Patient Name: _____

Appointment Date: _____ Time: _____

Physician: _____

Office Location: 7331 Watson Rd
St Louis, MO 63119

Ph. 314-633-8575
Fax 314-743-8399

Welcome to the office of Galanis Cataract & Laser Eye Center

Our health team is dedicated to providing you and your family with the best possible medical treatment. Achieving your best vision is our mission.

Patients are seen by appointment only. We will try to honor your scheduled appointment time because we value your time. Please understand that medical emergencies do occur and in these circumstances, we ask for your consideration. If you cannot keep an appointment, we ask that at least 24 hours' notice be given to the office.

Please bring the following with you to your first visit:

- Completed forms (enclosed)
- Insurance card(s)
- Medication list
- Eyeglasses and/or Contact Lenses
- Photo ID
- Insurance Co-Pay if applicable
- Insurance Referral from your Primary Care Doctor if applicable

Precautions Following Dilation:
It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We do allow our patients to drive after dilation. If you are uncomfortable driving we recommend that you arrange to have someone drive you home.

Surgery Evaluations:

- ***Please allow approximately 2 ½ hours for this first exam and testing.***
- Surgical evaluations for **cataract or LASIK**, we do recommend you stay out of your contact lenses for 2 weeks prior to your visit. Also, please start using "over- the-counter" artificial tears 3 days prior to your exam.
- To archive the best possible outcome for your vision and overall eye health, a variety of high-end/state-of-the-art technology will be used during your evaluation.
- You will meet with our surgical staff to discuss your surgical journey and options.

Learn more about our surgical services at www.drgalanis.com

Thank you,
The Doctors and Staff of Galanis Cataract & Laser Eye Center

Patient Information

Date: _____

Patient Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____

Zip: _____ **Social Security #** _____ Date of Birth: _____

Home Ph ( ) _____ Cell Ph ( ) _____ Work Ph. ( ) _____

Employer/School: _____ Occupation: _____

Preferred E-Mail Address: _____

Please complete the following information to meet requirements set forth by the Affordable Care Act:

Marital Status: ☐ Married ☐ Single ☐ Widow ☐Divorced **Birth Sex:** ☐ Male ☐Female

Primary Language: _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (please circle one) White Black/African American Asian Hispanic or Latino American Indian Alaskan Hawaiian/Pacific Islander Greek Multi-racial

Emergency Contact _____ Phone ( ) _____

Primary Care Physician _____ Phone ( ) _____

Referring Physician _____ Phone ( ) _____

Person Responsible _____ Relationship _____

Address (if different than above) _____ City _____

State _____ Zip _____ Phone ( ) _____ Social Security # _____

Insurance Information: *You must provide us with your current insurance card(s).*

Primary Insurance _____ ID#_____

Group # _____ Policy Holder _____

Date of Birth _____ Social Security # _____ Relationship to Patient _____

Secondary Insurance _____ ID#_____

Group # _____ Policy Holder _____

Date of Birth _____ Social Security # _____ Relationship to Patient _____

Vision Insurance _____ ID#_____

Group # _____ Policy Holder _____

Date of Birth _____ Social Security # _____ Relationship to Patient _____

To be signed for the following years' visits only. *I have reviewed the above information and it has remained exactly the same:*

Signature _____ *Date* _____

HEALTH HISTORY FORM

NAME_____ **DOB**_____ **DATE**_____

Describe in your own words why you are seeing us. List any vision or eye problems you are having:

_____

_____

SURGICAL HISTORY-(Include date and type of each procedure).

_____

_____

Heart Defibrillator? ☐ Yes ☐ No **Pacemaker? ☐ Yes ☐ No**

Previous Eye Surgery? ☐No ☐Yes If yes, what and when:_____

Previous Eye Injury? ☐No ☐Yes If yes, what and when:_____

EYE HISTORY- Have you been diagnosed with any of the following? If so, date?

☐ Cataract_____ ☐ Glaucoma_____ ☐ Diabetic retinopathy_____

☐ Corneal disease_____ ☐ Iritis_____ ☐ Macular degeneration_____

☐ Crossed/lazy eye_____ ☐ Other_____

FAMILY HISTORY-Has any of your blood relatives had any of the following? If so, note which relative.

☐ Cataract _____ ☐ Glaucoma _____ ☐ Diabetes_____

☐ Corneal disease_____ ☐ Macular degeneration_____ ☐ Stroke _____

☐ Crossed/lazy eye_____ ☐ Retina Disease_____ ☐ Heart Disease _____

MEDICAL HISTORY-Have you been diagnosed with any of the following?

