VISIONARY EYECARE & SURGERY, INC.
Mason F. Bias, M.D., F.A.C.S.

Patient Name _____

Vision and Lifestyle Questionnaire

Thank you for selecting our practice for your cataract care. An important first step in your cataract treatment is this Vision and Lifestyle Questionnaire. This will help us understand what is most important to you and assist us in recommending the lens implant that best suits your lifestyle and eye health. Please fill this form out completely. We will review it with you during your visit.

1. Would you like to reduce dependence on glasses or minimize their wear after your cataract procedure?
   □ Yes □ No

2. What is your occupation? _____

3. What activities do you regularly enjoy? *(please check all that apply)*

   □ Reading □ Sewing □ Computer □ Playing Cards □ Golfing □ Hunting

   □ Shopping □ Cooking □ Driving □ Sporting Events □ TV/Movies

   □ Other _____

4. Is driving at night a significant concern for you now or after your procedure? □ Yes □ No

5. Do you plan on doing a significant amount of night driving after your cataract procedure? □Yes □ No

6. Which tasks would you prefer to be able to do or see after surgery <u>*without glasses*</u>? ***(Choose only one)***

   □ Near activities (ie; reading, sewing, card playing)

   □ Intermediate activities (ie: shopping, computer, cooking)

7. Are you willing to pay a small additional amount out of pocket for the ability to reduce your dependence on glasses? □ Yes □ No

Thank you for completing this short questionnaire. We greatly appreciate your decision to trust us with you cataract care, and sincerely hope that you will recommend our services to your family and friends!

_____ _____
Patient Signature *Date*

At Visionary Eyecare & Surgery, our mission is your vision!

12855 North Outer Forty Drive, Suite 260, South Tower
St. Louis, MO 63141 (314) 983-9800 Toll Free: (877) 983-9807

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VISIONARY EYECARE & SURGERY, INC.
Mason F. Bias, M.D., F.A.C.S.

INFORMATION ABOUT REFRACTIONS & WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, *but they typically do not cover the eye service called "refraction*".

What is Refraction?

Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

When Does Insurance NOT Pay for a Refraction?

Most health insurance was not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs, and most private policies will not pay for refraction. Almost all insurance payors consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

When DOES Private Insurance Pay for Refraction?

Most health insurance will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, refraction will be performed as part of your eye evaluation. Refraction in this instance is necessary to learn your eye's best vision capability at the time of the examination. That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated. ***It is a necessary part of the exam for both medical and legal purposes*.** In this case, it is possible that the refraction may be covered by your insurance. **However, Medicare typically will not cover refraction under any circumstances.**

Who Has Made This Distinction for Insurance Coverage?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

What is Our Policy?

At Visionary Eyecare & Surgery Inc., we are dedicated to providing our patients with the very best medical and surgical eyecare in the region. Therefore, a refraction will be performed when medically necessary (typically *this includes all new patients, those presenting with decreased vision, and on a yearly basis thereafter*). Additionally, we are happy to perform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.

Our fee for the refraction is **$40.00**, and is collected at the time of your visit, in addition of any co-payments or deductible due for the medical portion of your examination.

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. The co-payment and deductible are separate from and not included in the refraction fee.

_____ _____

Patient Signature or Signature of person acting on patient's behalf *Date*

At Visionary Eyecare & Surgery, Our Mission is Your Vision!

12855 North Outer Forty Drive, Suite 260, South Tower
St. Louis, MO 63141 Phone: 314-983-9800 Fax: 314-983-9873

Patient Information (Please Print)			**Date**:
Patient Name:			
Social Security Number:	Date of Birth:	Age:	Sex:
Address:			County:
City:	State:		Zip:
Home Phone:	Cell Phone:		
Marital Status: ☐ Divorced ☐ Married ☐ Widowed ☐ Life Partner ☐ Single ☐ Other_____	Race: ☐ Asian ☐ Caucasion ☐ Native Indian ☐ African American ☐ Hispanic ☐ Other_____		
Primary Language: ☐ English ☐ Other _____ ☐ Spanish	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown or Not Reported		
Employer:	Occupation:		
Employer Address:	Work Phone:		
E-mail Address:			
Spouse's Name:	Date of Birth:		
Spouse's Social Security Number:	Employer:		
Spouse's Work Phone:			
Person Responsible for Payment (if other than self):			
Relationship:	Date of Birth:	Phone:	
Address:	Social Security Number:		
Family Physician:	Optometrist:		
Family Physician Address:			
Family Physician's Phone / Fax #	Optometrist's Address/ Phone		
Pharmacy Name	Pharmacy Address/Phone/ Fax #		
Whom May We Thank for Referring You?			

