STEP 1 • PATIENT INFORMATION

Go to eyegroupms.com, New Patient Center, to complete these forms, download, and email or fax prior to your appointment. If unable to do so, complete FRONT & BACK of each page, email, fax or bring to your appointment.
Email: info@eyegroupms.com Fax : 601.985.0122

Date _____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State ____ Zip _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

SS# _____ Date of Birth _____ Age _____

E-Mail Address _____ Gender [ ] Male [ ] Female

Marital Status [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated

Ethnicity [ ] Hispanic/Latino [ ] Not Hispanic/Latino

Preferred Language [ ] English [ ] Spanish [ ] Other _____

Race [ ] White [ ] Black/African American [ ] Asian [ ] American Indian/Alaska Native
[ ] Native Hawaiian/Pacific Islander [ ] Other _____

Employer _____ Occupation _____

Employer Address _____

Spouse's Name _____ Date of Birth _____ SS# _____

Spouse's Employer _____ Work (___) _____ Cell (___) _____

Emergency Contact Person _____ Phone (___) _____

Referred By [ ] TV [ ] Radio [ ] Yellow Page [ ] Insurance [ ] Website [ ] Brochure [ ] Self [ ] Magazine
[ ] Family [ ] Friend [ ] Patient [ ] Physician Name of Friend, Patient, or Physician: _____

Preferred Communication Method [ ] Mail [ ] Phone [ ] Text Message [ ] Email

(Eye Group will primarily use your preferred method of communication but may occasionally use texting and other methods you provide.)

Please Complete If Patient is Under 18 Years of Age

Mother's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Mother's Employer _____ Work (___) _____ Cell (___) _____

Address (If Different from Above) _____

Father's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Father's Employer _____ Work (___) _____ Cell (___) _____

Address (If Different from Above) _____

Preferred Pharmacy Information

Pharmacy Name _____ Pharmacy Phone _____

Address _____ City _____ State _____ Zip_____

Primary Insurance _____ Policy # _____

Address _____ Group # _____

NOTE: IF THE POLICY IS IN THE NAME OTHER THAN PATIENT PLEASE COMPLETE THE FOLLOWING INFORMATION:

Subscriber/Owner _____ Relation to Patient _____

SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

Secondary Insurance _____ Policy # _____

Address _____ Group # _____

Subscriber/Owner _____ Relation to Patient _____

SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. A copy is included in this packet.

A copy of our **Patient Rights and Responsibilities** is included in this packet. It explains your rights as a patient in the event that an in office or surgical procedure is to be performed.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from: Privacy Officer, Eye Group, 501 Baptist Drive, Suite 220, Madison, MS 39110.

By signing this form, you acknowledge that you have reviewed our **Notice of Privacy Practices** and our **Patient Rights and Responsibilities,** and have no further questions regarding these forms.

Patient or Responsible Party Signature _____ **Date**_____

Please complete the FRONT AND BACK of each page

Patient Name _____ Date of Birth _____ Date _____

RECORD OF MEDICAL CARE PATIENT HISTORY QUESTIONNAIRE

PAST HISTORY

INSTRUCTIONS: Please answer the following questions about your medical status and history.

Birth Date: _____/_____/_____ Last Medical Exam: _____/_____/_____ Last Eye Exam:_____/_____/_____

Name of Medical Doctor: _____ Medical Doctor's Phone (_____) _____

List any medical conditions (i.e., high blood pressure, diabetes, etc.) that you have had in the past or are currently experiencing. _____

_____

_____

Please complete the attached Medication List form.

Are you currently pregnant or nursing? [ ] Yes [ ] No

Have you ever taken Flomax or generic Flomax (Tamsulosin, Rapiflo)? [ ] Yes [ ] No

Do you currently wear Contact Lenses? [ ] Yes [ ] No Have you ever worn Contact Lenses? [ ] Yes [ ] No
If yes, please list Brand and Strength/power_____

Please bring any eyeglasses or sunglasses that you routinely wear to your visit.

