STILES
EYECARE
EXCELLENCE
CATARACTS AND GLAUCOMA

Welcome to Stiles Eyecare Excellence Cataracts and Glaucoma!

You have chosen a leading eye care facility with the goal of making your experience here as pleasant as possible. Everything we do here is geared toward providing you, our patient, with the highest quality medical and surgical care possible.

SEE is a specialist office that provides treatment and surgical intervention for complex eye conditions. Please arrive no more than 5 minutes prior to your scheduled appointment time with your completed paperwork, Insurance cards and photo ID. ***Please expect your new patient appointment to last 1 1/2 to 2 1/2 hours,*** depending on the extent of your examination and any additional tests, studies, or procedures that might be required.

PHYSICIANS:
Our physicians, Michael C. Stiles, M.D., Ann C. Stechschulte, M.D., Anita Campbell, M.D. and Amanda R. Strom, O.D. are trained in the diagnosis and treatment of all eye diseases with special interests in Cataracts and Glaucoma. We actively engage in Clinical Research and regularly invest in state-of-the-art technology to ensure our patients receive the best possible outcomes.

OFFICE WEBSITE:
Please visit our website at: www.stileseye.com

PLEASE BRING WITH YOU TO THE APPOINTMENT:
Medications/Eye Drops – please either bring a current list of all medications you are taking or the medications in the bottles as received from the pharmacy. Please bring a list of all eye drops or the bottles of drops you are currently using as received by the pharmacy.

Eyeglasses – please bring your best or most recent eyeglasses, even if they no longer improve your vision. The glasses will provide important information about the past condition of your eyes.

Insurance Cards – please bring all current Medical Insurance cards with you to the appointment. We will bill your medical insurance, primary and secondary, for the medical eye exam and any additional tests, studies or procedures performed. Any unpaid visits due to invalid insurance cards will become the patient's responsibility. We do not accept vision insurance policies. We will also copy your insurance each new calendar year.

Photo ID – We are required to obtain a copy of your photo ID. This is to protect you from someone else using your medical insurance (a type of identity theft).

INSURANCE & PAYMENT*(please refer to your insurance handbook for contract guidelines):*
Self-Pay – If you are not covered by medical insurance, you will be expected to pay-in-full at the time of service. All scheduled self-pay surgical procedures must be paid for prior to surgery.

Medicare – We accept assignment on Medicare. If you are a Medicare beneficiary and do not have secondary coverage, you will be responsible for payment of 20% of the Medicare allowed amount.

Deductible/Co-insurance – Be prepared to pay your medical insurance deductible and coinsurance if you have not met your deductible or out of pocket maximum for the year.

Copays – Per your contract with your insurance you are required to pay your insurance copay at the time of service. The copay amount is usually noted on your insurance card or can be found in your insurance handbook.

HMO/Managed Care/OHP – If you are insured through an HMO, Managed Care, or OHP, you may need a referral-authorization from your Primary Care physician before your appointment. This is the responsibility of the patient prior to the appointment. Any unpaid visits due to invalid or non-referral will become the patient's responsibility.

Non-Covered Services – Some services might not be covered by your insurance. Most medical insurance plans, including Medicare, do not pay for "routine eye exams." Routine Eye Exams are exams which **do not** result in a medical diagnosis. For example, diagnoses such as myopia (near-sightedness), hyperopia (far-sightedness), astigmatism, presbyopia (aging eyes) would not be considered medical. Routine eye exams also include "screening for eye disease" which does not result in a medical diagnosis. In the event of service not covered by your medical insurance, you will be responsible for the charges. Refractions (checking for eyeglasses) are not covered by medical insurance. We are happy to get you a referral to an optometrist for a glasses prescription.

Payment Options – We accept Cash, Check, American Express, Visa, MasterCard, Discover and Care Credit.

DILATION:

Your pupils will be dilated during the initial visit. Dilation lasts several hours and may blur your vision. If you have not previously driven with dilated pupils, you may be more comfortable bringing a driver.

GENERAL INFORMATION:

Office hours are Monday – Friday 8:00 am to 5:00 pm (except holidays). We encourage you to call us anytime you have a question or problem with your eyes. Non-emergency calls are best handled during business hours. Emergency after-hour calls are handled by our answering service who will then contact our technician on call.

Local Phone Number: 913-897-9299 **Toll Free:** 877-942-1113 **Fax Number:** 913-897-3031

LOCATIONS:

Overland Park - *Main Office Location*
7200 W 129th Street
Overland Park, KS 66213

Topeka – *satellite office at Heartland Eye Care*
619 SW Corporate View
Topeka, KS 66615

We look forward to seeing you at your appointment!
Stiles Eyecare Excellence

Today's Date: _____

STILES EYECARE EXCELLENCE
CATARACTS AND GLAUCOMA

Please complete and sign this form so we can verify that your information is correct.

