CAPE FEAR EYE
associates, p.a.

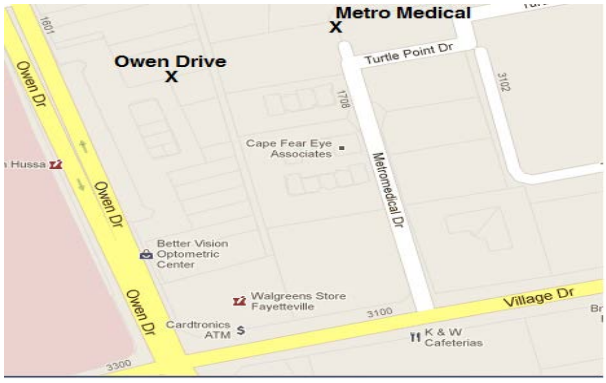
Welcome to Cape Fear Eye Associates. Your eye health and satisfaction with our services are our primary concerns. We look forward to having the opportunity to assist you with your current and future eye care needs. **We are open Monday – Friday from 7:30am to 5:00pm. You can contact us at (910) 484-2284 or (800) 829-2284.**

We have two locations to serve you

Metro Medical: 1726 Metro Medical Dr. Fayetteville, NC 28304

Owen Drive: 1629 Owen Drive Fayetteville, NC 28304

Cape Fear Eye Surgical Center:
1629 Owen Drive Fayetteville, NC 28304



Providers: J. Wayne Riggins, OD, MD | Sheel Patel, MD | Brett Campbell, MD
Xinxin Zhang, MD | Alex Stoddard, MD | Edward Kenshock, Jr., OD
Jonathan Cotto, PA-C

You are scheduled for an appointment on _____ _____ at _____ AM / PM. Your appointment is scheduled with Dr. _____ at our _____ location.

If you arrive more than 15 minutes late you will be rescheduled. 24 hour prior notice to cancel or reschedule to avoid a $75.00 no show fee.

What you MUST bring to your appointment to avoid being rescheduled:

- **This packet with ALL forms completed and signed**
  - **Patient and Billing Information**
  - **Medical History**
  - **Patient Acknowledgement Forms**
  - **Financial Policy Forms**
  - **Notice of Privacy Practices**
- **ALL of your current insurance cards AND photo ID**
- **Payment for out of pocket expenses**
- **ALL of your current medications, including any eye drops**
- **Eyeglasses**

What to expect on your FIRST visit

Check In: **If you arrive more than 15 minutes late you will be rescheduled.**

Your completed forms will be collected and placed inside your file. We will scan your insurance card(s) and photo ID and collect your co-pay and/or payment for service. **If you do not come with ALL of the required information and completed paperwork your appointment may be rescheduled.**

Waiting Time: Our goal is for our clinic to run on time, however, high demand and daily medical emergencies can result in delays. Generally, a comprehensive eye exam with dilation requires approximately two (2) hours. If you have urgent time restrictions, please let our staff know upon your arrival.

Initial Evaluation by Ophthalmic Technician: Depending upon the reason for your visit and your medical history you may undergo various tests before you see the doctor. One of these tests is called a refraction. A refraction is performed to determine if you need a prescription for glasses and/or contact lenses. **Please note that a refraction is NOT covered by Medicare and most insurance plans. Our office fee for a refraction is $40.00 and is due at the time service is rendered.** Once in the exam room, the ophthalmic technician will review your medical history and check your eye pressure. Other tests may be performed based on your primary complaint and past medical history. The technician will use eye drops to dilate your pupils. **Dilation is necessary to completely examine your eyes**, especially the retina. Then you will be moved to our dilation waiting area while the drops take effect.

Ophthalmologist's Exam: When your pupils are fully dilated, your eyes will be thoroughly examined by the doctor. Depending on the nature of your problem, we may perform additional tests on the day of your initial examination and, in some cases, treatment may be initiated. Please do not hesitate to ask any questions about the results of your examination or the treatment recommended by the physician. Your diagnosis and all possible treatment will be completely explained to you.

Because you will have temporarily blurred vision at near and in bright light after dilation, we **strongly recommend** that someone drive for you after the examination. Your pupils and vision will return to normal over the next 24 hours.

Check Out: Our receptionist will review your encounter slip and advise you of any balance due for the services you received. We file all major insurance claims including Medicare and Medicaid, and accept cash, check, major credit cards, and Care Credit. You will be asked to provide payment for co-pays, deductibles, and un-insured services such as the refraction fee and driver's forms. Please review our financial policy for further details.

