



## Advanced EyeCare

**DR. AMY SANDERSON**

**DR. JESSICA NORRIS**

**102 Intercom Drive**

**Madison, Alabama 35758**

**Phone: (256) 772-2929**

### For Our New Patients:

We would like to personally welcome you to Advanced EyeCare of Madison, P.C. It is our privilege to provide you with the best care we are capable of rendering. We offer a broad range of eye services from medical and emergency eye care, ophthalmic surgical co-management, refractive surgery consultations, annual vision care, contact lens examinations and dispensary services in glasses and contact lenses. Our office has the technology to fabricate your new eyewear in-house, saving you time and money. To help you prepare for your upcoming visit, please read the enclosed information. Please feel free to call in advance with any questions.

1. Depending on the type of examination and the number of test or treatment needed, please be prepared to spend about an hour with us. **Your appointment is reserved exclusively for you. Therefore, if you are late or are unable to maintain the appointment please give at least 24 hour notice to avoid being charged a broken appointment fee.**

Occasionally you may find that a patient has been called out of turn. These patients are emergency or postoperative patients who require immediate attention. Please try to understand should this happen to you and be assured that we will provide you with the same urgent and courteous attention if needed. We know your time is valuable and we apologize for any extended waiting periods, but please know that our main concern is to provide the best care possible to all our patients.

2. It is common for both of your eyes to be dilated, we therefore highly recommend that you have someone accompany you here and drive you home. Our office has new technology, called Optomap, which allows us to take a panoramic picture of the retina through a non-dilated pupil. Be sure to ask about this technology at your appointment.
3. Please bring a list of all medications that you use, their dosage and frequency, and the name of your doctor(s). Also, bring any prescription glasses you may wear as well as sunglasses and boxes of contacts lenses; if your pupils are dilated your eyes will be sensitive to light when you leave. Please bring all insurance cards, referral forms and any prior glasses or contact lens prescriptions available.
4. **To make your visit as efficient as possible, please complete the attached forms and bring them with you for your appointment. Please be prepared to pay all charges due by you on your date of service.**
5. **Our Collection Policy:** Our doctors participate in a variety of insurance plans. As a courtesy to our patients, we will be happy to file most claims. You will be expected to pay your co-pay, co-insurance and / or deductibles at each visit. **If your insurance requires a referral, it is your responsibility to contact your primary care physician and obtain the referral number and any other necessary information.** If you have any questions about your insurance or account, please feel free to contact us.

We hope this letter of introduction will help make your visit with us as pleasant and efficient as possible. If you have any questions, please don't hesitate to give us a call. Again, thank you for allowing us to participate in your eye care.

Sincerely,

Dr. Amy Sanderson Dr. Jessica Norris and Staff of Advanced EyeCare of Madison, P.C.

---



**Signature on File, Assignment of Benefits, Financial Agreement, Consent to Treatment**

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to *Dr. Amy Sanderson/Dr. Jessica Norris* for services furnished to me by *Advanced EyeCare of Madison*. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that 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 CMS (HCFA 1500) form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. *Advanced EyeCare of Madison* accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP:** I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to *Advanced EyeCare of Madison*. **I understand that the refraction fee is payable at time of exam due to non-covered service under my Medicare insurance.**
3. **OTHER INSURANCE:** I understand that *Advanced EyeCare of Madison* maintains a list of health care service plans with which it contracts and that *Advanced EyeCare of Madison* has no contract, expressed or implied, with any plan that does not appear on the list (A list of such plans is available from the business office). The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by *Advanced EyeCare of Madison* if I belong to a plan that does not appear on the mentioned list.
4. **RELEASE OF INFORMATION:** *Advanced EyeCare of Madison* may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to *Advanced EyeCare of Madison* for reimbursement for services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of the original.
5. **NON-COVERED SERVICES:** I understand that *Advanced EyeCare of Madison's* contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services, which are "covered" by the health care service plans. **Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered.** Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with *Advanced EyeCare of Madison* to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT: I agree that in return for the services/materials provided to the patient by Advanced EyeCare of Madison, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Advanced EyeCare of Madison for payment in accordance with Advanced EyeCare's billing policies. I hereby understand and agree that all services and/or materials provided by this office are non-refundable.** If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to *Advanced EyeCare of Madison*. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to *Advanced EyeCare of Madison*. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
7. **CONSENT TO TREATMENT:** I authorize *Dr. Amy Sanderson* and/or *Dr. Jessica Norris* of *Advanced EyeCare of Madison*, her associates, technical assistants and other health care providers under their direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination and **have been advised not to drive**. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

