



Dr. Dan Yoakum, O.D. P.A.

WELCOME TO OUR OFFICE!

We welcome you and thank you for choosing us to serve your eye care needs! We look forward to seeing you in our office and providing the very best eye care and eyewear available today.

Enclosed is our New Patient Forms that we ask you to fill out before coming in for your appointment. Please bring these forms along with the items listed below as this will be a great help to us. Feel free to call our office with any questions.

When you come to your appointment, **please be sure to bring the following:**

- List of any medications that you are taking, including any non-prescription medications, eye drops, herbals, ect.
- Your medical insurance and vision insurance cards, including a Medicare card, if applicable. **Please call your insurance company to verify your current vision benefits.** Also note that your vision coverage may be with a company different than your medical insurance. Your insurance company or employee benefits department should be able to help you determine your coverage.
- Your current pair of glasses as well as any prescription sunglasses or computer/reading glasses you might use.
- If you wear contact lenses, please wear or bring those to your visit, along with your current contact lens prescription.
- Completed New Patient Forms.

Our office is located in the Heritage Professional Park on Rogers Road in the Heritage subdivision of Wake Forest. You may visit our website at www.dranyoakum.com for directions or call our office at 453-1220.

Dr. Yoakum is committed to offering the highest level of service to as many people as possible, and provides the best resources available for your appointment. Therefore, we require a minimum of a 24 hour cancellation notice on all appointments. Cancellations with less than this time will be billed a \$ 25 fee after the 2nd time. No shows will be billed a \$ 35 fee after the 2nd time. Our staff will attempt to remind you of your appointment, but it is your responsibility to remember.

Our office is committed to excellence and personalized care. We are so grateful you have trusted us with your eye care needs. We look forward to seeing you!

Sincerely,

Dr. Dan Yoakum and Staff



Today's Date

Date of Birth

Last Name

Social Security #

First Name

Middle

If Under 18, Parent/Guardian's Name(s)

Nickname and/or Title

Please check:

Address

- Male
 Female

City

State

Zip

Please check:

Home Phone

- Married
 Widowed
 Single
 Divorced
 Legally Separated

Daytime Phone

Please check:

Mobile Phone

- Employed Full-Time
 Employed Part-Time
 Self-Employed
 Retired
 Full-Time Student
 Part-Time Student
 On Active Military Duty
 Not Employed

Email Address

Employer/School

Occupation

Referred By:

- Website Wake Weekly Super Saver Circa Other:

INSURANCE INFORMATION:

Primary Medical Insurance

Primary Insured's Name

Secondary Medical Insurance, If Any

Primary Insured's Date of Birth

Vision Insurance

Primary Insured's Social Security #

Group Name, Employer, or Self-Insured

Primary Insured's Relationship to Patient

HERITAGE EYE CARE HIPAA PRIVACY NOTICE & DISCLOSURES

In the course of providing services to you, Heritage Eye Care creates, receives and stores health information that identifies you. It is often necessary to use and disclose the health information in order to treat you, to obtain payment for our services, and to conduct health care operations in our office. The *Notice of Privacy Practices (NPP)* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *NPP*, the uses and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes: our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers; as well as other aspects of payment described in our *NPP*. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations and that you also signify that you have been provided with a copy of our *NPP*. Sometimes you may wish to have only certain parts (or medical conditions) of your medical records to be released to only certain physicians or people. **By signing below, I give permission to the person(s) listed in the table documented to receive information about my care. This permission will be considered ongoing until I state in writing otherwise.**

Please list name(s): _____

PATIENT SIGNATURE _____ DATE _____

HERITAGE EYE CARE APPOINTMENT, INSURANCE, AND BILLING POLICY

Billing your insurance is a courtesy provided by Heritage Eye Care. Services billed on your behalf are provided to you on credit, with no guarantee your insurance will cover any or all services provided. Therefore, the financial responsibility for services provided does not belong to your insurance company, but to the person receiving the services—the patient (or guardian). Once your medical insurance has paid according to the terms of their contract, any unpaid balance becomes your responsibility. It is very important that you realize that your insurance is a contract between you, your employer and the insurance company. Heritage Eye Care is not a party to that contract. All charges that you incur are your responsibility from the date that the services are rendered. Heritage Eye Care cannot leave an open balance on your account indefinitely waiting for an insurance company to make payment. There may be times when you will have to pay us directly and settle with your insurance company after the fact. If at any time we receive a payment from your insurance company after you have paid us, you will receive a refund promptly. We cannot waive any co-payments, deductibles or coinsurance amounts defined as patient responsibility under the terms of our contract with these various plans. You will be required to pay your co-pay at every visit, including, but not limited to, any follow-up visits. Accurate, up to date information is the patient's responsibility. You will be asked to show your insurance card at every visit and we also request that you verify your current insurance benefits before each appointment. We mail out statements after the 30th of every month and payment in full must be received by the 20th. After receiving 3 statements, your 4th statement will reflect a \$50.00 late fee and your account may be turned over to collections. We are happy to discuss any balance due, however, you must contact us within 30 days of your 1st statement and you must call your insurance company to verify your benefits before calling us. Please also note that we require a minimum of **24 hours notice** to cancel an appointment. Cancellations less than 24 hours may be billed a late fee after the 2nd time. If you do not call previous to your appointment and fail to show up, you may also incur a fee.