Thank you for choosing Cape Fear Eye Associates, P.A. for your eye care needs. We are committed to serving your eye health, so please let us know if we can improve our service in any way.

CAPE FEAR EYE associates, p.a.

Patient Information

Patient Name (Last, First, Middle)		Patient SSN#	Birthdate	Language	Sex
Patient Address		Billing Address **(if different)**			
CITY, STATE, ZIP	Patient Phone #	CITY, STATE, ZIP		Phone #	
Primary Care Physician	Referring Physician	**Email Address**			
Patient Employer		EMERGENCY CONTACT AND RELATIONSHIP			
Patient Occupation		EMERGENCY CONTACT PHONE #			
Diabetes Doctor		Patient Race		Patient Ethnicity	

How did you hear about us? _____

Policyholder for Primary Insurance **(If different than above)**

NAME (Last, First, Middle)	SSN#	Birthdate
ADDRESS	Employer / Occupation	
CITY, STATE, ZIP	CITY, STATE	
PHONE #	RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

Name of Insurance Company	Policy Number	Group Number	Effective Date

SECONDARY INSURANCE (If applicable)

Name of Insurance Company	Policy Number	Group Number	Effective Date

I hereby assign all benefits paid by my health insurance plan(s) for services I receive, to be payable to the service provider, Cape Fear Eye Associates, Pa. I authorize that any information needed to determine these benefits may be released to the Health Care Financing Administration and its agents. This document will remain in effect until revoked by me in writing and photocopies will be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance and that any deductible, co-insurance or other amount not covered by my insurance must be paid at the time of service.

SIGNATURE OF PATIENT/GUARDIAN DATE

CAPE FEAR EYE associates, p.a.

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP	
Blindness	☐	☐		
Glaucoma	☐	☐		
Arthritis	☐	☐		
Diabetes	☐	☐		
Heart Disease	☐	☐		
High Blood Pressure	☐	☐		
Kidney Disease	☐	☐		
Lupus	☐	☐		
Stroke	☐	☐		
Thyroid Disease	☐	☐		
Cancer-Type	☐	☐		
	☐	☐		
Other	☐	☐		
	☐	☐		
	☐	☐		

SOCIAL HISTORY

Current occupation:_____ Retired ☐ Disabled ☐ Unemployed ☐

Marital Status: (mark all that apply) Married ☐ Divorced/Separated ☐ Single ☐ Widowed ☐

Do you drive? Yes ☐ No ☐

Do you drink / consume caffeine? ☐ Yes ☐ No If yes: Occasionally ◯ 1 per day ◯ 2per day ◯ 4+ per day Do you drink alcohol? ☐ Yes ☐ No If yes: Occasionally ◯ 1 per day ◯ 2per day ◯ 4+ per day

Have you ever used tobacco? ☐ Yes ☐ No If yes: What type _____

How Often: ◯ Occasionally ◯ ½ pack a day ◯ 1 pack per day ◯ 1+ pack per day

How many years: _____ Have you ever had a blood transfusion? ☐ Yes ☐ No

_____

Patient Name (Please Print)

_____ _____

Signature of Patient/Guardian Date

CAPE FEAR EYE associates, p.a.

MEDICAL HISTORY QUESTIONNAIRE

NAME_____DOB_____VISIT DATE_____

List all major illnesses (glaucoma, high blood pressure, heart attack, etc.) or injuries (concussion, etc.) you have had:

_____

_____

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) please include the date(s):

_____

_____

_____

List all medications you are using at present, please include over the counter medications and vitamins:

Eye Medications **All other medications**

NAME	DOSE	FREQ.	EYE	NAME	DOSE	FREQ.

Are you allergic to any food or medication? ☐ Yes ☐ No Are you allergic to Latex? ☐ Yes ☐ No

If yes, please list the substance(s) with type of reaction:

_____

_____

_____

To assist you in receiving your medications in a timely manner, our practice sends prescriptions electronically. Please list the name and location of your pharmacy.

Pharmacy Name:_____Phone Number:_____

Address:_____City/State:_____

___Do you use Ft. Bragg to obtain your medication? ☐ Yes ☐ No

If you use a mail order pharmacy, please list that information here:_____

_____

Financial Policy

Insurance Participation

We participate in most major insurance plans. If you have any questions regarding insurance and your healthcare coverage, please call your insurance provider, which is listed on the back of your insurance card, or contact us to verify coverage prior to your appointment.

Third Party Payers

We will file your regular medical insurance if we participate and bill you according to insurance company instructions. We will file to a Workman's Compensation policy but **REQUIRE** the following information be provided at the time of the initial treatment: Workman's Compensation company name, claims mailing address, adjuster name, adjuster phone number and claim number.