**I HAVE READ AND FULLY AGREE TO ADVANCED EYECARE'S OFFICE POLICIES.**

**\*\*\*LEGALLY BINDING AGREEMENT, PLEASE READ BEFORE SIGNING.\*\*\***

PATIENT'S (GUARANTOR'S) SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



**Advanced EyeCare of Madison, P.C.**  
**Dr. Amy Sanderson Dr. Jessica Norris**

**Patient History Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of Family Doctor: \_\_\_\_\_ Family Dr's Phone No: \_\_\_\_\_  
 Name of Pharmacy: \_\_\_\_\_ Pharmacy Phone No: \_\_\_\_\_

**MEDICAL HISTORY INFORMATION**

What is your general health? \_\_\_\_\_

Do you have problems with any of these systems? *(Please mark all that apply)*

Eyes	No	Yes	Nervous	No	Yes	Gastrointestinal	No	Yes
Ears/Nose/Throat	No	Yes	Genitourinary	No	Yes	Endocrine (Glands)	No	Yes
Mental	No	Yes	Cardiovascular	No	Yes	Musculoskeletal	No	Yes
Blood/Lymph	No	Yes	Respiratory	No	Yes	Integumentary (Skin)	No	Yes
Allergic/Immunologic	No	Yes						

Please Explain: \_\_\_\_\_

**PLEASE ANSWER ALL:**

Diabetes No Yes Type: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
 Allergies No Yes Allergic to what? \_\_\_\_\_ What happens? \_\_\_\_\_  
 Medication Allergy No Yes What happens? \_\_\_\_\_ Headaches No Yes

Other health problems: \_\_\_\_\_

Current Medication(s): \_\_\_\_\_

Have you had any operations? No Yes Kind? \_\_\_\_\_ When? \_\_\_\_\_

Do you use Cigarettes/Tobacco? No Yes If yes, how much and how often? \_\_\_\_\_

Alcohol? No Yes If yes, how much and how often? \_\_\_\_\_

Other Substance(s)? No Yes If yes, how much and how often? \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_

**FAMILY HISTORY**

High Blood Pressure No Yes Relation: \_\_\_\_\_ Macular Degeneration No Yes Relation: \_\_\_\_\_

Diabetes No Yes Relation: \_\_\_\_\_ Retinal Detachment No Yes Relation: \_\_\_\_\_

Glaucoma No Yes Relation: \_\_\_\_\_ Cataracts No Yes Relation: \_\_\_\_\_

Other Eye Condition(s) No Yes What Kind? \_\_\_\_\_

**PERSONAL EYE INFORMATION**

Have you had any eye operations? No Yes Type: \_\_\_\_\_ Date: \_\_\_\_\_

Have you had an eye injury? No Yes Kind: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have glaucoma? No Yes Cataracts? No Yes Dry Eyes? No Yes Blurred Vision? No Yes

Other eye problems? No Yes What Kind? \_\_\_\_\_

Do you wear glasses? No Yes Contact Lenses? No Yes Type: \_\_\_\_\_

Are you interested in: Contacts Laser Vision Correction Additional Information: \_\_\_\_\_

.....  
 Dr.'s Initials: \_\_\_\_\_  
 .....



***Advanced EyeCare of Madison, P.C.***

**102 Intercom Drive**

**Madison, Alabama 35758**

**Contact Person: Medical Records Clerk**

**ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES**

I understand that in an attempt to protect the privacy of my identifiable health information, *Advanced EyeCare of Madison, P.C. (AEC)* has established a *Privacy Policy* and guidelines for *Privacy Practices* within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the *AEC Privacy Policy & Practices* has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

- < I have elected not to read the *Privacy Policy & Practices* of AEC.
  
- < A copy of the *AEC Policy & Practices* was given to me today.
  
- < I have read, understand and acknowledge the *Privacy Policy and Practices* of AEC.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Today's Date**



**Advanced EyeCare of Madison, P.C.**  
**NOTICE OF PRIVACY PRACTICES**  
**Effective Date of Notice: September 1, 2003**

**Amy Sanderson, O.D.**  
**Corporate Compliance Officer**  
**102 Intercom Drive**  
**Madison, AL 35758**  
[info@aecmadison.com](mailto:info@aecmadison.com)

**THIS NOTICE DESCRIBES HOW OPTOMETRIC & MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

At *Advanced EyeCare of Madison, P.C.* we respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our Privacy Practices. This Notice describes how we protect your health information and what rights you have regarding this information.