MEDICARE: I request that payment of all authorized Medicare benefits be made either to me, my beneficiary, or Heritage Eye Care for any services furnished to me by them.

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. I understand and agree to the stipulations of Heritage Eye Care's Appointment, Insurance, and Billing Policy as stated above.

PATIENT SIGNATURE _____ DATE _____

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Date of last eye exam: _____

Name of doctor: _____

Date of last physical: _____

Name of doctor: _____

Please check if you wear:

Glasses Distance Reading

Bifocal/Progressive

Contacts

wear every day

wear occasionally

sleep in lenses

Medications currently taking, including **eye drops**:

Allergies to medications or substances:

Are you experiencing any problems with your **current glasses or contact lenses**? Please explain:

Are you experiencing any problems with your **vision or eyesight**? Please explain:

In case of emergency, please provide a name and phone number of a person we can contact:

Please check if you, or an immediate blood relative, has had any of the following **EYE** problems:

LASIK/PRK Self _____

Blindness Self _____

Cataract Self _____

Glaucoma Self _____

Macular Degen Self _____

Prosthetic Eye Self _____

Retinal Detach Self _____

Eye Injury Self _____

Eye Surgery Self _____

Tumor Self _____

Foreign Body Self _____

Dry Eye Self _____

Lazy Eye Self _____

Crossed Eyes Self _____

Eye Allergies Self _____

_____ Self _____

_____ Self _____

_____ Self _____

Please check if you, or an immediate blood relative, has had any of the following **MEDICAL** problems:

Diabetes Self _____

Cancer Self _____

AIDS/HIV Self _____

Hepatitis Self _____

High Blood Press Self _____

High Cholesterol Self _____

Arthritis Self _____

Allergies Self _____

Heart Disease Self _____

Graves' Disease Self _____

Thyroid Cond Self _____

Stroke Self _____

_____ Self _____

_____ Self _____

_____ Self _____



PUPIL DILATION AND RETINAL IMAGING

As part of the comprehensive eye exam, pupil dilation allows Dr. Yoakum to examine the back of the eye, or the retina. This is very important to screen for, or follow, such conditions as macular degeneration, diabetes, glaucoma and other retinal diseases. It also provides the most accurate investigation into your ocular health and many important aspects of your general health. Dilation is done by putting drops in the eyes and waiting 15 to 30 minutes for the pupils to become enlarged. The drops can cause sensitivity to light as well as trouble focusing on close objects; however you should be able to drive. Your eyes may stay dilated from 2 to 6 hours, but some patients may stay dilated longer. **There is no additional charge for the dilation.**

Also as part of the comprehensive exam, retinal images can be taken to document the health and condition of your eyes at the present time. Retinal images are obtained by using a highly sophisticated digital camera to take a high resolution image of the macula, optic nerve head, and surrounding fundus. This image can be used to zoom in on areas of the retina that need further evaluation and can be compared year to year to document any changes or developing conditions. Retinal images can be taken on dilated and un-dilated eyes. Photo documentation of the retina is strongly recommended for patients with a retinal condition but is optional for patients when performed as preventative care. **For patients that have a retinal disease, insurance can, in some cases, be filed for this procedure. For all other patients the fee for the retinal photos is \$40.00.**

Please indicate your preference for the pupil dilation:

- I accept dilation today.
- I do not wish to be dilated this year and will not hold Heritage Eye Care liable for any missed diagnosis or treatment that would otherwise be followed as a consequence of this procedure.

Please indicate your preference for the retinal photos:

- I wish to have retinal photographs taken.
- I do not wish to have retinal photographs taken.

Signature of Patient or Guardian

Date



CONTACT LENS EXAM

A Contact Lens Exam is a separate fee from your routine eye exam. It involves more time and testing than a regular eye exam including:

- Biomicroscopic examination of the eyes,
- evaluation of corneal curvature and topography,
- tear analysis,
- corneal integrity and sensitivity,
- eyelid, eyelash, allergy, and medication consideration,
- position, movement, and centration of the contact lenses,
- visual acuity,
- insertion and removal of lenses, and
- care, handling, and cleaning directions.

The fees for an annual contact lens exam for a **new patient** vary from \$85.00 to \$150.00.
The fees for an annual contact lens exam for an **existing patient** vary from \$75.00 to \$125.00.
Please note that exams are not discounted except if covered under your insurance benefits.

Please be prepared to pay any amount in this category at time of service. Your fee is determined by whether or not you are a current contact lens wearer, which lenses you are fitted in, as well as individual requirements for time and instruction during the annual exam and any follow-up checks.

Follow-up visits for **a period of 3 months**, as well as any trial lens, insertion and removal help, and any other assistance you may need as a contact lens wearer is covered under this exam fee. Your contact lens prescription expires every year so you will need an exam annually to continue to order your contacts. You may request a copy of your contact lens prescription when it is finalized.

OTHER CONSIDERATIONS:

I understand that contact lenses have many benefits but, as with any other medical device, they are not without possible risks. A small percentage of wearers develop serious complications which can lead to permanent eye damage. **I agree to follow the advice and instructions given to me by this office. In the event I experience any unexplained eye pain, redness, or vision changes I will remove my contacts and seek medical care.**

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

**** We offer free shipping to your home, generous rebates, and a 10% discount when you order a year supply of your contact lenses. Ask us for details! Some exceptions may apply. ****