VISIONARY EYECARE & SURGERY, INC.

Patient Name _____ Date _____

Do you wear glasses? ☐ YES ☐ NO **Do you wear contacts?** ☐ YES ☐ NO

Have you ever been told by a doctor that you have:

☐ Glaucoma ☐ Cataracts ☐ Lazy/Crossed Eye ☐ Macular Degeneration ☐ Retinal Detachment

☐ Other: _____

Have you ever had any surgery on your eyes? ☐ YES ☐ NO

What type, on which eye and when? _____

Do you use any eye drops? ☐ YES ☐ NO **Please list name of drop, which eye you use it in and how often you use it -** _____

Have you ever been told by a doctor that you have:

☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Arthritis
☐ Heart Disease ☐ Migraines ☐ Kidney Disease ☐ Rosacea
☐ COPD ☐ Asthma ☐ Pulmonary Disease ☐ Liver Disease
☐ Seasonal Allergies ☐ Cancer – Type: _____ ☐ Other: _____

Have you had any surgeries, other than on your eyes? If YES, what type and when? _____

_____

_____

List ALL medications you take on a regular basis: ***Please include dosage & milligram information***.

_____ _____

_____ _____

_____ _____

_____ _____

Are you ALLERGIC to any MEDICATIONS or LATEX? ☐ YES ☐ NO **If YES, which ones?** ___
_____

Has anyone in your family been told they have:

☐ Glaucoma Who? _____ ☐ Heart Disease Who? _____

☐ Cataracts Who? _____ ☐ Diabetes Who? _____

☐ Crossed/Lazy Eye Who? _____ ☐ Cancer Who? _____

☐ Macular Degeneration Who? _____

Do you smoke? ☐ YES ☐ NO **How much?** _____ **For how long?** _____

Do you consume alcohol? ☐ YES ☐ NO **How much?** _____

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VISIONARY EYECARE & SURGERY, INC

Patient Name _____ Date _____

REVIEW OF SYSTEMS

Do you currently experience any of the following on a daily basis?
PLEASE circle "Y" or "N" for each item.

GENERAL/CONSITUTIONAL

Headaches	Y	N
Fatigue	Y	N
Insomnia	Y	N
Fever	Y	N

ENT

Hearing loss	Y	N
Ringing in the ears	Y	N
Sinus problems	Y	N
Vertigo	Y	N

RESPIRATORY

Shortness of Breath	Y	N
Wheezing	Y	N

CARDIOVASCULAR

Chest pain	Y	N
Heart palpitations	Y	N

GASTROINTESTINAL

Heartburn	Y	N
Nausea	Y	N
Constipation	Y	N
Diarrhea	Y	N
Abdominal pain	Y	N

GENITOURINARY

Urinary urgency/frequency	Y	N
Blood in urine	Y	N

INTEGUMENTARY

Skin rash	Y	N
Hives	Y	N

ENDOCRINE/IMMUNOLOGIC/LYMPHATIC

Increased thirst	Y	N
Increased urination	Y	N
Bleeding	Y	N
Bruising	Y	N

NEUROLOGICAL/PSYCHOLOGICAL

Fainting	Y	N
Tremors	Y	N
Dizziness	Y	N
Seizures	Y	N
Low mood	Y	N
Irritability	Y	N

MUSCULOSKELETAL

Joint pain	Y	N
Muscle pain	Y	N
Night cramps	Y	N

May I be represented by an attorney of my choice?
Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrators will hear the facts and decide the case whether or not the parties are represented by attorneys.

What does arbitration cost?
In general, the arbitration process is less expensive than court actions. However, arbitrators are paid a fee on an hourly basis, and the amount of the fee depends on the complexity and length of the case and the overall amount of time expended by the arbitrators. The arbitrators' fees are to be shared equally by the parties.