Eligibility Information

We will ask for your insurance card(s) at each appointment. If you do not have your current insurance card(s) and necessary information, you will be required to pay for the services rendered or asked to reschedule your appointment.

Claims Filing

We will file claims for those insurances with which we are contracted, as well as secondary insurance if we participate with your primary insurance. We accept the contractual write-off based on your primary insurance. Once we have received instruction from your insurance company, you will receive a bill for any outstanding balance. If we are unable to file your claim because of incorrect insurance, patient demographic, or guarantor information and you do not provide the correct information timely, then we will not file the claim for the service, but will treat the visit as a self-pay visit and you will be responsible for 100% of the visit costs.

Non-covered services by insurance payer

Patient will be responsible for all services that is non-covered by your insurance company.

Payment

We accept Checks, Cash, Visa/MC, AMX, Discover and Debit cards. All payments for service are due on the day the service is provided.

Alphaeon Credit

We accept Alphaeon Credit as a form of payment for services rendered. We are required to follow the Alphaeon Credit Operating Guidelines which stipulate: the card holder must be present with the card and must provide 2 forms of valid ID.

Co-Pays

Many plans require that a patient pay a co-pay at each visit. We are bound by our contracts with insurance companies to collect that co-pay at the time we render our services. In keeping with our contracts, we will collect your co-pay when you check in.

Appointments and No-Shows

We ask that all patients arrive 15 minutes early for their appointment. We understand the unexpected that may cause a patient to arrive late and we will accommodate your arrival time as best we can. However, if you arrive 15 minutes beyond your appointment time it will be rescheduled. **The following fees apply to no-show visits:** $75 for missed appointments. $100 for a missed in-office procedure and/or surgery. We require a 24-hour advance notice of cancellation so that we may offer that appointment to another patient. After 3 no-show appointments within a 12-month period you will be discharged from our practice and will be required to seek medical care from another practice.

Patient Refunds

Any over-payment made by the patient will be applied to any outstanding balance. If there is a remaining credit after outstanding balance is satisfied, it will be refunded to the patient.

Small Balances

You will not receive bills for balances less than $3. However, we will notify you of the balance at your next visit and expect payment.

Returned Checks

We charge a $30 fee for returned checks. Patients who have written a returned check will be required to pay by cash or credit for all future payments.

Bankruptcy

Accounts written off due to bankruptcy will also result in termination from our practice. However, you may work with your Bankruptcy attorney to draft a letter expressing your intent to pay our bill and continue as a patient.

Charge for Medical Records

Medical records requested will be copied for a flat fee of $12.00 **+** 75¢ per page 1-25, .50¢ per page 26-100, .25¢ per page over 100.

Forms

If forms are filled-out by your provider, there is a $25.00 fee for completion of these forms.

By signing below, I agree that I have read the above financial agreement. I understand and agree to adhere to the policies included within the agreement.

Patient/Guarantor Name: _____

Patient /Guarantor Signature: _____ Date: _____

Relationship to Patient: _____

CAPE FEAR EYE associates, p.a.

Medical Record #_____

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication error and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions-**Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions-**Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification-**Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Cape Fear Eye Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Cape Fear Eye Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient DOB

_____ _____

Signature of Patient/Guardian Date

_____

Relationship to Patient

HEALTHCARE OPERATIONS CONSENT FOR PURPOSES OF TREATMENT,

PAYMENT AND HEALTHCARE OPERATIONS

I consent the use or disclosure of my protected health information by Cape Fear Eye Associates, P.A., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Cape Fear Eye Associates, P.A. may be conditioned upon my consent as evidenced by my signature of this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Cape Fear Eye Associates, P.A. is not required to agree to the restriction(s) that I may request. However, if Cape Fear Eye Associates, P.A. agrees to a restriction that I requested, the restriction is binding on Cape Fear Eye Associates, P.A. and its physicians and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent Cape Fear Eye Associates, P.A. has taken action in reliance in the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This "protected health information" relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand I have the right to review Cape Fear Eye Associates, P.A. Notice Of Privacy Practices prior to signing this document. The Notice Of Privacy Practices describes the types and uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of health care operations of Cape Fear Eye Associates, P.A.

The Notice Of Privacy Practices for Cape Fear Eye Associates, P.A. is located at the reception desk. This Notice Of Privacy also describes my rights and Cape Fear Eye Associates, P.A. duties with respect to my protected health information.

