



Dear Patient:

Thank you for choosing Cokingtin Eye Center to share in the care of your vision needs. To make the most of your appointment and ensure all your questions will be answered, we would like to share some valuable information regarding Cataract Surgery.

Included in your welcome packet is a vision preference questionnaire to help you decide what surgical outcome best fits your expectations and a visual function analysis to assist the physician in determining your overall need for cataract surgery. Please complete these forms as directed.

Cokingtin Eye Center is a comprehensive medical and surgical eye care practice specializing in cataract and lens implant surgery. Employing the latest diagnostic technology and surgical techniques, along with state-of-the-art lens implants, our goal is to optimize surgical results to fit your individual needs and lifestyle.

Cataracts are a gradual and progressive clouding of the natural lens of the eye leading to blurred vision. Patients with cataracts note difficulty focusing, blurred vision for both reading and distance, and often experience glare symptoms. When daily activities are impaired because of these visual difficulties, cataract surgery is often advisable. Cataract surgery improves vision by replacing the clouded lens (cataract) with an intraocular lens (IOL).

Your evaluation will consist of one of two options based on your vision preferences:

Option 1 is our Standard Cataract Evaluation and is covered by most insurance plans and Medicare. This evaluation will include a comprehensive eye exam and measurements to determine an appropriate IOL power. This option does not include detailed macular or corneal mapping screening and is best suited for patients opting for a traditional lens implant to restore vision to one distance, either distance or near. Patients will typically have an ongoing need for glasses for most activities.

Option 2 is our Advanced Cataract Evaluation which includes a comprehensive eye exam along with additional diagnostic tests to provide a much more precise and thorough understanding of what is impacting the vision. Employing advanced diagnostic testing, we can identify certain conditions which can affect the surgical outcome and prognosis for visual recovery and determine the optional lens implant choice to correct your vision.

When used for screening purposes, these tests are not covered by Medicare or private insurers. For this reason, we offer an affordable package combining these tests. The cost for this package is \$125 for both eyes and is payable the day of your examination (\$175 for Post Refractive Patients).

This optional package is **NOT** required to undergo cataract surgery.

Premium IOLs

Various lens implants can be employed to restore vision. Those desiring more freedom from spectacles with an increased range of clearer vision may opt for "premium lens implant". Such implants are not covered by Medicare or commercial insurance plans and cost will very depending on which IOL technology is used. Your ophthalmologist will discuss the options available to you to optimize the results to fit your needs and lifestyle.

Please feel free to call our Surgical Coordinator, Janice Vanderveen, to answer any questions you may have at 913-491-3737 ext. 7224.



WHAT YOU MAY EXPECT DURING YOUR CATARACT CONSULTATION

We would like your visit with *Cokingtin Eye Center*, *PA* to be enjoyable. So that you will know what to expect on the day of your consultation, we have outlined the process below. Please expect to spend one and a half to two hours with us.

There are exciting new options for patients in regards to the treatment of cataracts. Our staff is highly trained to complete all necessary testing and to answer any questions you may have along the way. We are pleased to offer you the most advanced options for surgical eye care.

Before Your Appointment:

Contact lens patients must have soft lenses removed 1 week prior to their appointment and hard lenses removed 3 weeks prior to their appointment.

On the day of your examination please bring the following:

- Your current insurance cards.
- Your Driver's License with correct address
- Your current eye glasses, glasses prescriptions, and/or contact lens prescriptions.
- The forms that you were mailed. If there was not enough time for you to complete your paperwork you will be asked to complete it the day of your appointment. Please arrive 15 minutes prior to your examination to complete the paperwork.
- We will need information on all medications you are taking, including the names, dosages, and frequency.

After checking in at our front desk:

- A qualified technician will begin your examination. A complete history and preliminary testing will be done at this time:
 - o Your current eye glass prescription will be evaluated.
 - o Your eyes will be tested to verify your best corrected vision.
 - O Your eyes will be dilated to allow a complete evaluation by your Doctor.

Examination with your Doctor:

- A comprehensive diagnostic examination is performed to determine if cataract surgery is an option for you.
- Special testing may be ordered by your Doctor at this time.
- All testing may be done at this examination or may require a return visit.

If you will be scheduling surgery:

- You will speak with a surgical counselor to discuss the specific procedure and answer any remaining questions you may have.
- A financial counselor will be available by phone to verify insurance coverage and assist in payment options.

Thank you for choosing *Cokingtin Eye Center*, *PA* for your eye care and for allowing us to provide you the most advanced eye care available.

