S. Gregory Smith, M.D. & Associates

Cornea & Anterior Segment Surgery
Cataract & Refractive Surgery
Intraocular Lens Complications
Oculoplastics

Delaware Eye Surgeons, P.A.

2710 Centerville Road
Suite 102
Wilmington, Delaware 19808
302-993-1300
Fax 302-993-1400

2300 Pennsylvania Avenue
Suite 3-A
Wilmington, Delaware 19806
302-655-7600
Fax 302-655-4900

Dear_____:

Thank you for choosing Delaware Eye Surgeons as your eye care specialist. We look forward to your visit scheduled for _____ at _____ with Dr. _____.

In an effort to provide you with accurate and expedient service, please complete the enclosed forms and bring them with you when you come to the appointment, along with the following items:

- Insurance card(s)
- Referral (you will not be seen without a referral if your insurance company required it.)
- Co-pay (due at time of visit)
- Picture ID

If you have any questions, please feel free to contact us at (302) 993-1300.

There is a $40.00 fee for cancellations less than 24 hours or No Show.

Thank You
Delaware Eye Surgeons

DELAWARE EYE SURGEONS, P.A.
2710 Centerville Rd. Suite 102
Wilmington, DE 19808

Name:_____ Birthdate:_____Age:_____

Address:_____ Sex:_____ SS#_____

_____ Email:_____

Home Phone:_____ Marital Status:_____

Cell Phone:_____ Race:_____ Language:_____

Emergency Contact:_____Phone #:_____

Employer/Occupation:_____Phone #:_____

Primary Care Doctor:_____Phone #:_____

Pharmacy:_____Location:_____Phone#:_____

Referring Doctor:_____ Referred By:_____

INSURANCE INFORMATION- *Please fill in line 1,2, and 3 coverage is through a spouse or a patient. Line 1 if self.*

1. Primary Insurance:_____ ID#:_____ Group #:_____
2. Policy Holder:_____ Birthday:_____
3. Social Security #:_____Relation to Patient:_____
4. Language_____ Race: _____ Ethnicity: _____

INSURANCE INFORMATION- *Please fill in line 1,2, and 3 coverage is through a spouse or a patient. Line 1 if self.*

1. Secondary Insurance:_____ ID#:_____ Group #:_____
2. Policy Holder:_____ Birthday:_____
3. Social Security #:_____ Relation to Patient:_____
4. Language_____ Race: _____ Ethnicity: _____

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION AND THE FILING OF INSURANCE CLAIMS PERTAINING MY SERVICES RENDERED TO ME BY DELAWARE EYE SURGEONS, P. A

Patient or Legal Guardian Signature: _____ **Date:** _____

FINANCIAL POLICY FOR DELAWARE EYE SURGEONS, P.A.

INSURANCE- It is the patient's responsibility to supply ALL insurances at the time of visit. Failure to do so may result in claim denials which then becomes the patient's liability. It is also the patient's responsibility to fully understand their insurance coverage.

REFERRALS- If your insurance requires you to have a referral to see a specialist, you are required to have your referral prior to your visit. If the referral is not provided you will be asked to either reschedule or pay for the visit at the time of service.

CO-PAYS- ALL co-payments are due at the time of service. Failure to pay copay at the time of service may result in a late fee when billed. Any past due and payable balances are collected at the time of service.

SELF PAY ACCOUNTS- Self-pay accounts are patients with no insurance who pay out of pocket, an estimated amount for service is $150. Payment is required at the time of service for all services including surgeries.

NON-PARTICIPATING INSURANCE PLANS -The insurance company will be billed as a non-assigned claim as a courtesy to the patient with the patient's payment to the practice in full at the time of service. The insurance company may reimburse the patient or non-assigned claims. If the practice receives payment from the insurance company for a non- assigned claim, the patient will be refunded the amount paid. The following criteria must be met prior to issuing a refund: There are no outstanding insurance claims on the patient's account and there are not outstanding balances on the account.

AUTOMOTICE ACCIDENT & WORKERS COMPENSATION CASES -The patient will be treated as a self-pay account unless all information is received and verified through the insurance carrier.

CHILD CUSTODY CASES - The parent with custodial custody is usually the parent who the child lives with and usually accompanies the child to the practice for care. The custodial parent is responsible for the payment at the time of service whether the account is considered self-pay, participating insurance, or non-participating insurance. If the non-custodial parent carries the child's insurance the practice will bill the insurance company. The practice does not get involved with divorce specific's e.g., one parents pays 80% and the other pays 20%. It is the parent's obligation to work out an agreement between each other.

REFRACTIONS- Refractive services of routine eye exams are **NOT** covered by most medical insurances. Routine eye exams are **NOT** covered by Medicare; therefore, they are **NOT** subject to the waiver of liability provision. Advance notification to the beneficiary is not required.

This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification on any of the above policies, please feel free to contact us.

_____ Date: _____

Patient or Legal Guardian Signature

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Health Insurance Portability and Accountability Act

Patient Privacy Right and Disclosure

Delaware Eye Surgeons, P.A. and its employees disclose information given to us by the patient to, the patient's insurance company, primary care physician, or other medical professionals for the purpose of treatment, payment of services rendered, or health care operations.

We do not sell to mailing lists or disclose personal information about our patients except that which is needed to carry out our objective, patient care.