Cape Fear Eye Associates, P.A. reserves the right to change the privacy practices that are described in the Notice Of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling (910) 484-2284 and requesting that a revised copy be mailed to me or by obtaining a copy at the time of my appointment.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

CAPE FEAR EYE associates, p.a.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MEDICAL RECORD #_____

PATIENT INFORMATION:

NAME OF PATIENT:_____ **DOB:**_____

NAME AND ADDRESS OF PATIENT REPRESENTATIVE TO DISCUSS/REVIEW INFORMATION:

_____

_____

_____

_____

DESCRIPTION OF INFORMATION TO BE DISCUSSED/REVIEWED AT THE REQUEST OF THE PATIENT:

_____

_____

_____

_____

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effective until the requested items have been delivered or the information has been reviewed by the patient.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

1726 Metro Medical Drive
Fayetteville, NC 28304
Phone:(910) 484-2284
Fax:(910) 484-1673

1629 Owen Drive
Fayetteville, NC 28304
Phone:(910) 484-2284
Fax:(910) 672-5050

www.capefeareye.com
Toll Free: 1-800-829-2284

CAPE FEAR EYE associates, p.a.

Comprehensive Eye Care Services

The following are brief descriptions of our medical and surgical services. More detailed descriptions can be found on our website at www.capefeareye.com.

Comprehensive Eye exams: Eye exams at regular intervals as determined by your doctor are important in preserving your optimal eye health. This exam includes a full assessment of your refractive state and ocular health using the latest in automated equipment and diagnostic techniques.

Cataract Surgery: Cataracts are the most common cause of loss of vision in the world and their treatment is a major service of our practice. Surgery to remove cataracts is a safe, efficient and generally painless outpatient procedure.

Glaucoma & Ocular Hypertension: Glaucoma is another leading cause of blindness in the world, but it typically presents without any symptoms. With careful evaluation to determine your risk for glaucoma, a specific treatment plan is prescribed to preserve vision. Extensive testing involves an accurate measurement of intraocular pressure, **Automated Visual Field Analysis, Digital Fundus Photography, Nerve Fiber Analysis (NFA), and Corneal Pachymetry.** Treatments may include eye drops, laser treatment and/or surgery.

Diabetic Eye Disease: Diabetic Retinopathy is the number one cause of loss of vision in Americans under the age of 60. An annual dilated eye examination is necessary for all diabetics to discover and treat any early signs of the disease. Early detection is key to preserving vision. Detailed testing to look for signs of diabetic retinopathy may include **Digital Fundus Photography, Flourescein Angiography, and Nerve Fiber Analysis (NFA).** Treatment includes optimum blood sugar control, **Laser Photocoagulation** and surgery.

Age-Related Macular Degeneration (AMD): AMD is a major cause of visual disability in the aging population. Although the dry form of AMD is much more common, the wet form accounts for the greatest proportion of severe vision loss. Early detection by dilated eye examination may allow vision-saving treatment to be initiated, including pediatric and infant eye exams.

Eyelid Surgery: Many minor surgical procedures can be performed in our facility including removal of benign and cancerous skin lesions as well as reconstructive eyelid surgery. Cosmetic and functional eyelid surgery is also performed on site to improve the appearance of baggy and wrinkled eyelids, and to lift droopy lids.

Lacrimal Surgery: Adults and children can develop excessive tearing due to blocked tear drainage ducts. In children this is usually present at birth and may require probing to open the blocked duct. More extensive surgery is required in adults, but this can still be performed on an outpatient basis.

Laser Refractive Surgery (LASIK, LASEK, and PRK): We offer cutting-edge vision correction for nearsightedness, farsightedness and astigmatism. Call today to schedule a refractive consultation and see if you are a candidate for LASIK and learn more about your LASIK options.

CAPE FEAR EYE
associates, p.a.

Patient: _____ MR# _____

Cape Fear Eye Associates, PA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY CAPE FEAR EYE ASSOCIATES AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, Cynthia Suggs at 1726 Metro Medical Drive Fayetteville, NC 28304 | 910-484-2284 Ext. 241 | csuggs@capefeareye.com. File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Clinical Documentation: We utilize (DAX) technology which uses artificial intelligence and associated workflows to generate clinical documentation based on recorded audio of patient visits. We use a third-party service provider to process the recorded audio and we have appropriate agreements in place to ensure the confidentiality of your information. All documentation is reviewed and approved by your provider to ensure the accuracy and completeness of your medical record.

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
    For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Signature of patient or personal representative	Date
Print name of patient or personal representative	Relation of personal representative

Revision Date: October 11, 2023