Patient Name: _____ Pref name: _____
Last First Middle

Address: _____

City:_____State:_____ Zip Code: _____

Home phone:_____ Cell phone:_____

DOB: ____/____/____ Age: _____ Gender: _____ SSN : _____

Email: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Race: ○ American Indian / Alaska Native, ○ Asian, ○ Black/African American, ○ Native Hawaiian / Other Pacific Islander, ○ White, ○ Other

Ethnic Group: ○ Hispanic or Latino, ○ Not Hispanic or Latino, ○ Decline Pref Language: _____

Spouse name (parent if minor):_____ Spouse/Parent phone: _____

Person to notify in case of emergency: _____

Phone number(s): _____ Relationship: _____

Referring Physician: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Policy Holder's Name: _____

Relationship to Patient:_____ DOB:_____

Secondary Insurance: _____

Policy Holder's Name: _____

Relationship to Patient:_____ DOB:_____

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Stiles Eyecare Excellence to be applied to my account for services rendered _____ (please initial).

Are you willing to participate in Clinical Research Trials in our office? Y / N

Signature:_____ Date:____/____/____

PLEASE PRESENT INSURANCE CARD(S) AND PHOTO ID TO THE RECEPTIONIST WITH YOUR COPAY.

STILES EYECARE EXCELLENCE
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HIPAA Privacy Policy and Acknowledgement Receipt

I. How to Contact

I wish to be contacted in the following manner:

OK to leave message with detailed information at the following phone numbers:

- ☐ Home _____
- ☐ Cell _____
- ☐ Work _____

II. Who to Contact for Private Health Information:

I hereby give permission to Stiles Eyecare Excellence Cataracts and Glaucoma to disclose and discuss any information related to my medical condition(s) to/with the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

III. Who to Contact for Patient Billing Information:

I hereby give permission to Stiles Eyecare Excellence Cataracts and Glaucoma to disclose and discuss any information related to my medical billing/account information to/with the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ I do not wish to disclose any information with anyone other than my insurance company as provided in Stiles Eyecare Excellence Cataracts and Glaucoma Privacy Policy or as required by law.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____ / _____ / _____
Patient Name Date

_____
Signature (Responsible Party)

7200 W. 129th St
Overland Park, KS 66213
www.stileseye.com
P: (913) 897-9299
F: (913) 897-3031

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Health Information Sheet

Today's Date: ____/_____/_____

Patient's Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy: _____

Pharmacy Location (City/Cross Streets): _____

Please describe the reason for the visit today: _____

_____

_____

Past Medical History – Please list **ALL** past medical problems:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Surgical History – Please list all past surgeries and the date that they were performed:

1. _____ 3. _____
2. _____ 4. _____

Ocular Surgeries –

Cataract Surgery (Date of Surgery) _____ **Right / Left** Do you have lens implant? **Yes / No**

Retina Surgery (Date of Surgery) _____ **Right / Left**

Explanation of Eye Injury: _____

_____

Family History – Has anyone in your family (blood relative) had any of the following?

*NOTE RELATION TO PATIENT: F – Father M – Mother P – Paternal M – Maternal S – Sister B – Brother

GF – Grandfather GM – Grandmother U – Uncle A – Aunt

YES ☐ NO ☐	Cataracts _____	YES ☐ NO ☐	Diabetes IDDM/Type II _____
YES ☐ NO ☐	Glaucoma _____	YES ☐ NO ☐	Heart _____
YES ☐ NO ☐	Cornea Disease _____	YES ☐ NO ☐	Diabetic Retinopathy _____
YES ☐ NO ☐	Macular Degeneration _____	YES ☐ NO ☐	Retinal Detachment _____
YES ☐ NO ☐	Retinitis Pigmentosa _____	YES ☐ NO ☐	Stroke _____
YES ☐ NO ☐	Other Eye Problems _____	YES ☐ NO ☐	Other _____

Allergy History – Are you allergic to any **food, medicine, chemical, latex, and/or other?** YES ☐ NO ☐

If yes, please list: _____

_____

Social History – Please answer the following questions:

Do you currently smoke or have you smoked in the past? NO ☐ YES ☐ If yes, how long? _____

Do you consume alcohol? NO ☐ YES ☐ If yes, how many drinks per week? _____

Review of Systems – Please circle any signs/symptoms/conditions that you currently experience:

