Thank you for choosing Brumm Eye Center.

We look forward to serving your eye care needs!

COPAYMENTS ARE DUE AT TIME OF VISIT

- Arrive 15 minutes before your appointment time. If you're unable to make your appointment time please contact us.
- If you are more than 15 minutes late to your appointment we reserve the right to reschedule.
- Bring **ALL** prescription eyewear and contact lens information
- You **MUST** present all your insurance card(s), updated Medicine list, completed paperwork, & photo ID at check-in before services are provided.
- You are responsible for cost of all services and materials if you do **NOT** present your **CURRENT** Insurance information at the time of service.
- You are responsible for knowing the requirements and providers of your Medical Insurance and Medicare Plan coverage.
- Some insurance plans require a written referral/ authorization from your Primary Care Physician before services are provided.
- If patient is under the age of 19 they **MUST** be accompanied by a parent or guardian to be seen.
- Plan on being dilated, and bring a driver if you feel you may be uncomfortable driving afterwards.

Please make all checks payable to: *Brumm Eye Center*

Brumm Eye Center

PATIENT INFORMATION:

NAME: _____ E-MAIL ADDRESS: _____
LAST FIRST MIDDLE

MAILING ADDRESS: _____
STREET APT/LOT/ROOM CITY STATE ZIP CODE

TELEPHONE NUMBERS: (PLEASE INCLUDE AREA CODES) HOME: _____ WORK: _____ CELL/PAGER: _____

WHICH NUMBER WOULD YOU PREFER TO BE REACHED AT BETWEEN 9A-5P? CIRCLE: HOME / WORK / CELL

PATIENT BIRTH DATE: _____ ____ MALE ____ FEMALE SOCIAL SECURITY NUMBER: _____
MONTH/DAY/YEAR

SPOUSE'S NAME: _____ SPOUSE'S BIRTH DATE: _____
LAST FIRST MIDDLE MONTH/DAY/YEAR

EMERGENCY CONTACT (OTHER THAN SPOUSE) _____ DAYTIME PHONE #: _____
LAST FIRST (INCLUDE AREA CODE)

PRIMARY CARE PHYSICIAN: _____ OFFICE PHONE #: _____
(INCLUDE AREA CODE)

PATIENT'S EMPLOYER: _____ POSITION HELD: _____

BILLING INFORMATION: PERSON RESPONSIBLE FOR PATIENT ACCOUNT (EXCLUDES WORKERS COMPENSATION)

_____ SAME AS PATIENT _____ PARENT _____ POWER OF ATTORNEY (POA)* _____ GUARDIAN* _____ OTHER_____

NAME: _____ Phone #: _____
Last First Middle (Include Area Code)

ADDRESS: _____
STREET APT/LOT/ROOM CITY STATE ZIP CODE

RELATIONSHIP TO PATIENT: _____

* POA/GUARDIAN: WE WILL NEED TO MAKE PHOTOCOPIES OF THESE LEGAL PAPERS — PLEASE BRING TO PATIENT APPOINTMENT

GENERAL INFORMATION: HOW DID YOU HEAR ABOUT US? FAMILY/FRIEND/CO-WORKER/PHYSICIAN. WHO?_____

CIRCLE ALL THAT APPLY: PHONEBOOK / NEWSPAPER / INTERNET / RADIO / OTHER _____

INSURANCE INFORMATION:

1. NAME OF INSURANCE COMPANY: _____

MEMBER #: _____ GROUP #: _____

POLICY HOLDER/INSURED'S INFORMATION:

NAME: _____ RELATIONSHIP TO PATIENT: _____

BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____
(MONTH/DAY/YEAR)

EMPLOYER'S NAME: _____ EMPLOYER'S ADDRESS: _____

2. NAME OF INSURANCE COMPANY: _____

MEMBER #: _____ GROUP #: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____
(MONTH/DAY/YEAR)

EMPLOYER'S NAME: _____ EMPLOYER'S ADDRESS: _____

BY SIGNING BELOW, I CERTIFY ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
SIGNATURE OF PATIENT, RESPONSIBLE PARTY, OR BENEFICIARY DATE

Brumm Eye Center

Financial Policy, Privacy Notice, Routine vs. Medical Examination, and Refraction

Please Read Both Sides of This Sheet Before Your Eye Examination

Thank you for choosing us for your eye care needs. Please read the following information to help you understand our billing process, privacy policy, and Medicare authorization notice. All patients must agree to our financial and privacy policy before receiving treatment. If you are a Medicare participant, a signature is required stating that you agree with the financial terms of Medicare.