Sincerely,

The Staff of Cokingtin Eye Center, PA

PATIENT INFORMATION



DEMOGRAPHICS

LEGAL NAME			Date		Email	address	3		
	Last First Mi								
Street Address			Social Sec	curity #					
City			Special [□ Wheel C	Chair [□ Walke	r 🗆 Oth	ner	
			Needs [□ Hearing	Impaired	I □ Trar	nslator l	anguage	
State	County	Zip Code	Birthdate		A	ge R	Race	Se	ЭX
Home Phone	Work Phone		Maritial Sta	atus arried	□ Sing	e ⊓ſ	Divorced	□ Wid	dowed
Employer Name / Address			Position / I				31701000		
Employer Name / Address			F OSITION / I	Беранине	IIL				
Spouse			Work Phoi	ne ()				
Emergency Contact			Emergenc	y Phone	()			
BILLING									
			15.0						
Guarantor (Financially Respon	sible Person)		Relationsh		ent µse □ P	arent	□ Other		
Street Address			Phone /						
			()				
City			State			Zip Co	ode		
Primary Insurance	Policy Holder	Policy ID #	1	Social S	ecurity #			Insured's I	B/D
Secondary Insurance	Policy Holder	olicy Holder Policy ID #			Social Security #			Insured's I	3/D
Send Workers Compensation To			Authorized	d By/Posit	ion		ļ	Date of In	cident
Are you under the care of a skilled nursing facility? Yes No				yes, pleas	se list nar	ne and a	address a	nd phone i	number.
REFFERAL									
Whom may we thank for telling	□ Friend / F	amily □ Patie	nt □ P	rologue		Vewspan	oer		
you about our practice?			ent □ Prologue □ Newspaper						
			•		•				
Primary Care Doctor Description: Primary Care Doctor Phone ()									
Name									
Street Address		City	,			State	Ž	Zip Code	
Family Optometrist Name		I	Phor	ne ()	<u> </u>			
Street Address		City	I			State		Zip Code	



PATIENT HEALTH HISTORY

Other Problems

Name:		D.O.B	Date
Medical Doctor:		_ Eye Doctor:	
	PLEASE LIST ALL ME		
	MEDICATION	DOSAG	E HOW OFTEN
	PLEASE LIST ANY I	DIAGNOSED EYE PRO	DBLEMS
	PLEASE CIR	CLE ALL THAT APPLY	
Auto-Immune	Myasthenia Gravis, Lupus, Rh	eumatoid arthritis, Sjogren	s Syndrome, Addisons Disease,
Cardiovascular	·		
Circulatory			
Endocrine	Diabetes, Graves Disease, Thy	roid	
Gastrointestinal	Stomach, Intestines, Irritable E	Bowel Syndrome (IBS), Ga	stric Esophageal Reflux (GERD)
Genitourinary			
Hematological	Blood, Lymph Nodes, Leukem	nia, Anemia, Hepatitis	
Musculoskeletal	Chronic fatigue syndrome, Post	Stroke Paralysis, Osteo-artl	nritis,
Neurological	Alzheimer's, Epilepsy, Multip	le Sclerosis (MS), Muscul	ar Dystrophies (MD)
Psychiatric	Psychosis, Depression, Bi-polar (manic-depression), ADD (attention deficit disorder), ADHD (attention deficit hyperactive disorder)		
Respiratory	COPD, Asthma, Emphysema, Chronic Bronchitis, Lung Disease		

Name:				D.O.B		Date		
	<u>I</u>	LIST A	NY KNOWN	DRUG ALLERGI	<u>ES</u>			
Do you have an allergic re	eaction	to tape	or band aids?	Y N	Latex pro	oducts?	Y	N
			SOCIAL I	HISTORY				
Do you drink?		Y	N	How often				
Do you smoke?		Y	N	How often				
Do you use any Illegal substa	nces?	Y	N	How often				_
		FA	MILY MEDI	CAL HISTORY				
Relation codes: F-Father, M	I-Mothe			M-Grandmother, S-S rnal, (M)-Maternal	Sister, B-Br	other, U-U	ncle,	A-Aunt
I	Does any	membe	r of your family s	uffer from any of these c	conditions?			
Condition Yes	s N	o	Relation	Condition	Yes	No	R	Relation
Blindness				Heart				
Cataracts				Stroke				
Glaucoma				High Blood Pressu	re	 -		
Macular Degeneration				Kidney				
Retinal Detachment				Lupus				
Diabetes				Sjogrens				
Thyroid				Arthritis				
Cancer				Other				
			SURGICAL	<u> HISTORY</u>				
		Please	list any eye su	rgeries you have had	1.			
SURGERY				DATE		DOCTOR	<u> </u>	
			Please list all o	other surgeries.				
SURGERY		DA	TE	SURGERY	7	I	DATE	



VISION PREFERENCE QUESTIONNAIRE

Advancements in cataract surgery are giving patients more choices. During cataract surgery, the clouded lens (cataract) is removed and is replaced with an intraocular lens (IOL). A **conventional IOL** is covered by Medicare and most insurance companies, and is a good choice for patients who do not mind wearing glasses. **Premium IOLs** are not covered by insurance companies, but can offer patients more freedom from their glasses. Patients are responsible for additional fees for premium IOLs.

If cataract surgery is needed, your doctor will review the IOL options that are appropriate for you. Please fill out this questionnaire so our staff may understand your desires and goals after cataract surgery.