**TREATMENT, PAYMENT & HEALTH CARE OPERATIONS**

The most common reasons we use or disclose your health information is for treatment, payment or internal health care operations. By law, we are not required to receive your permission for these purposes. Examples of how we use /disclose information for **treatment purposes** are: setting up an appointment for you, testing & examining your eyes and vision; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; diagnosing the status of your vision and ocular health; showing you low vision aids; referring you to another health care provider or clinic; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use/disclose your health information for **payment purposes** are: asking you about your health and vision plans; asking about other sources of payment; verifying benefit enrollment and/or eligibility; preparing and sending bills or claims (either on paper or electronically); and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative functions that we perform in order to run our office. Examples of how we use/disclose your health information for **health care operations** are: financial or billing audits; internal quality assurance; participation in insurance and managed care plans; defense of legal matters; business planning and outside storage of our records.

We routinely use your health information *inside our office* for these purposes without any specific permission - it is not required by law. If we need to disclose your health information *outside our office* for these reasons, we usually will not ask for your specific permission. We will ask for specific written permission in the following situations: 1) marketing of products/services for which we may receive payment, 2) inclusion in medical studies or scientific research.

**USES & DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some situations, the law requires us to use or disclose your information without your specific permission. Not all of these situations will apply to our office or to you; some may never come up in our office. Such uses or disclosures are:

- When State or Federal law mandates disclosure;
- For public health purposes to prevent the spread of contagious disease, serious threat to public health or safety; for public health research or health care operations; and notices to/from the federal Food & Drug Administration regarding medications or medical devices;
- Disclosures regarding suspected victims of abuse, neglect or domestic violence;
- Disclosures for regulatory oversight by licensing boards, Medicare / Medicaid audits; or for investigation of possible health care fraud;
- Disclosures for judicial and administrative proceedings (i.e. subpoenas or court orders);
- Disclosures for law enforcement purposes; to provide information about a crime; or to report a crime;
- Disclosure to a medical examiner; funeral directors or organizations that handle organ/tissue donations;
- Uses/disclosures for health related research;
- Uses/disclosures relating to worker's compensation programs;
- Incidental disclosures that are an unavoidable by-product of permitted use/disclosure;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy or your health care information;

Unless you object, we will also share relevant information about your care with your immediate family or other caregivers (i.e. friends, legal representatives) who are helping you with your eye health care.

**APPOINTMENT REMINDERS**

We may call/write to remind you of scheduled appointments or to notify you when you have missed an appointment, or that it is time to make an appointment for continuing care. If you are away during our call, then we may leave a message on your answering machine. If you refuse to allow us to contact you in such a manner, it may become necessary for us to recommend you seek care from another provider/s/, especially if we feel your refusal jeopardizes your eye health and/or vision. While we respect your right to privacy, we insist that you become actively involved in your eye health care and cooperate with us in providing such care. We may also call/write to notify you of new/different treatments or services available for your vision and eye health condition.

## **OTHER USES AND DISCLOSURES**

We **will not** make any other uses or disclosures of your health information unless you sign a written Authorization Form. Federal law determines the content of an Authorization Form. We may, from time to time, initiate the "authorization process" if use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. In this situation, you will give us written instructions and authorization or you can use one of our standard forms.

If we initiate the process and ask you to complete an Authorization Form, you do **not** have to sign the authorization, and we cannot make the use or disclosure. If you do sign an Authorization Form, you may revoke it at any time (in writing) unless we have already acted in reliance upon the original authorization. Send revocations to the attention of the individual named at the beginning of this Notice.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your personally identifiable health information. You can:

- Ask us to restrict our use/disclosure for purposes of treatment (except emergencies), payment or health care operations. We **do not** have to agree to do this, but if we agree, we must honor the restrictions you describe. To ask for restrictions, send a written request to the individual named on the front of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address. We will make every attempt to accommodate these requests if they are reasonable, and if you agree to pay us for any extra costs. If you want to ask for confidential communications, send a written request to the individual named on the front of this Notice.
- Ask to see or get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review/copy your health information within 30 days of written notice (60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request we will send you a written explanation and instructions about impartial review of our decision if legally available. By law, we may have one 30-day extension of the time for us to give you access or photocopies if we send you written notice of the needed extension. If you want to review or get copies of your health information, send a written request to the individual named at the front of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. We are not required to agree with your request. If we agree, we will amend the information within 60 days of the written request. We will send the corrected information to persons who we know got the wrong information and others that you specify. If we do not agree, you can write a statement of your position and we will include it with your health information along with any rebuttal statement that we feel necessary. We **will not** amend health information falsely. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your information, send a written request to the individual named in the front of this Notice.
- Get a list of the disclosures we have made of your health information that fall outside the parameters outlined in this notice. You may request this information for any period up to and including six years from your last visit with us. By law, the list will **not** include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; and disclosures required by law (for a complete listing see sections entitled *Uses & Disclosures For Other Reasons Without Permission, Appointment Reminders, and Other Uses & Disclosures*). You are entitled to one such list per year without charge. If you want more frequent lists, if applicable, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving written notice. By law, we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the individual named in the front of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form previously. If you want additional copies, send a written request to the individual named in the front of this Notice.