1. Brumm Eye Center files insurance claims for patients as a courtesy. It is your responsibility to know if the physician you are seeing is a participating provider with your health plan. It is also your responsibility to verify the benefits covered by your plan, as some insurance companies may not cover all of the services provided to you. We cannot bill your insurance company unless we are given complete insurance information for commercial insurance, Medicare or Medicaid. Any balance left after processing of our claim by your carrier (deductible or co-insurance) is your responsibility. If your insurance company has not responded and paid its portion of your account in full within 45 days of the date of service, this balance will become your responsibility to pay in full by the statement due date.
2. Co-payments are always due at the time of service. Our contractual agreement with your insurance carrier prevents us from waiving your required co-payment amount. We have the right to refuse to see you if the co-payment is not paid in full at the time of service. Brumm Eye Center is considered a specialist to most insurance companies.
3. The patient balance is due within 15 days of the statement date unless you have made other arrangements with our business office. We will collect all outstanding patient balances prior to each visit. We have the right to refuse to see you if the previous balance is not paid in full at the next time of service. If you ignore our billing statements without paying them, we will assume that you do not intend to pay for the medical services that were provided and will forward your account to an outside collection agency.
4. If you cannot pay in full at the time of service, please call the business office at (402) 572-2020 to make other arrangements. Payment plans are determined by the amount of the owed balance. The following guidelines will be followed:
   - Balances up to $300 are to be paid in 3 monthly installments.
   - Balances up to $600 are to be paid in 4 monthly installments.
   - Balances greater than $600 are to be paid in 6 monthly installments.
5. A $25 service charge will be assessed for returned checks
6. We accept cash, checks, Visa, MasterCard, Discover, Amex and Care Credit
7. We file workers' compensation claims with your employer or your employer's compensation insurance carrier. Written or telephone authorization is required from your employer prior to each treatment. If prior authorization is not obtained, you are responsible for full payment at the time of service. If your company's workers' compensation carrier has not paid your account in full within 45 days of your date of service, the balance will be transferred to your account, and it is your responsibility to pay in full by the statement due date.
8. We do not file third-party claims but will provide you with any information that is required. The patient is ultimately responsible for all services provided.
9. Medicare Authorization for Medicare Participants: You may request that payment of authorized Medicare benefits, and if applicable, Medigap benefits be made either to you or on your behalf to Brumm Eye Center for any services furnished to you by that provider. To the extent permitted by law, you authorize any holder of medical or other information about you to be released to the Centers of Medicare and Medicaid Services, your Medigap insurer and their agents, and any information needed to determine these benefits for related services.
10. You have been given the opportunity to read and/or receive a copy of Brumm Eye Center "Notice of Privacy Practice Policy." You understand that you are to review the "Notice of Privacy Practice Policy" carefully and that this signed notification will be kept on file in the office of Brumm Eye Center.
11. By signing below you agree that you understand the difference between a routine vision examination and medical eye examination which is explained on the back of this page. You understand and agree to the potential implications of these differences. This will determine the type of insurance billed and the potential for fees that may include co-pays, deductibles, and/or co-insurance fees. You understand that you are responsible for any of these fees that your insurance does not cover. You further understand that a refraction is an important test that you may need, and if so, that you may be responsible to pay for this test.

I UNDERSTAND AND AGREE TO THE TERMS OF THE FINANCIAL POLICY, PRIVACY NOTICE, AND MEDICARE AUTHORIZATION. I UNDERSTAND MY APPOINTMENT MAY BE BILLED TO MY MEDICAL INSURANCE OR VISION INSURANCE DEPENDING ON THE NATURE AND FINDINGS OF THE VISIT.

_____ _____

Signature of patient, responsible party, or beneficiary Date

_____

Please print name

Brumm Eye Center

Routine Eye Exams, Medical Eye Exams, and Refractions

Please Read Before Your Eye Examination

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit so you will know how billing will be handled. Ultimately, it is your responsibility to know what your own medical or vision plan covers. We hope this information will help you understand how your visit is submitted to your insurance for today's visit and future visits with Brumm Eye Center.

Benefits may vary depending upon the reason for your visit. Your description of your eye examination will help us to determine whether your visit to the clinic is defined as "routine" or "medical." Your symptoms and eye examination will determine how your visit is coded and billed to your insurance.