☐ Asthma	☐ High blood pressure	☐ Seizures or fainting	☐ Heart Stent_____
☐ Cancer	☐ Heart disease	☐ Stroke	☐ COPD
☐ Carotid artery disease	☐ Kidney disease	☐ (Women) are you currently pregnant?	
☐ Diabetes ___# of years?	☐ Migraines	☐ Rheumatoid arthritis	
☐ Head/spinal injury	☐ Anxiety/depression	☐ Other_____	

SOCIAL HISTORY

Use of Alcohol? ☐Never ☐Rarely ☐Occasional ☐Daily ☐Moderate

Use of Tobacco?☐Never ☐Former Smoker/quit date_____ Current Packs/Day_____

Use of Drugs? ☐Never Type/Frequency_____

MEDICATIONS- List **all** medications (including eye drops) that you are currently using (include the dosage). If you have not provided a copy you may list below._____

_____

ALLERGIES: Allergic to any medications? ☐ No ☐ Yes If yes please list_____

PHARMACY NAME: _____ **PHARMACY PHONE #:** _____

INFORMATION ABOUT REFRACTION

What is Refraction?
Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see and can be used to write a prescription for eyeglasses.

Why Doesn't Insurance Pay for Refraction?
Most health insurance plans were not designed to pay for routine procedures. Medicare, Medicaid, and most private policies will not pay for refraction because it is considered routine.

Who Has Decided That Refraction is Not Covered?
It is our government (for Medicare and Medicaid) or your insurance company that determines exactly which services are covered, not your individual physician.

What is Our Policy?
In order to provide the very best eye care, refraction will be performed for all new patients, those presenting with decreased vision and on a yearly basis thereafter. Private insurance plans will be billed $70.00 for refraction but you will be responsible for a fee for service rate of **$50.00** if no vision coverage is available. **Medicare patients will be responsible for paying $50.00 at the time of your visit in addition to any co-payments or deductible due.**

I understand that refraction is a **non-covered** service. I accept full financial responsibility for the cost of this service in addition to any co-payments or deductible.

_____ _____
Patient Signature or Signature of patient's guardian *Date*

PERMISSION TO RELEASE HEALTH INFORMATION

I wish to be contacted in the following manner (check all that apply)

☐ Home Phone ( ) _____ ☐ Leave message with Detailed Information
☐ Leave message with Call Back Number Only

☐ Cell Phone ( ) _____ ☐ Leave message with Detailed Information
☐ Leave message with Call Back Number Only

☐ Work Phone ( ) _____ ☐ Leave message with Detailed Information
☐ Leave message with Call Back Number Only

Written Correspondence
☐ O.K. to mail to my home address ☐ O.K. to fax to: ( ) _____

To whom may we talk to about your medical and billing information?
☐ Name of Spouse _____
☐ Name of Parent _____
☐ Name of Child _____
☐ Other _____

_____ _____
Patient/Guardian Signature Date

Please complete the Back Side of this Form as well.....

We accept assignment on Part B Medicare patients. You will be expected to pay your deductible and 20% coinsurance. We will only file to one secondary policy.

Medicare Authorization

I understand that my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HICFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of medical information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Name: _____ Date:_____/_____/_____

Signature: _____ Medicare Policy # :_____

Financial Contract Agreement

We are committed to your successful treatment. Please note that payment of your account is considered a part of your treatment.

- All co-pays are due on the day of service (we accept Checks, MasterCard, Visa, Discover).
- If you do not have your current insurance card at the time of service you will be treated as a "self pay" patient.
- All "self pay" patients are asked to pay this visit fee in full at the time of service.
- All patients covered under an HMO plan must have a valid referral at the time of their visit
- **All delinquent accounts, 90 days past due, may be placed in collections, you may be responsible for all additional charges incurred to collect this account, including court costs and legal fees.**
- We do not get involved with litigation, disputed workman's' compensation cases, divorce decrees, or auto accidents; you will be 100% responsible for full payment at time of service or within 90 days of service with prior arrangements.
- The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of account.

Telephone Consumer Protection Act (TCPA) I agree that Galanis Cataract & Laser Eye Center, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

We accept assignment of benefits for insurance plans that we are contracted with. The balance is your responsibility. Please be aware that some or all of the services provided may be noncovered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. You are responsible for verifying the benefits of your policy.

If you have no insurance coverage and need financial help, our Business Office will be happy to work out an agreeable payment plan.

I understand and agree to this Financial Contract Agreement as stated above:

Signature: _____ Date:_____

Release of Information/Assignment of Benefits/Consent to Treat

I authorize the use of this form on all of my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this insurance authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on dispute claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider.

Signature: _____Date:_____

Receipt of Notice of Privacy Practices/Written Acknowledgement Form
I have received a copy of Galanis Cataract & Laser Eye Center. Notice of Privacy Practices dated 6/1/2021

Signature _____ Date _____

The above authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.