to make arrangements. Sometimes due to the medical necessity of your treatment, the doctor may have to perform surgery on the same day as your visit. Our Surgical Coordinator will provide you with an estimate of the cost of the surgery and will discuss payment arrangements with you at this time.

Please understand that our services are separate from the hospital and you will be billed separately by the hospital and anesthesiologist for their services.

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