

**PLEASE FILL OUT  
EVERY PAGE IN THE  
NEW PATIENT  
PACKET. IF YOU  
DON'T KNOW PLEASE  
PUT N/A YOUR  
PRIMARY DOCTOR IS  
NEEDED. ON THE LAST  
PAGE PLEASE INITIAL  
EACH LINE AND SIGN  
AND DATE.**

## Northlake Eye Center

### Patient Information and Insurance Information

PATIENT INFORMATION: **\*\*\*PLEASE FILL OUT EVERY SECTION, IF IT DOES NOT APPLY PLEASE FILL IN N/A\*\*\***

M F  TITLE _____  RACE _____	NAME _____  ADDRESS _____  ZIP _____ CITY/STATE _____
PREFERRED PHONE _____  OTHER PHONE _____  EMAIL _____  EMERGENCY CONTACT _____  EMERGENCY CONTACT # _____	MARITAL STATUS _____  BIRTHDATE _____  SSN# _____  Ethnicity HISPANIC or NON HISPANIC  Preferred Language: _____
EMPLOYER _____ PRIMARY DOCTOR _____	
_____	
HOW DID YOU LEARN ABOUT US? _____	

RESPONSIBLE PARTY:  CHECK BOX IF SAME AS ABOVE

NAME _____  ADDRESS _____  ZIP _____ CITY/STATE _____  PHONE _____ EMAIL _____	M F TITLE _____  BIRTHDATE _____  SSN# _____
EMPLOYER _____ EMPLOYMENT STATUS: FT PT RETIRED	
_____	_____
<b>GUARANTOR</b> _____  ADDRESS _____  ZIP _____ CITY/STATE _____	SS# _____  DOB _____  RELATIONSHIP _____

ARE YOU ON HOSPICE    Y    OR    N

If you require a REFERRAL, you must have it prior to seeing the doctor. We will submit your claims using the insurance information we have on file the day of service. If you want us to ONLY bill your vision insurance AND NOT your medical insurance you must let us know before you see the doctor. Once a claim is submitted it will not be resubmitted to a different insurance company.

**FILL OUT ALL SPOTS. PUT N/A IF YOU DO NOT KNOW**

**Past Medical History (Please Circle All That Apply)**

Diabetes	Stroke	Sickle Cell	Epilepsy
Hypertension	Cancer-Type _____	Ulcerative Colitis	Nutritional Deficiency
Heart Disease		Depression/Anxiety	Headache/Migraines
Heart Stent or Pacemaker	HIV/AIDS	Skin Condition	Hearing Disorder
Heart Attack	Hepatitis	Lupus	Vocal Problem
High Cholesterol	Alcoholism	Rheumatoid Arthritis	Smelling Defect
Graves Disease	Asthma	Thyroid Disease/Graves	Tasting Defect
Blocked Carotid Artery	Lyme Disease	Organ Transplant	Liver Disease
Temporal Arteritis	Arthritis	Parkinson's	
Anemia	Gall Bladder Disease	Multiple Sclerosis	
A-fib	GERD	Kidney Failure/Dialysis	
Premature Birth	Dementia/Alzheimer's	COPD	
Birth Defect	Sleep Apnea/Machine	Myasthenia Gravis	

Please List any Other Medical or Surgical History:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you drink alcohol? Y N How Often? \_\_\_\_\_

Do you smoke: Y N Former

When was your last comprehensive eye exam? \_\_\_\_\_

**Past Ocular History (Please Circle all that apply.)**

Cataracts Surgery? Year _____	Iritis/Uveitis	Double Vision	LASIK
Glaucoma Surgery ? Year _____	Eye Turns In/Out	Dry Eye Syndrome	Year _____
Diabetic Retinopathy Laser/Surgery ?	Surgery? Year _____	Retinal Detachment	PRK
Macular Degeneration Laser/Injects ?	Facial Palsy	Eye/Year _____	Year _____
Lazy Eye	Eyelid Tumor	Retinal Tear	RK
Retinal Vein Occlusion (stroke in eye)	Eyelid Cancer	Eye/Laser? _____	Year _____
Retinal Artery Occlusion	Droopy Eyelid	Tear Duct Disorder	Cosmetic Face Surgery
Severe Eye injury	Cancer in Eye	Floaters	Corneal Surgery
	Facial Pain	Flashes of Light	Eye/Year _____
	Conjunctivitis(Pink Eye)	Night Blindness	
	Orbital Tumor/Disease	Total Blindness	
	Optic Neuritis	Color Blindness	
	Optic Nerve Damage		



**NORTHLAKE EYE CENTER, APMC**

Andrew Benson, MD  
Terry Hemelt, MD  
Jessica Fawer, OD  
2243 Gause Boulevard East  
Slidell, Louisiana 70461

(985) 643-6355

**NEW CONTACT LENS FITTING INFORMATION**

Please fill in "N/A" if not interested \_\_\_\_\_

**Fitting Fee for New Contact Lens Fit**

- Soft (Includes Spherical and Toric).....\$150
- Soft Progressive and Monovision.....\$200
- RGP (hard lens).....\$250

THESE ARE FITTING FEES ONLY AND DO NOT INCLUDE THE COST OF THE LENSES.

LENS FEES VARY BY TYPE AND BRAND.

**FITTING INCLUDES:**

- Initial evaluation with trial lenses
- Unlimited trial lenses during the fitting period up to 90 days
- Unlimited Contact Lens exams for 90 days
- 45 min – 1 hour of instruction time (insertion, removal and cleaning)
- Contact Lens cleaning starter kit (while supplies last)

**REFUND POLICY**

- Initial Fitting.....\$100.00 (non-refundable)

\*\*\*Refund period ends 90 days after the initial fitting date

\*\*\*Contact Lens prescriptions expire after 12 months. A **comprehensive eye exam** is required annually. A **contact lens follow up exam (\$60)** must be completed yearly to renew contact lens prescriptions. Both exams may be performed at the same visit and will incur separate charges.