List all major injuries, surgeries, heart attacks, strokes, and/or hospitalizations you have had:
(Include EYE Surgery, Laser, Injury) [ ] None [ ] Yes _____

_____

_____

Mark any of the following that you have / had: [ ] None [ ] Crossed eyes [ ] Lazy eye [ ] Drooping eyelid
[ ] Glaucoma [ ] Prominent eyes [ ] Retinal disease or detachment [ ] Cataracts [ ] Eye infection
[ ] Eye injury [ ] Other _____

Patient Name _____ Date of Birth _____ Date _____

REVIEW OF SYSTEMS

INSTRUCTIONS: Do you currently or have you had any problems in the following areas? (IF YES, please explain.)

Neurologic		**Explain**	
Headaches	[ ] Yes	_____	[ ] No
Stroke	[ ] Yes	_____	[ ] No

Eyes		**Explain**	
Loss of vision	[ ] Yes	_____	[ ] No
Distorted vision	[ ] Yes	_____	[ ] No
Loss of side vision	[ ] Yes	_____	[ ] No
Double vision	[ ] Yes	_____	[ ] No
Dryness	[ ] Yes	_____	[ ] No
Itching	[ ] Yes	_____	[ ] No
Foreign body	[ ] Yes	_____	[ ] No
Eye pain/soreness	[ ] Yes	_____	[ ] No
Seeing flashes	[ ] Yes	_____	[ ] No
Chronic Infections	[ ] Yes	_____	[ ] No

Ear, Nose, Mouth & Throat		**Explain**	
Allergies	[ ] Yes	_____	[ ] No
Sinus Congestion	[ ] Yes	_____	[ ] No
Dry mouth/throat	[ ] Yes	_____	[ ] No
Chronic Cough	[ ] Yes	_____	[ ] No
Hearing Loss	[ ] Yes	_____	[ ] No

Respiratory		**Explain**	
Asthma	[ ] Yes	_____	[ ] No
Emphysema	[ ] Yes	_____	[ ] No
Sleep Apnea	[ ] Yes	_____	[ ] No
CPAP/BiPAP	[ ] Yes	_____	[ ] No

Cardiovascular		**Explain**	
High blood pressure	[ ] Yes	_____	[ ] No
History Heart Attack	[ ] Yes	_____	[ ] No
Pacemaker	[ ] Yes	_____	[ ] No
Defibrillator	[ ] Yes	_____	[ ] No
Taking Blood Thinner	[ ] Yes	_____	[ ] No

Other			
History of Hepatitis	[ ] Yes	_____	[ ] No
HIV/AIDS	[ ] Yes	_____	[ ] No
Shingles	[ ] Yes	_____	[ ] No

Neurologic		**Explain**	
Migraine	[ ] Yes	_____	[ ] No
Ocular migraine	[ ] Yes	_____	[ ] No

Eyes		**Explain**	
Blurred vision	[ ] Yes	_____	[ ] No
Halos/glare	[ ] Yes	_____	[ ] No
Loss of central vision	[ ] Yes	_____	[ ] No
Mucous discharge	[ ] Yes	_____	[ ] No
Sandy/gritty	[ ] Yes	_____	[ ] No
Burning	[ ] Yes	_____	[ ] No
Excess tearing	[ ] Yes	_____	[ ] No
Redness	[ ] Yes	_____	[ ] No
Tired eyes	[ ] Yes	_____	[ ] No
Stye/Chalazion	[ ] Yes	_____	[ ] No

Cancer/Other		**Explain**	
BPH (Benign Prostate Hyperplasia)	[ ] Yes	_____	[ ] No
Prostate Cancer	[ ] Yes	_____	[ ] No
Breast Cancer	[ ] Yes	_____	[ ] No
Other Cancer	[ ] Yes	_____	[ ] No
Chemotherapy/ Radiation/Tamoxifen	[ ] Yes	_____	[ ] No