## **OUR NOTICE OF PRIVACY PRACTICES**

We must abide by the terms of this Notice until we choose to make changes. We reserve the right to change this Notice at any time, as allowed by law. If we change the Notice, the new privacy policies will apply to your health information that we already have on file as well as to such information as we may create in the future. If we change our Notice or Privacy Practices, we will post the new Notice in our office, have copies available in our office, and post the Notice on our Web site. We, at *Advanced EyeCare of Madison, P.C.*, are committed to the privacy of your health information and have established corporate policies (in addition to those outlined in this Notice) that guide the training of our providers and staff members in our Privacy Practices. Further, we make every endeavor to assure that our business associates are aware of our Privacy Practices and agree (whenever possible or required by law) to abide by these practices.

## **CONCERNS**

If you think we may not have properly respected the privacy of your health information, you have the right to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We encourage you to notify us if you have a concern or complaint. We will make every attempt to investigate all legitimate reports. We will not retaliate against you if you make a complaint. If you want to register a concern or complaint, send a written statement or call the individual named on the front of this Notice.

## **FOR MORE INFORMATION**

If you would like more information about our Privacy Practices, feel free to call or write number or address listed on the front of this Notice.



**Advanced EyeCare of Madison, P.C.**  
**Dr. Amy Sanderson      Dr. Jessica Norris**

---

---

### **Contact Lens Fitting Agreement**

- I understand that the contact lens examination fees are in addition to the comprehensive eye health examination fee.
- I understand that the contact lens examination fees include adequate progress visits (not to exceed 30 days from initial visit) to fine-tune my fit and prescription, as well as personal instruction as how to care for contact lenses at no additional charge.
- I understand that the examination fee and the fitting fee do not include the cost of lenses, solutions, or other necessary supplies.
- I understand that a final contact lens prescription will be released after the initial progress period is successfully completed.
- I understand that most patients are able to successfully wear contact lenses, but a successful fit and wearing experience cannot be guaranteed. Therefore, no professional fees will be refunded.
- I understand that a current pair of spectacles is highly recommended by our doctors to have in the event that I cannot wear my contacts (i.e., injury or eye infection) and also to give my eyes a break from continuous over-wearing of my contact lenses. Therefore, a discount of 30% off designer eyewear is extended to me for 60 days after my initial eye exam. Also Advanced EyeCare has package frame and lens specials with scratch and ultra-violet protection along with a one year warranty that start at \$69.
- I understand that my eyes need protection from the sun and a pair of polarized sunglasses is highly recommended by our doctors to have for my comfort and protection. Therefore, Advanced EyeCare has many high quality sunglasses at greatly reduced pricing to ensure you have adequate ultra-violet protection (UVA/UVB).
- I acknowledge that I have read and understand this agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature (Parent or Guardian if patient is a Minor)

**A yearly examination is necessary to be sure there are no contact lens related problems and to assure that the lenses fit properly.**

**Yearly eye exams are important to the health of your eyes.**



## ***Advanced EyeCare of Madison***

We pride ourselves on providing our patients with the best possible standard of care; **because of this we now perform the Optomap Retinal Exam with all of our patients.** This non-invasive procedure allows for a much broader and more detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **Your doctor strongly believes that the Optomap Retinal Exam is an essential part of your comprehensive eye exam and prescribes it for all their patients once per year.**

As part of your pre-test work up we will capture Optomap images for review during your examination today. In most cases, this procedure can replace the need for dilation. Routine scans are performed at a discounted rate of \$39.00. The fee for this procedure is generally not covered by insurance unless being used to actively follow disease. Any questions you have about the Optomap exam can be directed to your doctor when they review the images with you during your examination.

### **OPTOMAP EXAM EXAMPLE**





# optomap<sup>®</sup>

## Retinal Exam

I understand the benefits of the annual **optomap<sup>®</sup>** Retinal Exam as:

- Fast, easy and comfortable.
- A permanent record to compare and track potential eye diseases.
- An in depth view of nearly the entire retina.
- Educational tool for your doctor to discuss your health and wellness

I understand that a wide field view of the retina is an important part of a comprehensive eye exam and that I am accepting the Doctor's recommendation to obtain a comprehensive view of my retina.

\_\_\_\_\_ I have elected to have the **optomap<sup>®</sup>** Retinal Exam today and  
(Initial here)  
understand I may be charged a fee of \$39 for the state of the art screening.

\_\_\_\_\_ I would like to talk with the doctor or technician about the **optomap<sup>®</sup>**  
(Initial here)  
Retinal Exam.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_