**I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICY:**

PRINT

SIGN

DATE

\*This policy will be superseded by the benefits of your vision plan if applicable.

**NORTHLAKE EYE CENTER, APMC**

2243 Gause Blvd E.  
Slidell, LA 70461  
(985) 643-6355  
Terry Hemelt, MD  
Martine Domangue, MD  
Jessica Fawer, OD

**DO YOU HAVE ROUTINE AND MEDICAL INSURANCE?**

**PLEASE READ VERY IMPORTANT**

**\*\*PLEASE READ THIS CAREFULLY SO THAT WE WILL FILE YOUR CLAIM WITH THE CORRECT INSURANCE COMPANY\*\***

Many patients have both routine and medical insurance plans. At Northlake Eye Center, we can accept and file to either your routine or medical insurance plan, but not both. It is **EXTREMELY** important that you inform us which insurance plan you would like us to file your claim with. It is also important to understand that there are some potentially vision threatening eye conditions that may be identified during your eye exam. Most of these conditions require additional testing that can be done on today's visit. These additional tests **ARE NOT** covered by your vision insurance plan, **HOWEVER**, they **ARE** covered by your medical insurance. Therefore, if you plan to have us file to your vision plan and you don't want us to do any additional testing you must let us know in advance below. Please read the three choices below and place your initials in the box to indicate how you would like us to proceed.

**CHOOSE ONLY 1 BOX!!!!**

- I DON'T HAVE VISION INSURANCE. USE MY **MEDICAL INSURANCE** TODAY.
- USE MY ROUTINE EYE INSURANCE **UNLESS** THE DOCTOR NEEDS TO DO ADDITIONAL TESTING THEN **USE MY MEDICAL INSURANCE ONLY.**
- FILE ROUTINE FOR EXAM AND MEDICAL FOR TESTING.
- FILE ROUTINE ONLY, I DON'T HAVE MEDICAL INSURANCE
- I DON'T HAVE ANY INSURANCE; I WILL PAY FOR MY EXAM MYSELF.

PLEASE FILL IN THE **MAIN REASON FOR YOUR VISIT** WITH US TODAY:

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NAME

SIGNATURE

DATE

NORTHLAKE EYE CENTER / SURGICAL EYE ASSOCIATES  
IMPORTANT POLICIES

\*\*\*\*\*PLEASE READ AND INITIAL **EVERY** LINE ITEM. THESE POLICIES MAY AFFECT THE **AMOUNT YOU OWE** AT THE END OF YOUR VISIT\*\*\*\*\*

\_\_\_\_\_ **3% CONVENIENCE FEE** for all debit/credit card transactions.

\_\_\_\_\_ **REFRACTION FEE (\$35)** this fee will be collected at the end of your visit if you receive a prescription for eyeglasses. If we have experience with your insurer that they will cover this fee, we will file the claim and **you will not be expected** to pay this fee at the time of your visit. You will be billed at a later time if your insurance company denies coverage for any reason.

\_\_\_\_\_ **CONTACT LENS UPDATE FEE (\$60)** if you wear contact lenses that are managed by our doctors, you will be charged this fee no more than once a year. This fee is for the service provided by your doctor to insure that you have the correct prescription and the proper fit. This fee is waived for initial fittings. See the contact lens pricing sheet for further details. If you wear contact lenses and you are having them updated elsewhere please let us know so we do not charge you and please remove them from your eyes prior to your visit. If you plan to take advantage of this service you may leave your contact lenses in.

\_\_\_\_\_ **NSF Check fee (\$30)** this fee and the amount of the check must be paid in cash. Future payments will require payment by cash, debit or credit card.

\_\_\_\_\_ **PAYMENT FOR SERVICES PROVIDED IS EXPECTED AT TIME OF SERVICE. We will collect all co-pays, co-insurance, deductibles and non-covered services at the time of you visit.** We will file your claim with your insurance company on your behalf. **IT IS YOUR RESPONSIBILITY:** 1. To provide accurate insurance information to our staff 2. Provide accurate secondary insurance information to our staff 3. Provide us with any vision insurance plan information. 4. Inform us which insurers you would like us to file or not file with. 5. If required, know the status of your referral and provide us with an up to date referral for the date of your service. Failure to provide this information will result in you having to pay for your visit in full if your claim is denied by your insurance company. 6. Pay any outstanding balances in a timely manner.

\_\_\_\_\_ **FAILURE TO PAY** your bill in a timely manner will result in us turning your past due account over to a third party collection agency. We do not have the resources to run our own collection agency.

\_\_\_\_\_ **SPECIALTY CATARACT SURGERY LENSES** have additional costs which your surgeon will discuss with you. If you choose one of these lenses, payment is expected prior to surgery. **Standard cataract surgery lenses** do not incur additional fees.

\_\_\_\_\_ **SELF PAY/FEEs NOT COVERED BY INSURANCE.** These fees are expected to be paid prior to surgery or at the time of service.

\_\_\_\_\_ **OUTSTANDING BALANCES.** These must be paid in full before being seen by the doctor. No contact lenses will be ordered until these obligations have been met.

\_\_\_\_\_ **HIPPA ACKNOWLEDGEMENT.** You have been given an opportunity to review/receive a copy of this practices privacy policies.

NAME: \_\_\_\_\_ WITNESS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_