Incompliance with HIPPA guidelines the patient understands that they have the right to review any information which is documented in the patient's record and the right to add an addendum to such records and the right to add an addendum to such records, if the record is disputed.

By signing this consent, you agree to allow Delaware Eye Surgeons P.A. to use and disclose personal information about you for the reasons above.

You have the right to revoke this consent at any time, but be aware that we cannot guarantee care unless we can communicate with the other health professionals.

I have read and understand the above policies:

_____ _____

Patient or Legal Guardian Signature Date

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ABOUT YOUR INSURANCE

There are two types of insurances that may help pay for your eye care services and materials. You may have both and our practice will verify we accept your insurance before your appointment: 1) Medical Insurance (Ex. Medicare and BC/BS) and 2) Vision Insurance (Ex. VSP and Eye Med).

- Vision insurance only covers **ROUTINE VISION EXAMS** along with eye glasses and contact lenses.
- Medical insurance must be used is you have any health problems that have ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your case history.
- We will bill your insurance plan for services if we are participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits in the attempt to let you know what is covered. Any co-pays, deductibles or non-covered services will be your responsibility.

I have read and understand the above policies:

Patient or Legal Guardian Signature _____ Date _____

Patient Portal

Name: _____

Delaware Eye Surgeons is now offering our patients web-based access to communicate remotely. The patient portal allows the patient to request an appointment, update demographic info, leave messages among other things.

To enroll in the patient portal, please supply the receptionist with your e-mail. You will receive instructions through your e-mail on how to enroll.

E-mail:_____ OR Decline

PAST MEDICAL HISTORY

Name_____Date_____

OCULAR HISTORY

Please indicate if you have been diagnosed with any of the following:

_____ Cataracts
_____ Glaucoma
_____ Retinal detachment
_____ Macular degeneration

Please ***indicate the RELATIONSHIP*** of any immediate family members (Mother, father, brother sister even if deceased) who have been diagnosed with the following:

_____ Glaucoma	_____ Cataracts	_____ High blood pressure
_____ Retinal detachment	_____ Cancer	_____ Heart problems
_____ Macular degeneration	_____ Strabismus	_____ Diabetes

GENERAL MEDICAL HISTORY

Please indicate if you have been diagnosed with any of the following:

_____ Diabetes For how many years: _____ A1C Level _____
_____ Cancer - What type: _____
_____ Asthma
_____ Hypertension
_____ Arthritis
_____ Cholesterol
_____ Thyroid conditions
_____ Neurological conditions
_____ Ear, nose, throat conditions
_____ Heart disease
_____ Heart attack When: _____
_____ Shortness of breath
_____ Gastric intestinal conditions
_____ Urinary conditions
_____ Hepatitis/HIV
_____ Infectious disease
_____ Sleep apnea – Cpac machine Yes or No

Please list any other medical conditions:
_____
_____
_____
_____
_____

SURGICAL HISTORY

Have you had eye surgery? Yes No (Circle one)
If yes, please supply the dates and procedures _____
Have you had facial surgery? Yes No (Circle one)
If yes, please supply the dates and procedures _____

MEDICATION HISTORY

Pneumococcal Vaccination Yes No (Circle One)
Covid Vaccination Yes No (Circle One)

Please list ALL medicine **allergies:** _____

Please fill out attached form OR If you have a written list we can make a copy.

Smoking History: Current _____ Former _____ Never _____
Drinking History: Current _____ Former _____ Never _____
Height _____ Weight _____ Blood pressure _____

Dear Patient,

Here at the Delaware Eye Surgeons we take medication delivery very seriously. We believe that you are the key member of the team involved in your treatment. In order to provide the highest quality of care we would like for you to document the most accurate and complete list of the medications you are taking, including name, dose, and frequency of each medication. You may also inquire about a current list of medications from your primary care physician. Please feel free to contact us at (302)993-1300 with any questions.

Medication or Supplement	Amount Taken (Dose)	How Taken (Route)	How Often (Frequency)
Example: Aspirin	*Example: 80 mg*	*Example: By Mouth*	*Example: Once a day*

Name:_____

Date:_____

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DIRECTIONS TO DELAWARE EYE SURGEONS P.A.

We are in the 2 story red brick building, on the 1st floor

I-95 NORTH

FROM I-95 NORTH, take exit #5 for Route 141N
Take Route 141N to Exit #5, Boxwood Road
Stay Straight on Centerville Road, Pass the GM plant on your right. Cross Faulkland Road.
We are ½ mile up on the right.

I-95 SOUTH

FROM I-95 SOUTH, take exit #5 for Route 141N
Take Route 141N to Exit #5, Boxwood Road
Stay Straight on Centerville Road, Pass the GM plant on your right. Cross Faulkland Road.
We are ½ mile up on the right.

FROM 202

Astra Zeneca is your landmark on 202
Turn right onto Route 141S, follow to Lancaster Pike (Route 48W)
Make a right onto Route 48W
At the first light, turn left onto Centerville Road
On Centerville Road, Travel ½ mile to building on left

FROM KIRKWOOD HIGHWAY, ROUTE 2

Take Route 141N Fairfax
Follow 141N to Lancaster Pike (Route 48W)
Make a left on Route 48W
At first light, turn left onto Centerville Road
On Centerville Road travel ½ Mile to building on left.