Routine Eye Examinations: A routine eye exam takes place when you come for an eye examination without any medical eye problem and *no medical problems are found.* Glasses and contact lens prescriptions may be updated.

Medical Eye Examinations: Your visit will be coded as a medical eye examination whenever you are being evaluated or treated for a medical condition or symptoms, eye problems you tell our staff about, or a condition that the doctor finds during the examination. Examples that will necessitate your visit being submitted to your medical insurance include headache, diabetes mellitus, eye irritation, dry eyes, allergies, floaters, contact lens intolerance, glaucoma, cataract, eye muscle imbalance, lazy eye, macular degeneration and others. Please note that if you have diabetes mellitus, we will send a letter to your primary care physician regarding your eye examination, and the visit will be coded as a medical eye examination.

Vision Service Signature Plan (VSP) and Eyemed: If your vision plan is Vision Service Signature Plan (VSP) or Eyemed, we need to be aware of this coverage prior to your exam to obtain an authorization from them. VSP and Eyemed cover *only* routine eye examinations. If you report symptoms during your visit related to an eye problem, disease, or injury, or your doctor determines that your problem falls under the category of a medical eye examination, your visit will be billed to your medical insurance instead of your vision insurance, which will be subject to co-pays and deductibles according to your plan.

In summary, how your eye exam will be submitted to your insurance carrier will depend not only upon what you tell the doctor, but also what the doctor finds upon examination. Remember, there are vision plans that do not cover medical exams and medical plans that do not cover routine eye care. If you have any questions, please ask a member of our staff.

What is a Refraction?

A refraction is a vision test that determines your best-corrected visual acuity with eyeglasses. This is a measurement that the doctor or technician takes with an instrument called a phoropter that holds corrective lenses in front of your eyes. While you look at the eye chart through the phoropter, the lenses are adjusted until the clearest vision is achieved. You may hear the doctor or the technician say something like, "Which is better, lens one or lens two?"

This test is performed on your first visit with us, your annual visit, and anytime there is a vision change. This test may allow us to provide you with a prescription for updated glasses, or it may be required by Medicare, Tricare, or other insurance plans to determine if you qualify for particular eye procedures such as cataract or laser eye surgeries.

Will your insurance pay for a refraction?

VSP INSURANCE AND EYEMED INSURANCE: This will be covered when it is submitted with the routine eye exam.
MEDICARE INSURANCE: Even though this is a vital test to the care of your eyes, the refraction is a non-covered service through Medicare and many Medicare replacement or supplement insurance plans. Unfortunately, these plans do not differentiate between medical refractions and refractions performed solely for the purpose of providing glasses. We are required to charge for the service regardless or whether insurance will pay.

There is a fee of $25.00 for this test that you will be asked to pay at the time of your visit. As a courtesy to our patients, we file this charge to the insurance companies. If your insurance plan should reimburse our office for this test, we will refund you the difference. This is a routine charge at all medical and surgical ophthalmologists' offices. If you wish to forego the refraction, please inform us before we begin doing any testing of your eyes.

Brumm Eye Center

Name: _____ **Preferred/Nickname:** _____ **Date of Birth:** ____/____/_____

Primary Care Physician: _____ **Referring/Specialty Dr.** _____

Previous Eye Doctor: _____ **Date of Last Eye Exam:** ____/____/_____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Past Eye History (Mark all that apply)

☐ Overall Healthy	☐ Dry Eyes	☐ Macular Degeneration
☐ Amblyopia (Lazy eye)	☐ Glaucoma	☐ Myopia (Near sighted)
☐ Aphakia	☐ Hyperopia (Far sighted)	☐ Optic Neuritis
☐ Astigmatism	☐ Iritis	☐ Retinal Detachment
☐ Cataracts	☐ Keratoconus	☐ Trauma
☐ Diabetic Retinopathy		
Other: _____		

Eye Surgeries: (Mark all that apply and provide dates)

☐ No prior eye surgery	☐ Retinal Laser Surgery (Date) _____	☐ Strabismus/Muscle Surgery (Date) _____
☐ Blepharoplasty (Date) _____	☐ LASIK (Date) _____	☐ Retinal detachment repair (Date) _____
☐ Cataract Surgery (Date) _____	☐ PRK (Date) _____	☐ Trabeculectomy (Glaucoma surgery) (Date) _____
☐ Corneal Transplant (Date) _____	☐ Punctal Plugs (Date) _____	☐ Vitrectomy (Date) _____
☐ Foreign Body Removal (Date) _____	☐ RK (Date) _____	
Other: _____		

