COKINGTIN EYE CENTER P.A.
5520 College Blvd., Suite 201
Overland Park, KS 66211
Phone: 913-491-3737

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 vary 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.

COKINGTIN EYE CENTER PA

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:
  - Your current eye glass prescription will be evaluated.
  - Your eyes will be tested to verify your best corrected vision.
  - 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*

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PATIENT INFORMATION

DEMOGRAPHICS

LEGAL NAME Last First Mi			Date	Email address		
Street Address			Social Security #			
City			Special Needs ☐ Wheel Chair ☐ Walker ☐ Other_____ ☐ Hearing Impaired ☐ Translator Language _____			
State	County	Zip Code	Birthdate	Age	Race	Sex
Home Phone ( )	Work Phone ( )		Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed			
Employer Name / Address			Position / Department			
Spouse			Work Phone ( )			
Emergency Contact			Emergency Phone ( )			

BILLING

Guarantor (Financially Responsible Person) Name			Relationship To Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_____	
Street Address			Phone ( )	
City			State	Zip Code
Primary Insurance	Policy Holder	Policy ID #	Social Security #	Insured's B/D
Secondary Insurance	Policy Holder	Policy ID #	Social Security #	Insured's B/D
Send Workers Compensation To			Authorized By/Position	Date of Incident
Are you under the care of a skilled nursing facility? Yes No			If yes, please list name and address and phone number.	

REFFERAL

Whom may we thank for telling you about our practice?	☐ Friend / Family ☐ Patient ☐ Prologue ☐ Newspaper_____ ☐ Sign ☐ Radio ☐ Yellow Pages ☐ Screening ☐ Other_____ ☐ MD_____ ☐ Optometrist _____		
Primary Care Doctor Name		Phone ( )	
Street Address	City	State	Zip Code
Family Optometrist Name		Phone ( )	
Street Address	City	State	Zip Code

COKINGTIN EYE CENTER PA

PATIENT HEALTH HISTORY

Name:_____ D.O.B._____ Date _____

Medical Doctor:_____ Eye Doctor: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

MEDICATION	DOSAGE	HOW OFTEN

PLEASE LIST ANY DIAGNOSED EYE PROBLEMS

_____

_____

_____

PLEASE CIRCLE ALL THAT APPLY

Auto-Immune Myasthenia Gravis, Lupus, Rheumatoid arthritis, Sjogren's Syndrome, Addison's Disease, HIV, Hay Fever

Cardiovascular Heart, Coronary Artery Disease, Pace Maker, Defibrillator

Circulatory High Blood Pressure, High Cholesterol, TIA (transient ischemic attack)

Endocrine Diabetes, Grave's Disease, Thyroid

Gastrointestinal Stomach, Intestines, Irritable Bowel Syndrome (IBS), Gastric Esophageal Reflux (GERD)

Genitourinary Urinary frequency, History of kidney stones, Female problems (reproductive), Male Problems (prostate)

Hematological Blood, Lymph Nodes, Leukemia, Anemia, Hepatitis

Musculoskeletal Chronic fatigue syndrome, Post Stroke Paralysis, Osteo-arthritis,

Neurological Alzheimer's, Epilepsy, Multiple Sclerosis (MS), Muscular 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

Other Problems _____

USE BACK OF FORM IF MORE SPACE IS NEEDED

Name:_____ D.O.B._____ Date _____

LIST ANY KNOWN DRUG ALLERGIES

_____

_____

_____

Do you have an allergic reaction to tape or band aids? Y N Latex products? Y N

SOCIAL HISTORY

Do you drink? Y N How often _____
Do you smoke? Y N How often _____
Do you use any Illegal substances? Y N How often _____

FAMILY MEDICAL HISTORY

Relation codes: F-Father, M-Mother, GF-Grandfather, GM-Grandmother, S-Sister, B-Brother, U-Uncle, A-Aunt, C-Cousin, (P)-Paternal, (M)-Maternal

Does any member of your family suffer from any of these conditions?

Condition	Yes	No	Relation	Condition	Yes	No	Relation
Blindness				Heart			
Cataracts				Stroke			
Glaucoma				High Blood Pressure			
Macular Degeneration				Kidney			
Retinal Detachment				Lupus			
Diabetes				Sjogrens			
Thyroid				Arthritis			
Cancer				Other			

SURGICAL HISTORY

Please list any eye surgeries you have had.

SURGERY	DATE	DOCTOR

Please list all other surgeries.

SURGERY	DATE	SURGERY	DATE

USE BACK OF FORM IF MORE SPACE IS NEEDED

COKINGTIN EYE CENTER PA

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.

1) Would you prefer to wear glasses full time after cataract surgery? Yes___ No___

(If you answered no, you may be interested in the premium IOL technology. Please continue with the remaining questions.)

2) What are your favorite hobbies/activities?_____

3) What activities would you like to do without glasses? _____

4) What activities would you not mind wearing glasses? _____

5) If you have significant astigmatism and you could have good distance vision without glasses, would this upgrade interest you (additional fees apply)? Yes____No_____

6) If you could have good vision without glasses for both distance and near, but the compromise was that you might see some halos around lights at night, would this premium IOL option interest you (additional fees apply)? Yes No _____

_____ _____ _____

Printed Name Patient Signature Date

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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?	☒	☒

SYMPTOMS

Have you been bothered by:	YES	NO
1. Poor night vision?	☒	☒
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 driving during the day because of your vision?
   - ˜ No difficulty
   - ˜ A little difficulty
   - ˜ A moderate amount of difficulty
   - ˜ A great deal of difficulty

4. How much difficulty do you have driving at night because of your vision?
   - ˜ No difficulty
   - ˜ A little difficulty
   - ˜ A moderate amount of difficulty
   - ˜ A great deal of difficulty

5. When did you stop driving?
   - ˜ Less than 6 months ago
   - ˜ 6-12 months ago
   - ˜ More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, and if, the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

˜ YES ˜ NO

Patient Signature_____ Date _____

Witness _____ Date _____

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Patients Name _____

Date of Birth _____

PHARMACY INFORMATION

Pharmacy Name _____

Pharmacy Address _____

City _____

State _____

Zip _____

Phone _____

Fax _____

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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.

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

Signature:_____ Date:_____

Printed Name:_____

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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 benefits 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:_____