NORTH IDAHO EYE INSTITUTE

Coeur d'Alene Location
1814 Lincoln Way
Coeur d'Alene, ID 83814
Phone: (208) 667-2531
Fax: (208) 765-9385

Post Falls Location
1110 Polston Ave
Post Falls, ID 83854
Phone: (208) 773-1180
Fax: (208) 262-7217

D. Justin StormoGipson, MD * Tad Buckland, MD * Alison Granier, MD
David Dance, MD * Sara Duke, MD * Patrick Parden, MD * Roderick Kent, MD
Stephen Moss, MD * David Wold, MD * John Weisel, OD

It is the goal of North Idaho Eye Institute's Physicians and Staff to Provide Compassionate and Exceptional Eye Care.

Dear New Patient,

Thank you for trusting us with your eye care needs. Our physicians and staff are committed to medical excellence in a compassionate environment. We measure our success by our patient's satisfaction and exceptional medical outcomes. For your convenience, we have two locations: Coeur d'Alene and Post Falls.

In order to serve you efficiently, we ask that you bring to your appointment:

* Insurance cards
* List of current medications (including eye drops)
* The glasses you usually wear and sunglasses, if you own a pair
* If you wear contact lenses, **come to your appointment with your contacts in.**
* Please complete the enclosed forms (blue and white)

If your appointment is for a Comprehensive Eye Exam, please allow approximately 1 ½ hours and anticipate having your pupils dilated. Your vision will be blurred for an average of 3-4 hours. Many of our patients are able to drive home with the aid of sunglasses for glare. If you have not had the experience of pupil dilation, for enhanced safety, it is advised to bring someone to drive you.

If you have need of glasses or contact lenses, our certified opticians and contact lens specialists will serve you with expertise and care. Our Optical department offers a full line of fashion frames, optically precise lenses, a wide variety of contact lenses as well as sports glasses and sunglasses.

The Physicians and staff of North Idaho Eye Institute and Coeur d'Alene Optical welcome you to our office and look forward to providing you with excellent and compassionate eye care.

Sincerely,

Karen Sines,
Administrator

"Providing compassionate and exceptional eye care"

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REFRACTION POLICY

A refraction is a test that is done to measure your best possible vision. During the test, different lenses are placed in front of the eye to determine which one performs the best.

A refraction is done for many different reasons:

1. To determine the best potential vision for each eye
2. To establish a reference point, against which the extent of any eye problem can be measured
3. To evaluate and monitor medical conditions of the eye such as diabetes, cataracts, glaucoma, or macular degeneration
4. Pre-operative care to aid in surgical management
5. Post operative care to optimize the post surgical result
6. To determine the correct prescription for glasses or contacts

Medicare, Medicare HMO's and most insurance plans secondary to Medicare do not cover refractions regardless of the medical condition associated with the office visit. This is a formal Medicare policy. Medicare requires that we charge separately for this service, since they have determined that it is never a covered service. *

Some commercial insurance policies will pay for the refraction test, and some will not.

It is our office policy that when we understand that your insurance company will not cover the refraction charge – as with other charges – you will be responsible for payment at the time of service.

*Since 1992, under section 1862 (a) (1) (A) of the Social Security Act Title XVIII – Health Insurance for the Aged and Disabled, Medicare has classified refractions as a non-covered service for patients. This is a Federal law.

Welcome To the North Idaho Eye Institute, Post Falls Eye Clinic, North Idaho Cataract & Laser Center and Coeur d'Alene Optical.

Due to the many changes in health care, North Idaho Eye Institute, Post Falls Eye Clinic, North Idaho Cataract & Laser Center and Coeur d'Alene Optical are finding that a large amount of our staff time and clinic resources are being spent on collecting fees instead of on patient focused tasks needed to provide you with total quality eye care. The intent of our payment policy is to help us dedicate more time to you and keep the costs of medical services to a minimum by reducing the cost of billing.

A) MEDICARE PATIENTS: North Idaho Eye Institute, Post Falls Eye Clinic, North Idaho Cataract & Laser Center all accept assignment. If you do not have a supplement insurance that covers the deductible and/or co insurance, you will be expected to pay those amounts at the time of service. Coeur d'Alene Optical does not accept Medicare assignment.