Printed Name	Patient Signature	Date
6) If you could have good vision was that you might see some halos a you (additional fees apply)? Yes	round lights at night, would this p	, 1
5) If you have significant astigmati would this upgrade interest you (add		-
4) What activities would you not m	ind wearing glasses?	
3) What activities would you like to	o do without glasses?	
2) What are your favorite hobbies/a	ectivities?	
(If you answered no, you may be int the remaining questions.)	erested in the premium IOL techn	ology. Please continue with
1) Would you prefer to wear glasse	s full time after cataract surgery?	Yes No



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PRE-SURGICAL CATARACT PATIENT QUESTIONNAIRE

Patient Name	
Chart Number	
Eye Being Evaluated	⊠ RT ⊠LT

VISUAL FUNCTIONING				
Do you have difficulty, even with glasses, with the following activities?	YES	NO		
1. Reading small print, such as labels on medicine				
bottles, telephone books, or food labels?				
2. Reading a newspaper or book?				
3. Reading a large-print book, or large-print newspaper, or				
large numbers on a telephone?				
4. Recognizing people when they are close to you?				
5. Seeing steps, stairs or curbs?				
6. Reading traffic signs, street signs, or store signs?				
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?	×			
8. Writing checks or filling out forms?				
9. Playing games such as bingo, dominos, or card games?				
10. Taking part in sports like bowling, handball, tennis, or golf?				
11. Cooking?				
12. Watching television?				

<u>SYMPTOMS</u>		
Have you been bothered by:	YES	NO
1. Poor night vision?	\boxtimes	
2. Seeing rings or halos around lights?		
3. Glare caused by headlights or bright sunlight?		
4. Hazy and/or blurry vision?		

SYMPTOMS (continued)		YES NO
5. Seeing well in poor or dim light?		~ ~
6. Poor color vision?		~ ~
7. Double vision?		~ ~
DRIVING		
1. Have you ever driven a car?	~ YES (continue)	~ NO (stop)
2. Do you currently drive a car?	~ YES (continue)	~ NO (stop)
3. How much difficulty do you have d	driving during the day becau	use of your vision?
~ No difficulty	[~] A moderate an	nount of difficulty
[~] A little difficulty	A great deal of	f difficulty
4. How much difficulty do you have d	driving at night because of y	our vision?
No difficulty A moderate amount of difficulty		
A little difficulty	A great deal of	f difficulty
5. When did you stop driving?		
Less than 6 months ago 6-	12 months ago ~ More	e than 1 year ago
Cataract surgery can almost always better vision. If stronger glasses won only way to help you see better is cata is bad enough to consider cataract sur	t improve your vision and aract surgery, do you feel	y more, and if the
Patient Signature	Date	;
Witness	Date	2



Phone: 913-491-3737

Patients Name
Date of Birth
PHARMACY INFORMATION
FIIARWACI IN ORWATION
Pharmacy Name
Pharmacy Address
City
State
Zip
Phone
Eav



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Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physicians as is necessary in his/her judgement.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Cokingtin Eye Center, PA for services furnished to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that 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 HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medical Supplemental policy is a health insurance policy or other health plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

	ya
Signature:	Date:
Printed Name	

This agreement is in effect until revoked in writing by the patient.



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COKINGTIN EYE CENTER, PA • MIDWEST EYE CONSULTANTS

FINANCIAL POLICY

Thank you for choosing our office to assist you with your eye care needs. We strive to provide you with the highest quality care possible, and in return, we ask that you assist us not only in monitoring your eye health care, but also by paying for our services in a responsible and timely manner.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement and feel free to ask us any questions you may have relating to our policy. Then sign the statement at the bottom of this form.

Acceptable Payment Methods:

We accept cash, checks, Visa, MasterCard and American Express. Under certain circumstances, with prior credit approval, we do offer extended payment plans. If you need additional information on that, please talk to our billing staff.

- **Insurance:** Our office accepts assignment of benefits from many insurance companies, HMO and PPO programs. However, we do not accept all benefit programs. Therefore, please inquire (call them to be sure) as to whether or not your insurance company is accepted by this office.
- Affordable Care Act Insurance: Our Office accepts assignment of benefits from the Affordable Care Act with participating plans. Please inquire (call them to be sure) as to whether or not your physician accepts your insurance plan and alert our staff if you are receiving benefits from the Affordable Care Act. The Affordable Care Act does not provide full coverage and it will be patient responsibility to pay their share of the bill.
- We do require that your co-payment, deductible and any non-covered services, such as refractions and contact lens related charges, be made at the time of service. In the event that we do not accept assignment of benefits from a particular insurance company, we require you to pay your bill in full at the time of each visit or be pre-approved on our extended payment plan.
- Your bill is your responsibility: If your insurance company or other benefit program doesn't cover the entire bill, it's your responsibility to pay the balance. Unless you are on an extended payment plan, we expect payment in full within 60 days of being notified of any balance due. It is our policy to mail out 3 billing statements. Failure to pay the balance in full or contact our office regarding a payment plan after 60 days will result in your account being sent to collections.

I certify that I have read and understand the "Financial Policy" and agree to all terms and conditions stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, HMO or PPO, Medicare, Medicaid, Affordable Care Act or other benefit program and that I am ultimately responsible for payment in full for any outstanding balances incurred.

Signature:	Date:
Print Name:	