If either party does not like the arbitration result, could there still be a jury trial in court?
Generally, the answer is "no." The whole purpose of arbitration is to avoid the expense, time, delay and inconvenience of going to court. Arbitration awards may be appealed to a court, but they may be overturned only under extremely limited circumstances.

Do I really have a choice?
Yes. You are not required to sign the agreement. If you do sign the agreement and change your mind, you can cancel the agreement by giving written notice to your Provider within seven (7) days after the date you sign the agreement. If you do sign the agreement and do not cancel it within that seven (7) day period, then you and the Provider will be bound by the agreement for the course of, and for any disputes or controversies relating to, your treatment by the Provider.

What if I have other questions?
If you have any questions about the agreement, we would urge you to contact your personal attorney. You are also free to speak with the Provider or the Provider's Professional Liability carrier about any questions you may have.

The undersigned hereby acknowledges that he or she has read this Patient Introduction carefully, has received this Patient Introduction in connection with the Provider–Patient Voluntary Arbitration Agreement, and has obtained a copy of the Patient Introduction and the Provider–Patient Voluntary Arbitration Agreement.

_____ _____

Signature Patient Name (print)

_____

Date

A signed copy of this document is to be given to the patient.
Original is to be filed in the patient's medical record.

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Prior to signing this document, Patient may confer with Provider in order to request any change or modification to the provisions of this document. Patient is encouraged to notify Provider of any provision Patient disagrees with and Patient and Provider may amend any provision in writing which both agree to change. This Arbitration Agreement contains the entire agreement of the parties with respect to the resolution of disputes between the undersigned Patient and Provider.

If Patient intends this Arbitration Agreement to cover services rendered before the date it is signed (for example, emergency treatment), Patient should initial below.

Effective as of the date of first medical services. _____
Patient's initials

THE UNDERSIGNED ACKNOWLEDGE THAT EACH OF THEM HAS READ THIS ARBITRATION AGREEMENT AND UNDERSTANDS THAT BY SIGNING THIS ARBITRATION AGREEMENT, EACH HAS WAIVED HIS OR HER RIGHT TO A TRIAL, BEFORE A JUDGE OR A JURY, AND THAT EACH OF THEM VOLUNTARILY CONSENTS TO ALL OF THE TERMS OF THIS ARBITRATION AGREEMENT.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

"PROVIDER"

Visionary Eyecare & Surgery, Inc.
Company Name

_____
Signature of Authorized Representative

_____
Signature of Physician

Mason F. Bias, M.D., F.A.C.S.
Physician Name

Translated by (if applicable):

_____
Signature Date

_____
Print Name

"PATIENT"

_____
Patient's Name

_____
Signature of Patient Date

_____
Name of Patients Agent or Representative

_____
Relationship to Patient

_____
Signature of Agent or Representative

A signed copy of this document is to be given to the patient.
Original is to be filed in the patient's medical record.

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AGREEMENT

For and in consideration of the medical care and services provided by Mason F. Bias, M.D., F.A.C.S. and the agents, employees, associates, staff members, partners, officers, directors, shareholders, proprietors or equity owners of Visionary Eyecare & Surgery, Inc. (collectively referred to as the "Provider") to the undersigned, the undersigned agrees that in the event there shall be a claim, dispute or disagreement pertaining to the provision of medical care, or lack of medical care, including any claim of negligence (meaning the failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of Provider's profession) by or on behalf of Provider or any agent, employee, associate, staff member, partner, officer, director, shareholder, proprietor or equity owner of Provider, the undersigned agrees that in such event: (i) prior to making any claim against Provider or any person included within the term Provider, the undersigned shall obtain a signed affidavit from a Missouri-licensed medical doctor practicing and board certified in the subspecialty of the medical services which are the subject of the claim, stating that the Provider was negligent (as defined above) in providing medical care, and deliver such affidavit to Provider, and (ii) each and every expert witness testifying in any proceeding on the undersigned's behalf shall be a Missouri-licensed medical doctor practicing and board certified in the subspecialty of the medical services which are the subject of the claim.

_____
Patient Signature

_____
Date

A signed copy of this document is to be given to the patient.
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VISIONARY EYECARE & SURGERY, INC.

Mason F. Bias, M.D., F.A.C.S.