Chest: fast heart rate, palpitations

Constitutional: chills, fatigue, fever, night sweats

Ears: discharge, ear congestion, ear itching, earache, hearing loss, vertigo

Mouth and Throat: dry mouth, sore throat

Endocrine: cold intolerance, heat intolerance, increased thirst, weight gain, weight loss

Eyes: blurred vision, itch, redness, watery

Frequent infections: bronchitis, ear (otitis), pneumonia, sinusitis, skin

GI: diarrhea, heartburn, reflux, trouble swallowing, vomiting

Hematology: swollen lymph nodes, unusual bleeding, unusual bruising

Musculoskeletal: muscle pain, red/swollen joints, stiff/sore joints

Neurologic: headaches, numbness, weakness

Nose: congestion, itch, loss of smell, runny, sneezing, snoring

Psychology: anxious, depressed, stressed

Respiratory: cough, croup, shortness of breath, tight chest, wheeze

Sinus: pain, post nasal drip, pressure

Skin: dry, hives, itch, rash, swelling

Current Medication – Please list current medicines including **dose and directions.** (Over the Counter, prescription medicine and herbal remedies)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

*Are you currently on any blood thinners? NO ☐ YES ☐ If yes, please list: _____

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Notice of Privacy Practices

Notice of Privacy Practices: You have been provided a copy of our Notice of Privacy Practices. A copy of our Notice of Privacy Practices is also posted on our website and available at our office. Our office complies with **HIPAA (Health Insurance Portability and Accountability Act of 1996)** and all federal and state laws governing the privacy of your information. If you have any questions regarding the information in the Notice, please contact the representative designated in the Notice.

Use of Information: By signing this form, you consent to our use and disclosure of your Protected Health Information (PHI) to carry out Treatment, Payment activities, and Healthcare Operations (TPO). You are also acknowledging receipt, understanding and agreement to our Notice of Privacy Practices. The duration of this consent is indefinite and continues until revoked in writing.

You may refuse to sign this authorization.

_____

Patient Name DOB

_____

Signature (Responsible Party)

_____ / _____ / _____

Date

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Overland Park, KS 66213

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Patient Financial Responsibility Agreement

Patient Acknowledgement Regarding Financial Responsibility

In order for us to provide our patients with quality medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for the services rendered is our patient's responsibility. This document explains the patient's obligations and to meet them. In exchange for services rendered, each patient or patient's guarantor agrees:

- To authorize payment of surgical and medical benefits to us, which would otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V,XVII, and or XIX of the Social Security Act is correct.
- To pay for all non-covered charges, co-pays, co-insurance, deductible, out-of-network charges, and refractions (the measurement of the eye in order to obtain a prescription for glasses) at the time of service or when otherwise advised. If this is not possible, you agree to contact our Billing Office at (913) 897-9299 BEFORE services are rendered. If we have to send you a statement for your co-pay or you fail to notify us of an appointment cancellation at least 24 hours in advance, you may incur a processing fee.
- To provide us with a copy of your most recent insurance card or other proof of insurance and/or register with the receptionist at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit, and your insurance company subsequently denies our claim, you are personally responsible for any and all charges.
- To obtain any authorization or referral required by your insurance plan and/or from your Primary Care Physician prior to each appointment. If you do not receive the required authorization, your insurance company may not pay us for our services. In this case, you are personally responsible for any and all charges. Additionally, we may need to reschedule your visit if you do not have your authorization or referral.
- To monitor your insurance company's payment of your account and if unpaid 30 days after the date of service, to contact them regarding their non-payment. You also agree to cooperate with us in resolving the unpaid status of your account.

As a courtesy to our self-pay patients seeking routine eye care, we will provide a reduced charge for payment made at the time of service. The entire balance must be paid in full to receive the discount. Once you accept the discount, we will not be responsible for filing claims to any insurance company nor will we accept payment on a discounted rate from the insurance company. In the event we receive a payment from an insurance company under this circumstance, we will refund the money to the insurance company.

As a patient or guarantor of a patient, I agree that in consideration of the services rendered by us, that I am individually obligated to pay for all services in accordance with the regular rates, terms and conditions of Stiles Eyecare Excellence & Glaucoma Institute, PA. In the event we must refer the patient's account to a collection agency or attorney for collection of an amount 90 days or older, the patient and/or guarantor agrees to pay our collection fee, including any accrued interest and all applicable bank fees incurred for a returned check.

I voluntarily consent to healthcare treatment from the physicians and staff at Stiles Eyecare Excellence Cataracts and Glaucoma. I am aware that the practice of medicine is not an exact science and no guarantees have been made to me regarding the results of treatment or examination by my provider. I consent to the use and disclosure of protected health information about me for treatment, payment and operations.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above provisions.

_____ _____

Patient or Guarantor – Signature Date