Bones/Joints/Muscles		**Explain**	
Osteoarthritis (age-related)	[ ] Yes	_____	[ ] No
Rheumatoid Arthritis (autoimmune)	[ ] Yes	_____	[ ] No
Restless Legs	[ ] Yes	_____	[ ] No

Lymphatic/Hematologic		**Explain**	
Anemia	[ ] Yes	_____	[ ] No
Bleeding	[ ] Yes	_____	[ ] No

Endocrine		**Explain**	
Thyroid/other glands	[ ] Yes	_____	[ ] No
Diabetes	[ ] Yes	_____	[ ] No
High Cholesterol	[ ] Yes	_____	[ ] No

Please complete the FRONT AND BACK of each page

Patient Name _____ Date of Birth _____ Date _____

REVIEW OF SYSTEMS (continued)

INSTRUCTIONS: Do you currently or have you had any problems in the following areas? (IF YES, please explain.)

Psychiatric	Explain	Psychiatric	Explain
Depression	[ ] Yes_____ [ ] No	Anxiety	[ ] Yes_____ [ ] No
ADD/ADHD	[ ] Yes_____ [ ] No	Dementia/Alzheimer's	[ ] Yes_____ [ ] No

FAMILY HISTORY

INSTRUCTIONS: Please note any FAMILY history (parents, grandparents, siblings, and/or children – living or deceased) of the following medical conditions:

	Relation		Relation
Blindness	[ ] Yes_____ [ ] No	Lupus	[ ] Yes_____ [ ] No
Crossed eyes	[ ] Yes_____ [ ] No	Cancer	[ ] Yes_____ [ ] No
Macular degeneration	[ ] Yes_____ [ ] No	Heart disease	[ ] Yes_____ [ ] No
Cataract	[ ] Yes_____ [ ] No	Kidney disease	[ ] Yes_____ [ ] No
Glaucoma	[ ] Yes_____ [ ] No	Thyroid disease	[ ] Yes_____ [ ] No
High blood pressure	[ ] Yes_____ [ ] No	Diabetes	[ ] Yes_____ [ ] No
Arthritis	[ ] Yes_____ [ ] No	Loss of central vision	[ ] Yes_____ [ ] No
Retinal Detachment	[ ] Yes_____ [ ] No	Other	[ ] Yes_____ [ ] No

SOCIAL HISTORY

INSTRUCTIONS: Please answer the following questions related to your social history:

	Current			
Tobacco:	[ ] Every day	[ ] Some days	[ ] Former	[ ] Never
Alcohol:	[ ] Every day	[ ] Some days	[ ] Former	[ ] Never
Illegal drugs:	[ ] Every day	[ ] Some days	[ ] Former	[ ] Never
Infection/exposure:	[ ] Every day	[ ] Some days	[ ] Former	[ ] Never

Cataract Evaluation Appointments - Leave contact lenses out prior to your appointment as follows:
Soft Lenses - 7 days Gas Perm/Hard Lenses - 14 days

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensible drugs covered by a particular drug benefit plan.

By signing below I give permission for **Eye Group** and/or **Eye Surgery and Laser Center (ESLC)** to access my pharmacy benefits data electronically through SureScripts.

This consent will enable **Eye Group** and/or **ESLC**:

Determine the pharmacy benefits and drug copays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain your prescription plan information, and/or download the medications that you are taking.

Please Initial only ONE and **Provide your Name and Date of Birth**

_____ Yes, I agree to the above
Initial

_____ No, I do not agree to the above
Initial

Patient Name _____ Patient Date of Birth _____

Patient Name: _____
DOB: _____

Medication List

Last Updated: _____ **Pharmacy:** _____

Current Medications:

Discharge Medications (Office Use Only)

Routinely Taken Medication Name (Includes OTC & Herbs)	Strength/Dose	Frequency	Resume After Surgery	
			Yes	No

(Continue on a Separate Page if Necessary)

Allergies	Reaction

Patient Signature: _____
Date: _____

Physician Signature: _____
Date: _____

Elizabeth Wyatt Mitchell, M.D.
Kevin Kosek, M.D.
Lee E. Moore, M.D.
Kyle Lewis, M.D.
Elliott Browning, M.D.
The Eye Surgery and Laser Center,LLC

PATIENT RIGHTS AND RESPONSIBILITIES

Patient rights and responsibilities are established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his family, his physician, and the facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, cultural, physical handicap or personal value and belief systems.