B) NO INSURANCE: If you have no insurance, payment is expected at the time of service.

C) INSURANCE: If you have insurance, please have your insurance card available for the front desk. North Idaho Eye Institute, Post Falls Eye Clinic, North Idaho Cataract & Laser Center are contracted with a large number of insurance companies. If your insurance coverage is through a company that we are not contracted with we will be happy to assist you in submitting your medical claim. Coeur d'Alene Optical is only contracted with Vision Service Plan.

If we are contracted with your insurance company, payment is expected for any co-payment, deductible and/or non-covered services at the time of service. If we are not contracted with your insurance company, payment for your exam will be expected at the time of service. Payments can be made via credit card (Visa and MasterCard), traveler's check, cashier's check and personal checks and cash.

* REFERRALS: It is your responsibility to ensure that our office receives the referral your insurance company requires before your visit. If our office has not received a referral, you have the choice of rescheduling your appointment or being responsible for full payment of our eye exam charges. A Waiver Of Liability will be required for all patients who are covered by a HMO, PPO or VSP.

D) SERVICE CHARGE: A service charge to cover the cost of postage and billing services of $5.00 per month may be charged to overdue accounts and late co-payments. In addition, interest at the rate of 12% APR may be applied to overdue accounts.

E) PAYMENT PLANS: If you have a need to establish a payment plan, please contact the business office at the number listed below.

F.) REFRACTION FEE: A Refraction is a test that is done to measure your best possible vision. Many insurances do not cover refractions regardless of the medical condition associated with the office visit. Medicare considers this a "non covered service" and requires the refraction to be billed to the patient. It is our policy that when we understand that your insurance company will not cover the refraction charge – as with others – you will be responsible for payment at the time of service.

If you have any questions, please feel free to call our business office at 667-5540.

Signature _____ Date _____

Office Representative _____

Patient Name _____

NORTH IDAHO EYE INSTITUTE, PA

*** PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST**

Date _____ Account # _____

PATIENT IDENTIFICATION: (please print)

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Last Name:_____ First:_____ Middle: _____

Maiden Name _____ Other Names Used_____

Mailing Address:_____

City:_____ State:_____ Zip_____

Home Phone: ( )_____ Cell Phone: ( )_____ E-mail_____

Social Security #:_____-_____-_____ Age_____ Birthdate_____

Patient's Occupation_____ Employer's Name_____

WK Phone: ( )_____ Address_____

Spouse's Name _____ Place of Work_____ Phone:( )_____

Person to notify (Name and relationship of friend or relative not residing with you):

Name:_____ Relationship_____ Phone:( )_____

Please circle how you would prefer to be reached: Phone Cell E-mail

RESPONSIBLE PERSON:

Last Name:_____ First:_____ Middle:_____

Relationship to Patient_____ Social Security #_____-_____-_____ Birthdate_____

Address:_____ City_____ State_____ Zip_____

Home Phone:( )_____ Work Phone ( ) _____

Employer: _____

Do you have routine vision insurance? YES_____ NO_____ * PLEASE PRESENT YOUR INSURANCE CARD

Do you have medical insurance? YES_____ NO_____ * PLEASE PRESENT YOUR INSURANCE CARD

Please circle which insurance you would like us to bill for today's appointment: VISION OR MEDICAL

FOR INSURANCES WE ARE CONTRACTED TO BILL:

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to NORTH IDAHO EYE INSTITUTE, COEUR D'ALENE OPTICAL, AND NORTH IDAHO CATARACT AND LASER CENTER for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the health Care Financing Administration/my insurance company and its agents, any information needed to determine these benefits payable for related services.

Signature _____ Date_____

NORTH IDAHO EYE INSTITUTE, P.A.

Staff: Update and initial

Updated_____ Updated_____ Updated_____ Updated_____ Updated_____ Updated_____ Updated_____ Updated_____

CONSENT FOR MINOR TURN OVER

AUTHORIZATION FOR TREATMENT OF MINOR LACKING CAPACITY TO CONSENT:

I will authorize North Idaho Eye Institute Physicians to provide medical care, including examination, treatment, X-ray examination, laboratory tests, local anesthetics, medical diagnosis, and hospital care to _____, a minor. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the afore mentioned doctors.