Systemic Illnesses:

☐ No history of illnesses	☐ Congestive Heart Failure	☐ Hepatitis	☐ Lung Disease
☐ Anemia	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Lupus
☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Eczema	☐ HIV
☐ Asthma	☐ Fibromyalgia	☐ Kidney Disease	☐ Psychiatric Disorder
☐ Bleeding Disorder	☐ Headache	☐ Kidney Stones	☐ Skin Cancer
☐ Cancer (type) _____	☐ Hearing Loss	☐ Liver Disease	☐ Stroke
☐ Thyroid Disease	☐ Graves' Disease	☐ Coronary artery disease	☐ Depression
☐ Myasthenia Gravis	☐ High cholesterol	☐ GERD/Acid reflux	☐ Diabetes

☐ Deep vein thrombosis / blood clot

Family History (other than yourself): (please circle applicable family members)

☐ Glaucoma	Mother	Father	Sister	Brother	Grandmother	Grandfather	☐ Unknown Family History
☐ Macular Degeneration	Mother	Father	Sister	Brother	Grandmother	Grandfather	
☐ Blindness	Mother	Father	Sister	Brother	Grandmother	Grandfather	
☐ Diabetes	Mother	Father	Sister	Brother	Grandmother	Grandfather	
☐ Cancer	Mother	Father	Sister	Brother	Grandmother	Grandfather	
☐ Heart Disease	Mother	Father	Sister	Brother	Grandmother	Grandfather	
☐ High Blood Pressure	Mother	Father	Sister	Brother	Grandmother	Grandfather	

Surgical History: (Please list previous surgeries and dates) _____

_____

Social History: (Mark all that apply)				
Smoking: ☐ current every day smoker	☐ current some day smoker	☐ former smoker	☐ never smoked	
Alcohol Use: ☐Yes ☐No If yes, how much and how often? _____				
Pneumonia Vaccine: ☐Yes ☐No If yes, when? _____				
Recreational Drug Use: ☐ Yes ☐ No If yes what and how often? _____				

Current Medications:

Pharmacy: _____ **Address:** _____

Prescription name	Dose	Frequency	Route (oral, injection, etc.)

Medication Allergies:	Medication	Reaction

Have you ever taken prostate medicines / alpha blockers? ☐ Yes ☐ No

Please circle: Flomax / Tamsulosin / Hytrin / Cardura / Saw Palmetto / Doxazosin / Terazosin / Uroxatral / Rapaflo

Review of Systems: (Mark all that apply)

Cardiovascular
- ☐ chest pain
- ☐ irregular heartbeat
- ☐ shortness of breath

Constitutional
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ weakness
- ☐ weight loss

Genitourinary
- ☐ genital discharge
- ☐ genital lesions
- ☐ painful urination
- ☐ urgency

HEENT
- ☐ dizziness
- ☐ hearing loss
- ☐ hoarseness
- ☐ ringing in ears
- ☐ sore throat

Hematologic
- ☐ bleeding
- ☐ bruising
- ☐ tender nodes

Metabolic
- ☐ cold intolerance
- ☐ excess hunger
- ☐ excessive thirst
- ☐ frequent urination
- ☐ heat intolerance

Musculoskeletal
- ☐ back pain
- ☐ joint pain
- ☐ muscle aches
- ☐ stiffness
- ☐ swelling

Neurological
- ☐ balance problems
- ☐ headache
- ☐ numbness
- ☐ tingling

Psychiatric
- ☐ anxiety
- ☐ depression
- ☐ insomnia
- ☐ irritability

Respiratory
- ☐ cough
- ☐ trouble breathing
- ☐ wheezing

Skin
- ☐ hair loss
- ☐ rash
- ☐ skin lesions

Allergy
- ☐ itching
- ☐ hives
- ☐ chronic runny nose
- ☐ seasonal allergies

Blood Pressure Control
- ☐ good BP control
- ☐ borderline BP control
- ☐ poor BP control
- ☐ unknown BP control

Diabetes Control
- ☐ good DM control
- ☐ borderline DM control
- ☐ poor DM control
- ☐ unknown DM control

Pregnancy
- ☐ pregnancy-first trimester
- ☐ pregnancy-second trimester
- ☐ pregnancy-third trimester
- ☐ not pregnant

Patient Signature: _____ Date: _____