Miller Ophthalmology Associates, LLC
16 S. Jefferson Rd.
Whippany, NJ 07981
(973) 325-3300

Refraction Fee & Office Policy

Dear Patient:

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. We will provide you with a copy of your prescription, which can be used to purchase eyeglasses or contacts.

Many medical insurance plans, *including Medicare*, do NOT cover refractions. They require that we charge separately for this service, since often it is non-covered. (Medicare beneficiaries see Chapter 6.3 of the Medicare handbook.)

If you have a separate **vision plan** that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Are you covered by Vision Service Plan (VSP) or EyeMed? _____ **Yes** _____ **No**

Our office fee for a refraction is $75.00, and is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly. We routinely refract children as part of our complete exam and adults as indicated. If you are unhappy with your prescription, we will make every attempt to rectify the situation free of charge within 30 days.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

☐ **I decline the refraction service. I understand that without a refraction, the health and function of my eyes may not be fully assessed.**

Ophthalmic testing performed on same day as Routine Vision Exam will be billed to the primary medical insurance carrier. Co-pay, deductible and/or cost-share may be applied. Testing may include, fundus photography, visual field testing, optical coherence tomography (OCT,) corneal topography or pachymetry.

Patient No-Show/Cancellation Policy:
We make every attempt to see our patients at the time of their scheduled appointment. We require a 24-hour notice if an appointment must be cancelled. We have voicemail and an answering service 24/7, for your convenience after hours or on weekends. In the event the patient (parent or legal guardian) does not contact our office to cancel the appointment, a "No Show" fee of $25 may be charged.

Medical Records: If you request copies of your medical records from our office, a charge of $1/per page may be charged. Please allow 7-14 days. Thank you for your cooperation.

Patient Acknowledgement:
I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I also understand that any co-payment, co-insurance, or deductible I may have are separate from and not included in the refraction fee, and also due at time of service.

_____
Patient Name (Please Print)

_____ _____
Patient/Parent/Guardian Signature Date

MILLER OPHTHALMOLOGY ASSOCIATES, LLC

Welcome to our practice. Please fill out this form to the best of your ability. (You may use the back of this form if you need additional space.)

NAME: _____ DATE: _____

Ears, nose, or throat (sinus problems)	YES	NO	Describe_____
Cardiac (heart attack/arrhythmia/murmur/angina)	YES	NO	Describe_____
Circulatory (high blood pressure)	YES	NO	Describe_____
Lungs/respiratory (asthma/bronchitis)	YES	NO	Describe_____
Gastrointestinal (ulcers/colitis/Crohn's)	YES	NO	Describe_____
Genitourinary (kidney/prostate problems)	YES	NO	Describe_____
Gynecologic (fibroids)	YES	NO	Describe_____
Skin (basal cell/psoriasis/chicken pox/eczema)	YES	NO	Describe_____
Musculoskeletal (arthritis/joint replacement/)	YES	NO	Describe_____
Neurologic (headache/seizures/Parkinson's/stroke)	YES	NO	Describe_____
Blood or bleeding disorders (Sickle cell trait)	YES	NO	Describe_____
Immunologic	YES	NO	Describe_____
Endocrine (thyroid disease/diabetes)	YES	NO	Describe_____
Cancer	YES	NO	Describe_____
Eye problems (glaucoma/cataracts/macular)	YES	NO	Describe_____
Eye (or eye muscle surgery)	YES	NO	Describe_____
Any medical problems not mentioned	YES	NO	Describe_____

Do you have a history of depression, anxiety or other mental disorder? YES NO

Are you currently experiencing depression, anxiety or other psychological complaints? YES NO

Have you ever been treated by anyone for these symptoms? YES NO

Are you currently being treated with any medication or other forms of treatment for a mental health problem? YES NO

If so, what?_____

Family history of *eye* problems (keratoconus, lazy eye, glaucoma, macular degeneration)? YES NO

Describe_____

Family history of *medical* problems: YES NO

Describe_____

Please list any *eye medications* you are taking: _____

Please list any prescription medications you are taking: (include hormones, birth control pills, etc.):

_____

_____

Please list any nutritional/dietary supplements and/or herbal medications you are taking:

_____

Do you have any allergies to medicine?	YES	NO	Describe_____
Environmental allergies (hayfever, cats, dogs)?	YES	NO	Describe_____
Do you smoke?	YES	NO	If so, how much per day? _____
Do you drink alcohol?	YES	NO	If so, how much per day? _____

Who is your primary physician (name, address, phone): _____

_____

_____

_____

1. Are you aware that we offer laser vision correction (LASIK) to correct nearsightedness, farsightedness and astigmatism? YES NO
2. Would you like to discuss laser vision correction with our technical staff? YES NO
3. Would you like information on LASIK and/or financing to take home? YES NO

FEEL FREE TO BROWSE OUR OPTICAL SHOP

Miller Ophthalmology Associates, LLC
Laser Vision Correction Center of New Jersey

Informed Consent for Optos Retinal Imaging

The Optomap retinal exam is a screening procedure, which eliminates the need for dilation and is or 3rd party insurances. The Optomap ultra-widefield retinal image is a new and unique technology that captures more than 80% of your retina in one panoramic image, while traditional imaging methods typically only show 15% of your retina at one time. Optomap ultra-widefield view helps your eye care practitioner detect early signs of retinal disease more effectively and efficiently than with traditional eye exams.

The benefits of having an Optomap performed are:

- facilitates early protection from vision impairment or blindness,
- facilitates early detection of life-threatening diseases like cancer, stroke & cardiovascular disease
- replaces the need for dilation (in most circumstances.)

Why is a retinal exam so important?

Some of the first signs of diseases such as stroke, diabetes and even some cancers can be seen in your retina, often before you have other symptoms. An optomap makes it easier to see them.

Is an Optomap safe for children?

Yes. In fact, many vision problems begin in early childhood, so it's important for children to receive quality routine eye care.

What is an Optomap?

The Optomap is a panoramic digital image of the retina produced by Optos scanning laser technology. It is the only technology that can show a wide 82% view of your retina at one time.

Does it hurt?

No. It is completely comfortable and the scan takes less than a second.

How will Optomap benefit me?

The ultra-widefield Optomap may help your eye doctor detect problems more quickly and easily. Unlike traditional retinal exams, the Optomap image can be saved for future comparisons.

How often should I have an Optomap?

This is a decision that should be made by your doctor. However, it is generally recommended that you have an Optomap each time you have an eye exam.

Are there side effects?

Optomap images are created by non-invasive, low-intensity scanning lasers. No adverse health effects have been reported in over 50 million sessions.

____ **I give my consent for Optomap retinal screening, instead of dilation.** I understand the fee for this service is **$55.** It is not medically necessary and is not reimbursable by my health insurance company.

____ I **do not give my consent for Optomap** retinal screening; however, **I do consent to dilation.** I understand dilation lasts approximately 4-6 hours and is accompanied by light sensitivity, blurred vision and inability to see clearly at near.

Name (Please Print) Date

Signature Date