Integrated Eye Center
160 NW 2nd Ave
Canby, OR 97013
Office: (503) 263-3937
Fax: (503) 263-3938

Lake Oswego Eye Clinic
530 First ST, Suite A
Lake Oswego, OR 97068
Office: (503) 636-9608
Fax: (503) 636-9600

FINANCIAL POLICY

PAYMENT AGREEMENT:

We accept most insurance plans as a courtesy. It is your responsibility to understand your coverage and know your carrier's guidelines for obtaining medical services. Please verify with your insurance that we are in-network for your plan. Please call your insurance if you have questions about what your out-of-pocket responsibilities will be. Our relationship is with you, the patient, not your insurance company. If claims for service provided to you are denied by your insurance company, you will be responsible for payment. For your convenience we accept cash, check, Visa, Master Card, and Care Credit.

- **Insurance Cards**: Please bring current insurance cards so that we can bill insurance in a timely and accurate manner.
- **Secondary Insurance**: We will only bill your primary insurance. We will provide you with the statement necessary for you to request reimbursement from secondary insurances. The only exception is Medicare supplemental.
- **Co-pays**: Co-pays are due at time of service. A statement charge of $5.00 will be applied if a bill is sent.
- **Deductibles**: Charges for your exam may be applied to your deductible. Please consult with your insurance regarding your deductible prior to your exam. Deductibles that are not met will be required to pay a $150 deposit at time of service.
- **Referrals**: It is the patient's responsibility to know if they need a referral to see a specialist and to obtain one from their primary care provider (PCP). If you have questions about this contact your insurance company prior to your exam.
- **Non-insured Patients**: If you do not have insurance, payment is due at the time of service.
- **No Proof of Insurance**: If insurance is not provided at the time your appointment is scheduled a deposit of $189 will be collected the day of your appointment.
- **Non-Sufficient Funds:** When checks are returned to Patrick J. Gregg MD PC for non-sufficient funds, at $25 charge will be added to your account and you will be asked to pay with cash or credit cards for future visits.
- **Non-covered Services**: OHP/Commercial insurance patients will be required to make payment in full at time of service for services not covered by insurance.
- **Statement Fees**: If we have to bill you multiple times statement fees and interest will be applied.
- **Collections**: Past due accounts will be assigned to collections after 120 days.
- **Missed Appointments**: Missed appointments disrupt the clinic schedule and take away appointment spaces that could have been made available to other patients. Please call at least 48 hours in advance to cancel or reschedule appointments. We may choose to discharge a patient from care for repeated incidents of missed appointments.
- ***We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact our office promptly for assistance in management of your account.***

I acknowledge and accept the financial policy and understand that I am responsible for any remaining balance after my insurance has been billed.

SIGNATURE_____ Date: ___/___/___

Patient Name (printed): _____ Date of Birth _____/ _____/_____

Representative authority if signing for patient_____

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HIPAA ACKNOWLEDGEMENT AND CONSENT

I understand that Lake Oswego Eye Clinic, Integrated Eye Center, and Patrick J. Gregg MD, P.C. (referred to below as "This Practice) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administration and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Policy in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient Name:_____ Date of Birth _____

By: _____ Date: _____
(Patient)

By: _____ Date: _____
(Patient Representative)

Description of Representative Authority: _____

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Medical History

Name_____ **Age:**_____ **Date**_____

Date of last Eye Exam:_____ **Eye Doctor's Name:**_____

Reason for today's visit:_____ **Preferred Pharmacy:** _____

CURRENT MEDICATIONS **Please list medications (or attach a list)**	

ALLERGIES TO MEDICATIONS	☐ **NONE**

SOCIAL HISTORY	**YES**	
Do you currently wear glasses?		**If yes, how old are your current glasses?**
Do you currently wear contact lenses?		**If yes, what brand?**
Are you pregnant?		**If yes, expected due date: ___/____/____**
Do you smoke? (please check one)	☐Never ☐Former ☐ Occasional ☐ Daily	

FAMILY HISTORY	**YES**	**Relation to Patient : M=Mom D=Dad GP= Grandparent S=sibling**
Glaucoma		
Macular Degeneration		
Lazy/Crossed Eyes		
Diabetes Mellitus		

MEDICAL HISTORY (please check)	**EYE HISTORY & SURGERIES** (please list)
☐ Diabetes ☐ High Blood Pressure ☐Cholesterol	
☐Stroke ☐ Heart Attack ☐ Emphysema	
☐Thyroid List Others:	**PREVIOUS SURGERIES** (please list)
If Diabetic last A1C:	

Check any of the following areas that apply, examples are given, please explain.		
ALLERGIC/IMMUNOLOGIC : allergies, seasonal		
BLOOD/LYMPH: excessive bleeding		
CARDIOVASCULAR: chest pain		
EARS, NOSE, THROAT: hearing loss		
ENDOCRINE: excessive thirst		
EYES: vision loss, eye pain, redness		
GENERAL: fever, weight loss, fatigue		
GENITAL, KIDNEY, BLADDER: frequent urination		
NEUROLOGICAL: headache, loss of consciousness		
RESPIRATORY: shortness of breath, cough		

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Today's Eye Exam:
Notices and Fees

VISION VS. MEDICAL

For insurance purposes, eye exams are broken into two categories; Medical Exams and Vision Exams. Medical insurance will not pay for routine eye care. Vision insurance will not pay for medical eye care. Regardless of the type of exam you have, you will receive excellent care at our clinic. Understanding the difference between Medical Exams and Vision or Routine Eye Exams helps us bill your insurance properly and helps to prevent unexpected out of pocket expense for you.

Medical Exams:

Medical Exams include evaluation, assessment, and/or treatment for medical conditions related to the eyes including, but not limited to, diabetic retinopathy, glaucoma, cataracts, macular degeneration, dry eye syndrome, infection or injury. Medical Exams are billed to your medical insurance.

Vision Exams:

Vision or Routine Exams include a general screening for eye disease and a refraction (a measurement done to prescribe glasses and/or contact lenses). Routine eye examinations **DO NOT** include focused evaluation or treatment of medical conditions (corneal disorders, diabetes, cataracts, glaucoma, or dry eye disease). Should a medical condition be discovered during your Vision or Routine Exam, you may be scheduled for another appointment to complete further medical evaluation.

* I understand the difference between a Medical Exam and a Vision or Routine Exam. _____ initial

CONTACT LENSES:

Additional fees apply for contact lens evaluation and/or fitting. This is due to the supplemental examination, consultation, and follow up required for contact lenses. Fees vary based upon the complexity of the service rendered and the type on contact lens involved. The contact lens evaluation fee for new patients is $60. Contact lens fitting fees range from$60-150. Your vision insurance may cover these fees, but you are responsible for any amount that is not covered. **Wear your contacts to your exam, if you are a new patient please bring your previous Prescription or Lens packaging materials. If you are out of contacts please let our office know prior to exam.**

* I understand that additional fees apply to contact lens services. _____ initial

REFRACTION FEE:

A refraction is a measurement used to determine the amount of prescriptions needed to correct your vision. Glasses and/or contact lenses may be prescribed from the refraction. Most medical insurances WILL NOT cover a refraction during a Medical Exam, in which case, the $60.00 refraction fee will be due at the time of service.

* I understand that refractions are not covered by medical insurance. _____ initial

I have read all of the information above and understand that my services will be billed to the appropriate insurance based upon the information outlined in this document. I understand that additional fees apply for contact lens and refraction services and I assume responsibility for any fees that are not covered by my insurance.

Patient Name (print): _____ Date of Birth_____

Responsible Party Signature: _____ Date: _____