Privacy Notice Receipt, Signature on File, Assignment of Benefits, Financial Agreement

_____

Patient Name (*print*)

HIPAA Notice of Privacy Practices: I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Visionary Eyecare & Surgery, Inc., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Medicare/Medigap: I request that payment of authorized Medicare and/or Medigap benefits be made on my behalf to Visionary Eyecare & Surgery, Inc., for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents and to the insurer or agency of the Medigap policy any information needed to determine these benefits payable for related services. Visionary Eyecare & Surgery, Inc. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Release of Information: Visionary Eyecare & Surgery, Inc. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Visionary Eyecare & Surgery, Inc. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Visionary Eyecare & Surgery, Inc. may also disclose on any anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Other Insurance: I understand that Visionary Eyecare & Surgery, Inc. maintains a list of health care service plans with which it contracts and a list of plans is available from the business office. Visionary Eyecare & Surgery, Inc. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charge of all services rendered to me by Visionary Eyecare & Surgery, Inc. if I belong to a plan that does not appear on the above mentioned list.

Non-Covered Services: I understand that Visionary Eyecare & Surgery, Inc.'s contracts with health care service plans relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered.

A signed copy of this document is to be given to the patient.
Original is to be filed in the patient's medical record.

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Assignment of Benefits: I request that payment of insurance benefits be made to Visionary Eyecare & Surgery, Inc. or Mason F. Bias, M.D., for any services furnished me by that provider. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Visionary Eyecare & Surgery, Inc.

I agree that in the event I receive any check, draft or other payment subject for services provided me by Visionary Eyecare & Surgery, Inc. that I will immediately deliver said check, draft or payment to Visionary Eyecare & Surgery, Inc., who will apply the proceeds from the check, draft or payment to my account for the services rendered.

Financial Agreement: I realize that all medical and surgical charges incurred by me or my dependents for services rendered by Visionary Eyecare & Surgery, Inc. are my financial responsibility. In the event of any default in the performance of this agreement, all amounts due Visionary Eyecare & Surgery, Inc. shall become immediately due and payable. Should this account be placed with an attorney for collection, I agree to pay the collection expenses and reasonable attorney's fees. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

_____ _____

Patient Signature or Authorized Party Date

_____ _____

Witness Date

A signed copy of this document is to be given to the patient.
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VISIONARY EYECARE & SURGERY, INC.
Mason F. Bias, M.D., F.A.C.S.

Pre-Surgical Cataract Patient Questionnaire

Patient Name (printed): _____

** Please check the following activities you have difficulty with or symptoms you experience, even with glasses:

- ❒ Reading small print, such as medicine labels, telephone books, newspaper or a book.
- ❒ Doing fine handwork like threading a needle, sewing or carpentry.
- ❒ Reading traffic or street signs or recognizing someone's face from across the street.
- ❒ Writing checks or filling out forms.
- ❒ Watching television.
- ❒ Seeing halos or starbursts around lights at night.
- ❒ Glare caused by headlights or bright sunlight.
- ❒ Seeing well in poor or dim light.
- ❒ Double vision, hazy and/or blurry vision, or poor color vision.

1) How much difficulty do you have driving during the day because of your vision?
❒ Little difficulty ❒ Moderate amount of difficulty ❒ Great deal of difficulty

2) Insurance will pay for Cataract Surgery, but only when BOTH the doctor and you, the patient, are in agreement that your vision is limited by the presence of a cataract. The doctor will examine you today and document his opinion. Do **YOU** feel that your vision has become bad enough to warrant surgery?
❒ Yes ❒ No

Patient Signature: _____ Date: _____

At Visionary Eyecare & Surgery, our mission is your vision!

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VISIONARY EYECARE & SURGERY, INC.

Mason F. Bias, M.D., F.A.C.S.

AUTHORIZATION FORM FOR DISCLOSURES TO FAMILY MEMBERS, CARE GIVERS AND OTHERS PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to share PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of information to be disclosed to your specified relatives, care givers, or others: Diagnosis, treatment, test results, follow-up recommendations, and billing information.

The Practice employees and doctors may disclose this information.

Individuals who may receive and use the disclosed information:

Name	Relationship	Name	Relationship
1)_____	_____	2)_____	_____
3)_____	_____	4)_____	_____

This authorization will remain effective until revoked or replaced by the patient.

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Office Manager of the Practice.

_____	_____	_____
Patient Signature/Representative	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date

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