Standard 1. - That the patient will receive the care necessary to help regain or maintain their maximum state of health and, if necessary, cope with deaths.

Standard 2. - That the facility personnel who care for the patient are qualified through education and experience to perform the services for which they are responsible. The patient has the right to identify the professional status of all individuals providing services to them.

Standard 3. -
That the patient will be treated with consideration, respect, dignity, and full recognition of individuality; including privacy in treatment and in care. Facility personnel will keep adequate records and will treat with confidence all personal matters that relate to the patient.

Standard 4.
That the patient is provided to the extent known by the physician, complete information regarding diagnosis, treatment and prognosis as well as alternate treatments or procedures and the possible risks and side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.

Standard 5.
That the patient or responsible person will be fully informed of the scope of services available in the facility, provisions for after hours and emergency care, payment policies, and related fees for services. The patient will accept personal financial responsibility for any charges not covered by his/her insurance.

Standard 6.
That the patient will be a participant in decisions regarding the intensity and scope of treatment. Circumstances under which the patient may be unable to participate in his/her plan of care are recognized. In these situations, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.

Standard 7.
That the patient will have the right to refuse treatment to the extent permitted by the law and to be informed of the medical consequences of such refusal. The patient will be requested to sign a release of responsibility form and if refused, a registered letter will be sent.

Standard 8.
That plans will be made with the patient and family so that continuing services will be available to the patient throughout the period of need. The plans should be timely and involve the use of all appropriate personnel and community resources.

Standard 9.
That the patient and family are responsible for providing to their caregivers the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, unexpected changes in the patient's condition, medications, including over-the-counter and dietary supplements, any sensitivities or allergies, or any other patient health matter.

Elizabeth Wyatt Mitchell, M.D.
Kevin Kosek, M.D.
Lee E. Moore, M.D.
Kyle Lewis, M.D.
Elliott Browning, M.D.
The Eye Surgery and Laser Center,LLC

Standard 10.
That patient disclosures and records are treated confidentially. That the patient has the right to approve or refuse the release of medical records to any individual outside the facility, except as required by law or third party payment contract.

Standard 11.
That the patient has the right to be informed of any human experimentation or research/educational projects affecting his/her care or treatment and refuse participation in such experimentation or research without compromise to the patient's usual care. The patient also has the right to review this decision periodically.

Standard 12.
That the Surgery Center provides for and welcomes the expression of grievances/complaints and suggestions by the patient at all times. This feedback allows the Center to understand and improve the patients care and environment.

Standard 13.
That the patient has the right to change primary or specialty physicians if other qualified physicians are available.

Standard 14.
That the patient has the right to be free from all forms of abuse or harassment.

Standard 15.
That the patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Standard 16.
That the patient has the right to present an Advanced Directive, living will, or healthcare proxy. These documents express the patient's choices about future care or name someone to decide if the patient cannot speak for himself/herself. The patient who has an Advanced Directive must provide a copy to the Surgery Center and to their physician for their wishes to be made known and honored.

Standard 17.
That the patient has a right to be fully informed before any transfer to another facility or organization.

Standard 18.
That the patient be respectful of the health care providers, staff, and other patients.

Standard 19.
That the patient has a responsibility to observe the prescribed rules of the Surgery Center for their stay and treatment and, if instructions are not followed, forfeits the right to care at the center and is responsible for the outcome.

The Eye Surgery and Laser Center, LLC:

Owner: Lee E. Moore, M.D. and Kevin Kosek, M.D.

Eye Group:
Elizabeth Wyatt Mitchell, M.D
Kevin Kosek, M.D.
Lee E. Moore, M.D.
Kyle Lewis, M.D.
Elliott Browning, M.D.

NOTICE OF PRIVACY PRACTICES

Eye Group and The Eye Surgery and Laser Center, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Effective: June 19,2025

The physicians and staff of Elizabeth W. Mitchell Eye Care, P.A., Kevin Kosek Eye Care, P.A., Ophthalmology Consultants, PLLC. and Eye Surgery and Laser Center, LLC(hereinafter referred to as "Group"), are legally required to protect the privacy of your health information and to abide by the requirements stated in this document. This Notice of Privacy Practices describes our legal duty to protect the privacy of your health information and the policies and procedures this office has in place to do so.

Our office is required to prominently post the most current notice at all times. A copy of the current Notice of Privacy Practices for "Group", will be given to each patient on their first visit. You will be asked to sign an acknowledgement that you received a copy. A copy of this notice will be provided to any individual upon request.
If you need additional information about anything contained in this notice, please contact our Privacy Officer by calling 601-985-9120. We encourage you to ask questions about anything that you do not understand.

"Group" reserves the right to change its Notice of Privacy Practices without advance notice to you and apply the revised Notice of Privacy Practices to your health information. Any changes that are made will be highlighted on the most current Notice of Privacy Practices that is posted in our office so that they are easily recognized. If changes are made to this Notice of Privacy Practices, you will be provided a copy of the revised Notice on your first visit following the revision.

"Group" has policies and procedures to ensure that your health information is protected. These include specific guidelines for how and when your health information is used, when and how it is disclosed, how confidentiality is maintained, who has access to your health information, and when your health information can be shared with others. Our office will use and disclose your health information to provide your care and treatment, bill and collect payment of services received and carry out the routine health care operations of this office. The uses and disclosures include but are not limited to the following:

- *Administrative functions within the office-assembling health information, filing records, scheduling appointments, reminding patients of appointment and other schedule activities, billing and collecting for services*
- *Record creation, documentation and monitoring of your health status*
- *Communication among the workforce of this office, either verbally or in writing, information that is required for them to perform the functions of their job*
- *Consulting with other providers and their workforce, providing health information as required and making referrals*
- *Verifying your benefits and eligibility with your insurance company*
- *Obtaining authorization from your insurance company as required*
- *Calling prescriptions to your pharmacy*
- *Providing health information as needed for scheduling appointments for diagnostic tests, surgery, admission, consultations, home health and other services that you may require*
- *Providing health information to your insurance company as requested for their administrative requirements*

Our office may contact your directly by phone, answering machine, fax, electronically or by mail for any of the following activities:

- *Providing appointment reminders for this office*
- *Scheduling appointments for this office and/or other offices as necessary and providing you with appointment information*
- *Describing or recommending treatment alternatives*
- *Providing pre-test instructions and test results*
- *Providing information about health related benefits and services that may be of interest to you such as classes or education opportunities*

If "Group", needs to treat you in an emergency situation, you will be provided with a copy of the Notice after your emergency has been taken care of and a good faith effort will be made to obtain your acknowledgement of receipt of this Notice.

Your health information may be used and disclosed without your authorization in the following circumstances if you are informed and given the opportunity to agree or object. If you are not present or the opportunity for you to agree or object cannot be provided, we may decide whether the disclosure is in your best interest based on professional judgement.

- *To a family member or other relative, close personal friend, or other person identified by you, the health information relevant to that person's involvement in your care or payment*
- *For suspected child abuse or neglect as required by law*
- *To a public or private organization authorized by law to assist in disaster relief efforts as required by law*

Your health information may be used without your authorization or the opportunity for you to agree or object in the following circumstances as required by law.

- *To the Food and Drug Administration to report adverse events including adverse drug reactions and product defects or problems as required by law*
- *To your employer if you have a work related injury or illness or a workplace related medical surveillance as required by law*
- *To a government authority if you are a victim of abuse, neglect or domestic violence (you must be informed of such a report unless, in the exercise of professional judgement it puts you at risk of serious harm) as required by law*
- *To a health oversight agency as authorized by law including audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary actions as required by law*
- *To law enforcement officials for the purpose of identifying or locating a suspect, fugitive, material witness or missing person as required by law*
- *To law enforcement officials if you are suspected to be a victim of a crime as required by law*
- *To law enforcement officials for a death if we suspect that the death may have resulted from criminal conduct as required by law*
- *To a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law*
- *To a funeral director as necessary to carry out their duties as required by law*
- *To organ procurement organizations engaged in procurement, banking or transplantation of cadaver organs, eyes, or tissue as required by law*

All other uses and disclosures of your health information will require your specific authorization.

You have the following rights regarding your health information:

- *The right to request restrictions on how your health information is used or disclosed. Every effort will be made to honor your request but we are not required to agree to as requested restriction*
- *The right to receive confidential communications of health information*
- *The right to see and receive a copy of your health information*
- *The right to request an amendment or correction to your health information*
- *The right to receive an accounting or list of each time your health information has been disclosed. The first accounting within a twelve-month period is provided at no cost to you. The provider may charge a reasonable cost-based fee for each subsequent request within the twelve-month period.*

If you believe your privacy rights have been violated, you may make a complaint to our Privacy Officer by calling 601-985-9120 or in writing to the office address. You may also make a complaint to the Secretary of Health and Human Services at the address listed below. The complaint must be in writing and contain the name of the physician or office describing the act or omission believed to be in violation and must be filed within 180 days of the incident. You will not suffer a retaliation for filing a complaint.

Secretary of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Please complete the FRONT AND BACK of each page

AUTHORIZED RELEASE OF PERSONAL MEDICAL INFORMATION

Please list family member/others whom our staff may speak with regarding,
but not limited to, your medical information such as:

• Coordination of Care • Billing / Insurance • Scheduling

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Please list any Specific Instructions or Limitations:

_____

_____

_____

This authorization will remain in effect unless request is received by our office in writing.

By signing this form, I authorize the release of my personal medical information to above persons.

Patient or Responsible Party Signature _____ **Date**_____

If you have a Healthcare Power of Attorney, please bring that document with you to your first appointment.

Elizabeth Mitchell Eyecare, P.A.; Kevin Kosek Eye Clinic, P.A.; Lee Moore, M.D., Kyle Lewis, M.D.,
and Elliott Browning, M.D. (Ophthalmology Consultants, PLLC); d/b/a Eye Group | ESLC
Rev 6/2025

IMPORTANT MEDICAL INSURANCE INFORMATION

Eye Group no longer accepts assignment on Vision Plans for new patients.

We have a dedicated billing staff that is available to assist you at your request.
We thank you again for chooosing us to be your eye care provider.

Patient or Responsible Party Signature _____ **Date**_____

SELF-PAY PATIENTS

Self-Pay Patients are required to pay for their Office Visit in FULL on the Day the services are rendered.

Patient or Responsible Party Signature _____ **Date**_____

WINDOW TINTING

The Eye Group Physicians do not write prescriptions for car window tinting.

Please complete the FRONT AND BACK of each page

BILLING AND INSURANCE POLICIES

PLEASE READ AND SIGN:

We look forward to treating your ophthalmic needs. To enable us to best treat you we would like to provide you with our billing and insurance policies as they relate to you.

I request that assignment of my healthcare insurance benefits be made to Drs. Elizabeth Wyatt Mitchell and/or Kevin Kosek and/or Lee Moore and/or Kyle T. Lewis and/or Elliott Browning and/or Eye Surgery and Laser Center, LLC for any services furnished to me. I authorize the release of any medical information necessary to process these claims.

We may require you to have a refraction once a year. Refraction is the test to determine whether you need a prescription for eyeglasses in order to obtain your best vision or if your current glasses need to be updated. This is a necessary part of a thorough eye exam and is not a covered service by insurance. There will be a charge which will be paid at the time of the visit. An eyeglass prescription will not be issued otherwise.

Our policy requires you to present insurance cards (if applicable) at every visit. Every effort is made to verify insurance coverage before services can be rendered. Verification of insurance coverage is not a guarantee of payment by your insurance company. If we are unable to verify your coverage and benefits you may be required to pay in full up front. However, if your insurance company does reimburse for services we will refund you the amount overpaid. **Please note that if your insurance requires an authorization to see a specialist, you will need to call your primary care physician at least 72 hours prior to each appointment. Our office cannot obtain authorization for you.**

As mandated by the federal governemnt, all insurance companies including Medicare require that you, the patient, pay your co-pay/deductible/co-insurance as part of your contract with your insurance company. Failure to do so is a violation of your contract and against the law. Because of this we cannot waive co-pays and deductibles. We require you pay your co-pay/deductive/co-insurance at the time of each appointment.

I agree to pay 1 $^{1}/_{2}$ % of the unpaid past due balances for collection costs, or alternatively the maximum lawful fee, at such time account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court. I give my consent to receive communication from servicers and collectors of my accounts with contact information provided by Eye Group.

Eye Group reserves the right to contact and bill the patient by phone.

Patient or Responsible Party Signature _____ **Date**_____

PLEASE READ AND SIGN:

I understand that there may be a charge for providing me or my representative(s) with copies of my medical records in accordance with the guidelines provided by the MS State Board of Medical Licensure.

I understand that there may be a charge for the completion of forms such as, but not limited to, FMLA, appeals, physicals, workman's compensation, etc. Forms shall be completed within a reasonable time. Forms shall NOT be completed the same day of the request.

If I have a medical problem and seen as a same day work in patient, I may be charged CPT Code 99058. This charge may not be paid by my insurance company.

Eye Group is open daily, Monday through Thursday until 4:30, and until noon on Friday. "Late" is defined as 15 minutes after the scheduled appointment and may result in having to reschedule the appointment. If you need to cancel or reschedule your appointment, please do so 24 hours prior to the appointment. Failure to give proper notice or cancellation may result in assessment of a no show fee. Patients that accrue three no shows may be discharged from the practice.

Requests for copies of medical records and prescriptions will be processed within 3 to 5 days of the request. Requests may be made by either calling, emailing, or through the website/portal.

I understand the Eye Group and/or The Eye Surgery and Laser Center, LLC may use phone texts to contact me for appointments, upcoming events, or education purposes. If I receive a text, I will have the ability to opt out of future texts at that time.

In the event of a security breach or other system wide correspondence that requires my notification, I authorize you to contact me by the email address I have provided to you. I understand that: If I do not have access to email, that I will be informed by phone or mail; That I am responsible for giving you any updates of my email address; and that the Eye Group will not be held responsible if they are unable to contact me if I have not done so.

Eye Group reserves the right to contact and bill the patient by phone.

Patient or Responsible Party Signature _____ **Date**_____

BILLING AND INSURANCE POLICIES

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. A copy is included in this packet.

A copy of our **Patient Rights and Responsibilities** is included in this packet. It explains your rights as a patient in the event that an in office or surgical procedure is to be performed.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from:

Privacy Officer
Eye Group
501 Baptist Drive, Suite 220
Madison, MS 39110

By signing this form, you acknowledge that you have been provided a copy of and have reviewed our **Notice of Privacy Practices** and our **Patient Rights and Responsibilities**, and have no further questions regarding these forms.

Patient or Responsible Party Signature _____ **Date**_____

STEP 3 • FOR CATARACT SURGERY PATIENTS ONLY
LIFESTYLE QUESTIONNAIRE

It is important to make sure we have a complete understanding of your vision needs. This questionnaire will help us recommend treatment options best suited to your unique lifestyle.

Name: _____ Date of Birth: _____ Occupation: _____

What hobbies, outdoor or indoor recreational activities do you enjoy?

AFTER surgery would you be comfortable wearing glasses for the following?

Distance Vision (Driving, Outdoor Activities, Watching TV, etc.)	☐ Yes	☐ No
Intermediate Vision (Computer, Menus, Price Tags, Cooking, etc.)	☐ Yes	☐ No
Near Vision (Phone, Books, Newspapers, Detailed Handwork, etc.)	☐ Yes	☐ No

If you had to wear glasses after surgery, which would you be most comfortable wearing?

☐ Distance Glasses ☐ Intermediate Glasses ☐ Near Glasses

Please check the single statement that best describes you in terms of night vision:

___ Night vision is extremely important to me, and I require the best possible quality night vision.

___ I want to be able to drive comfortably at night, but I would tolerate slight imperfections.

___ Night vision is not particularly important to me.

Would you be okay wearing glasses for the following activities?

Reading Books or Newspaper	☐ Yes	☐ No	Shaving your face	☐ Yes	☐ No
Reading Medicine Labels	☐ Yes	☐ No	Putting on makeup	☐ Yes	☐ No
Looking at your phone	☐ Yes	☐ No	Knitting/needlepoint	☐ Yes	☐ No
Looking at your watch	☐ Yes	☐ No	Card or table games	☐ Yes	☐ No
Using a handheld tablet	☐ Yes	☐ No	Using a computer	☐ Yes	☐ No
Outdoor activities (Golfing, Hunting, Sports, etc.)	☐ Yes	☐ No	Watching TV	☐ Yes	☐ No

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STEP 3 • FOR CATARACT SURGERY PATIENTS ONLY
PATIENT PRE-SURGICAL QUESTIONNAIRE

Patient Name_____

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 hallows around lights?	☐	☐
3. Glare caused by headlights or bright sunlight?	☐	☐
4. Hazy and/or blurry vision?	☐	☐
5. Seeing well in poor or dim light?	☐	☐
6. Poor color vision?	☐	☐
7. Double vision?	☐	☐

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STEP 3 • FOR CATARACT SURGERY PATIENTS ONLY
PATIENT PRE-SURGICAL QUESTIONNAIRE

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 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 anymore, 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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Cataract Surgery Intraocular Lens (IOL) Options

- Cataract surgery is high-tech, quick, effective, and safe.
- Advanced technology has increased the precision and safety of surgery.
- The lenses used in modern cataract surgery provide many options for your vision. Learning as much as you can about these options prior to your examination helps to ensure you get the results you desire.
- Patients should choose a lens based on their lifestyle needs and how much independence from glasses they want.
- The standard lens is the conventional monofocal lens.
  - **Conventional Monofocal Lens**
    - Corrects vision for distance or near but not both. Does not correct astigmatism.
    - Patients will need glasses to correct for astigmatism and for reading.
    - Included with insurance coverage
- **Premium lenses** are also available. A brief review of these lenses is included on the back of this page.
- You can also visit our website for any additional information on the lenses or contact our office with any questions.
  - https://www.eyegroupms.com/lens-options-for-cataract-surgery

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STEP 3 • FOR CATARACT SURGERY PATIENTS ONLY
INTRAOCULAR LENS (IOL) OPTIONS

Premium Lens Options – additional out-of-pocket cost

Toric Lens

- Corrects distance vision **AND** astigmatism
- Astigmatism is a common cause of decreased vision caused by an irregularly shaped cornea.
- Patients will still need reading glasses.

Multifocal Lens

- Gives vision for distance, intermediate, and near
- Available in a toric option for astigmatism.
- Provides greatest glasses independence at all distances
- Most patients **DO NOT** need glasses for any distance when using this lens, but may need glasses for the most demanding visual things.
- With this lens design, patients may notice non-disruptive halos around lights at night.

RxSight® Light Adjustable Lens

- Latest, most advanced IOL allowing customization **AFTER** surgery
- Corrects astigmatism
- Preferred lens in patients with previous monovison
- Preferred lens in patient with previous LASIK or RK surgery.
- Patients are 2x as likely to achieve 20/20 distance vision at six months compared to those using the conventional IOL.
- Gives the ability to "try out" vision and make changes up to 3x before locking in the final vision

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