This authorization will remain in effect until the minor turns 18 or consent is revoked in writing,

Signature of Parent/Legal Guardian/Person Having Custody_____ _____

Printed Name of Parent/Legal Guardian/Person Having Custody_____

Relationship to Patient_____Date_____

NORTH IDAHO EYE INSTITUTE
NORTH IDAHO CATARACT & LASER CENTER (Coeur d Alene only)
COEUR d' ALENE OPTICAL

Coeur d Alene Location:	1814 Lincoln Way - Coeur d Alene, Idaho 83814	208-667-2531
Post Falls Location:	1110 Polston Avenue - Post Falls Idaho, 83854	208-773-1180
WEBSITE:	northidahoeye.com	

It is the goal of North Idaho Eye Institute's Physicians and Staff to Provide Compassionate and Exceptional Vision Care

DATE_____

NAME_____DATE OF BIRTH_____OCCUPATION _____

WHAT IS THE MAIN REASON YOU ARE HERE TODAY? _____

_____

REFERRING DOCTOR?_____FAMILY DOCTOR_____

PLEASE CIRCLE ALL QUESTIONS EITHER ***YES*** OR ***NO***

HAVE YOU HAD OR DO YOU HAVE:

YES NO Diabetes
YES NO High blood pressure
YES NO Heart disease
YES NO High cholesterol
YES NO Asthma/emphysema/other
YES NO Sleep apnea
YES NO Brain disorder/stroke/MS/other
YES NO Thyroid disease
YES NO Musculoskeletal disease/arthritis
YES NO Ear,nose,throat/sinus disease
YES NO Gastrointestinal disease
YES NO Kidney/urinary disease
YES NO Unexpected weight loss
YES NO Psychiatric disease/depression
YES NO Cancer
YES NO Skin problems
YES NO Are you HIV positive/have AIDS?
YES NO Do you smoke? (How much?_____)
YES NO Have you smoked in the past?
YES NO Do you drink alcohol?
YES NO Recent hospitalization?
YES NO Recent surgeries?
YES NO Are you pregnant?
YES NO Have you ever taken Prednisone/steroids?
YES NO Have you ever taken Prostate Medications?

DO YOU HAVE ANY ALLERGIES TO:

YES NO Medications
YES NO Food
YES NO Eye drops

_____
_____
_____
_____

FAMILY HISTORY

Does your **FAMILY** have a history of:

YES NO Macular degeneration
YES NO Glaucoma
YES NO Other eye diseases
YES NO Other medical diseases
(such as cancer, heart disease, stroke,etc.)

If yes, please explain:_____

_____
_____
_____

_____

PLEASE LIST YOUR CURRENT MEDICATIONS:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

UPDATE: OFFICE USE ONLY

_____
_____
_____

Acknowledgement of Receipt of Notice of Privacy Practices

NORTH IDAHO EYE INSTITUTE, P.A. *

* Refers to all entities: North Idaho Eye Institute, North Idaho Cataract & Laser Center, Coeur D Alene Optical, DBA: Coeur D Alene Eye Clinic, Post Falls Eye Clinic, Post Falls Optical

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of SEPTEMBER 23, 2013.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

We may use or disclose your health information in certain special situations as described in our Notice of Privacy Practices. You have the right to limit these uses and disclosures.

If you wish to limit to whom we can disclose your health information as stated in our Notice of Privacy Practice, please list below those to whom you do NOT wish your health information to be released.

Name _____

Relationship _____

Name _____

Relationship _____

For Office Use Only: Documentation of Good Faith Efforts to obtain patient's acknowledgement that they received our Notice of Privacy Practices

Patient Name _____presented to the office on _____ and was provided with a copy of North Idaho Eye Institute's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the notice. However, such acknowledgement was not obtained because:

Patient refused to sign

Patient was unable to sign or initial because _____

Other reason (describe)