



## **What to Expect at Your Appointment**

All patients can expect to be treated respectfully throughout the course of their visit. Each patient will receive a thorough exam from our highly experienced doctors and can also expect to have their needs assessed by our top notch eyewear team when selecting eyewear. *It should be noted that all diabetic patients will be dilated.*

## **What to Bring to Your Appointment**

Please bring the enclosed paperwork filled out in its entirety along with your insurance cards. It would also be helpful for you to bring your current eyeglasses (even if rarely used) and, if applicable, contact lens boxes that are currently prescribed to you. This will help our doctors determine the best care for your eyes. If you would like to have your previous records sent to us, you may fill out a Release of Records form in our office and we will fax it to your previous eye care provider.

## **Patient Expectations**

Payment for services is due at the time the services are rendered. This includes any co-pays that are applicable. Payment for materials, such as glasses or contacts, must be paid in full at the time of order. We accept many forms of payment which include Visa, Mastercard, Discover, American Express, Care Credit, cash and personal check.

## **Insurance**

We are providers for most all major vision insurances including, but not limited to: VSP, Eyemed, Medicare, Medicaid, and Avesis. We are also providers for most health insurances. Our team will do a complimentary benefits check for you and explain your benefits in detail upon your request. You will be expected to pay what is determined as not payable by your insurance for service and materials at time of service.

Today's Date: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_ Date Of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Marital Status: S M W D

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**How did you hear about us or whom may we thank for referring you?** \_\_\_\_\_

Can we get a hold of you via email?	Yes	No	Email address: _____
Can we get a hold of you via text?	Yes	No	

**RESPONSIBLE PARTY/MAIN INSURED/GUARDIAN**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # \_\_\_\_\_ Employer: \_\_\_\_\_

I authorize this office to release any information necessary to expedite processing insurance claims. I understand and agree I am personally responsible for all charges, regardless of insurance coverage for services and materials provided by Dr. K. Andrew Yaryan LLC. Insurance charges unpaid within sixty (60) days following the date of service will be transferred to the responsible party or patient. I understand and accept responsibility for service charges, late fees and other costs.

_____	_____
Patient	Parent/Guardian (Responsible Party)

**NOTICE OF PRIVACY PRACTICES**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X \_\_\_\_\_ OR X \_\_\_\_\_

Patient Signature Parent or Guardian (Responsible Party)

Medical History

Patient Name \_\_\_\_\_

Date Of Birth \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Specialist would include (Cardiologist, Neurologist, Endocrinologist, etc...)

List any Medications you are currently taking (prescription and/or over-the-counter)

Provide a list if necessary:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have Allergies to any medications? (Latex, Penicillin, Sulfa Drugs, etc.) Yes No

If so, please list below:

\_\_\_\_\_  
\_\_\_\_\_

List all Illnesses or Injuries (Glaucoma, Diabetes, High Blood Pressure, Heart Attack, Stroke)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any surgeries you have had (Lasik, Cataract, Tonsillectomy, Appendectomy, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do any family members have any eye diseases (glaucoma, macular degeneration, retinal detachment, etc.)	Yes	No
Do any family members have diabetes, high blood pressure, high cholesterol?	Yes	No
Do you Smoke? For How Long? How Much?	Yes	No
Do you drink alcohol? How much?	Yes	No

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent or Guardian (Responsible Party) Signature \_\_\_\_\_



Printed Patient Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Consent to Release Patient Information**

I hereby authorize Yaryan Eyecare to disclose the above patient information and records obtained in the course of the assessment, diagnosis and/or treatment, as well as picking up and/or repair of any materials. This authorization shall remain valid for one year following the date signed above.

_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Patient Signature	Parent/Guardian/POA	

**HIPAA Acknowledgement**

I have been made aware that my medical information will be regarded, as stated in the Health Insurance Portability and Accountability Act, and is available to review at my request.

_____	_____
Patient Signature	Parent/Guardian/POA

**Consent for Dilation**

I hereby authorize the Doctors and/or such assistants as may be designated by them to administer dilating drops. I understand that eye drops are necessary to diagnose my condition and/or examine my eyes.

_____	_____	_____
Patient Signature	Parent/Guardian/POA	I do NOT give consent

**Indiana Health Plan(s) ELIGIBILITY**

\*This statement serves as documentation to the provider that I have not received a routine vision exam/refraction and/or materials with in the last 12 months if 20 years of age and under OR a routine vision exam/refraction with in the last two (2) years and/or materials with in the last five (5) years if 21 years of age or older.

\*If the provider's claim for reimbursement is denied due to my ineligibility because I have received eye care services or materials paid for by the program during the time stated above or for any other reason, I agree to assume full responsibility for the cost of services and/or materials provided.

_____	_____
Patient Signature	Parent/Guardian/POA



# Yaryan Eyecare Center

## Retina Imaging Policy

By choosing *Yaryan EyeCare Center*, you have entrusted us to care for your eyes:

**We take this responsibility very seriously.**

We pride ourselves on providing our patients with the best possible standard of care.

**Because of this, we now perform the optomap® Retinal Exam on all of our patients.**

The Doctors strongly believe that the optomap Retinal Exam is an essential part of your comprehensive eye exam and prescribes it for all patients once per year.

**It is our belief that an eye exam without this element is incomplete.**

Today, we will perform this fast, easy and comfortable screening test as part of your annual comprehensive examination. This is not a covered service by your insurance and the \$20.00 charge will be in addition to your examination fee or vision plan co-pay.

**By offering the optomap®, the doctor MAY NOT need to dilate your eyes.**

Any questions you have about the optomap® Retinal Exam can be directed to the doctor when the images are reviewed during your examination.

Thank you for allowing us to monitor the health of your eyes: Remember, they are the only two you have, and that is why we take your eye care seriously.

Sincerely-

The Doctors and staff of *Yaryan EyeCare Center*

I have read and understand this document:

Sign: \_\_\_\_\_ Date: \_\_\_\_\_



## ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Yaryan Eye Care Center accepts most insurance plans in both categories:

- 1) **Vision Plans** (such as VSP, EyeMed and others)
- 2) **Medical Insurance** (such as Blue Cross/Blue Shield, Medicare and others).

**Vision plans only cover routine vision wellness exams and additionally may cover eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).** Medical insurance must be used for medical eye care.

Ex: photos/scans for diabetes, glaucoma, retinal disease, diabetic eye exams, etc.

This does not include optional retinal screenings.

- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense, when available.
- If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

**It is your responsibility to inform us of exactly what medical and vision insurance plans you have, before your exam. Once we are aware, we will perform a complimentary benefits check for you. Once we have billed your insurance for the exam, and ordered glasses, or contact lenses, we cannot change it.**

**If you inform us you have vision insurance after we have performed an exam, or ordered glasses, it is your responsibility to work with your insurance for reimbursement.**

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare/Medicaid card on file in case we should need it in the future for billing your insurance.

I have read and accept these policies.

\_\_\_\_\_  
Patient signature (parent if child)

\_\_\_\_\_  
Date



## No Show Agreement for Doctor Appointments

Dear Patient,

Thank you for choosing to be a patient at Yaryan Eye Care Center. It is a policy of Yaryan Eye Care Center that any patient that has 3 or more "No Shows" will be put on a "Call in Basis" only status. We define a "No Show" as any appointment that is not given a 24 hour cancellation notice. While we appreciate your business and are glad you are here, we ask that you be respectful of other patients if you are unable to make it to your visit. Appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely medical care.

*By signing below, I understand the agreement written above.*

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature