Dr. Jane Kokinakis
Board Certified Ophthalmologist

Dr. Garrett Webster
Ophthalmologist

Beaufort Eye Center

Specializing in Adult Eye Disease & Surgery

Let There Be Sight

Dr. Perin Diana
Board Certified Ophthalmologist

Welcome to the Beaufort Eye Center! We appreciate your selection of our office for your complete eye care.

New patient appointments usually take 1 to 2 hours. As part of a thorough new patient exam, your eyes will be dilated unless medically contraindicated. Most people are able to drive following dilation, but you may want to bring a driver if you have experienced problems driving after dilation in the past or if your eyes have never been dilated. Please bring your sunglasses with you to your appointment. We can provide disposable sunglasses if you do not have any.

For your convenience, we are enclosing the new patient information packet. By filling these forms out ahead of time, you will save significant time at the beginning of your visit. If you have any questions when filling out these forms, our staff will be happy to assist you with these questions on the day of your visit.

At the time of your appointment, please bring your completed forms, insurance card(s), and picture ID. If you wear glasses, please bring them to your appointment as well as a list of any medications you may be taking. In addition, contact lens wearers should bring boxes from the contact lenses currently being worn or the written contact lens prescription if possible. Please be mindful that our doctors are ophthalmologists and do not fit for contact lens but are able to prescribe them.

Payment is due at the time services are rendered. We participate with many major health insurance plans. For these plans, co-payments, deductibles, and coinsurance will be collected at the time of service. Payment in full is requested at the time of the visit for patients on insurance plans with which we do not participate, or patients who are self- pay. We accept cash, checks, Discover, MasterCard, Visa and American Express.

Our doctors are ophthalmologists and are considered specialist doctors. Patients with a plan that requires a referral from a primary care doctor in order to see a specialist should contact their doctor and obtain a referral prior to their visit. Referrals can be faxed to 843-521-4538.

If you have any questions, please call us at 843-522-8466.

Thanks again for selecting our office for your complete eye care. We look forward to seeing you soon.

Dr. Jane Kokinakis

Dr. Perin Diana

Dr. Garrett Webster

1664 Ribaut Rd. Port Royal, SC 29935 Tele (843) 522-8466 Fax (843) 521-4538

BEAUFORT EYE CENTER
DR. JANE KOKINAKIS / DR. PERIN DIANA / DR. GARRETT WEBSTER

Patient Name: _____ Date of Birth: ____/____/____
Social Security Number:_____ Age: _____ Sex: M / F
Mailing Address: _____ City: _____ State: _____ Zip:_____
Home Phone: (____)_____ Cell Phone: (____)_____
Email Address:_____
Marital Status: Single Married Widow Divorced
Employer Name: _____ Job Title: _____
Are you retired: Y / N Work Phone (____)_____
Emergency Contact Name: _____ Relationship: _____ Phone: _____

Please circle:
May we contact you and send appointment reminders via text message? Yes No
May we video conference with you if needed? Yes No
If so, please list your telephone number _____
Do you have an Android or an I Phone? Android I Phone

Do You Have Medical Insurance: Y / N
Primary Insurance: _____ **Member ID #:** _____
Secondary Insurance: _____ **Member ID #:** _____

If your insurance is through your spouse, we will need the information below to process your insurance claim(s).

Spouse Name: _____ **Birth Date:** ____/____/____

Were you referred to Beaufort Eye Center? Y / N By whom:_____

The Beaufort Eye Center respects privacy in accordance with the Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPAA. By law, HIPAA requires the Beaufort Eye Center to maintain the privacy of your personal health information and to provide you with a copy of their legal duties and privacy policies with respect to your personal health information. You may request a copy of this policy in writing addressed to Dr. Jane Kokinakis, 1664 Ribaut Avenue, Port Royal, SC 29935, who is the chief privacy officer and this can be mailed or e-mailed to you.

I understand and agree that regardless of my insurance status I am ultimately responsible for my account and professional services rendered.

Missed Appointment Policy: If you do not call to cancel an existing appointment or no show for an appointment you will be responsible to pay $35.00 prior to having another appointment made.

I authorize payment of medical benefits to Beaufort Eye Center and to the release of medical or other information needed to process my claims and to assist in my health benefit(s). I authorize Beaufort Eye Center to obtain any information from other health care providers that may be beneficial in my evaluation and treatment. I agree to be personally responsible for payment for medications and a refraction fee which is not covered services by Medicare or other insurance companies.

My signature signifies I have read the authorization releases above and do grant permission to Beaufort Eye Center / Dr. Jane Kokinakis accordingly.

SIGNATURE: _____ DATE: _____

GUARDIAN/RESPONSIBLE PARTY SIGNATURE: _____

Name:_____ **Date:** _____/_____/20_____

Primary Physician Name: _____ **Location:** _____

Your Preferred Pharmacy: _____ **Location:** _____

Please list all medications that you are currently taking and include the dosage if known:

_____

_____

_____

Do you have any medication allergies? YES / NO

If you answered yes, please list the name(s) and your reaction to them:

_____

_____

Are you allergic to any of the following: Please check all that apply.

- ☐ Latex Reaction: _____
- ☐ Surgical Tape Reaction: _____
- ☐ Adhesive Tape Reaction: _____

Please check all that apply.

Do you smoke?	_____	Do you consume alcohol?	_____
Do you exercise?	_____	Do you drive?	_____
Do you use recreational drugs?	_____	Are you pregnant?	_____

REVIEW OF SYSTEMS: <u>Have you ever had any of the following?</u> Please circle all that apply and include location and date of diagnosis.

Stroke	High Cholesterol	Kidney Disease	Depression
Heart Attack	Sarcoidosis	Dialysis	Migraine Headaches
High Blood Pressure	COPD/Emphysema	Kidney Transplant	Parkinson's
Coronary Artery Disease	Oxygen use	Thyroid Problems	Alzheimer's
Irregular heart beat	C-Pap machine	HIV+	Multiple Sclerosis
Pacemaker	Sleep Apnea	Hepatitis	Arthritis
Congestive Heart Failure	Asthma	Herpes	Leukemia
Atrial Fibrillation	Trouble Breathing	Shingles	Crohn's Disease
Rheumatic Fever	Type 1 Diabetes	Sickle Cell	Ulcerative Colitis
	Type 2 Diabetes	Seizures	Changes in Bowel Habits

Other:_____

Have you ever had cancer? YES / NO

If yes, please list the type of cancer, the location, and the year diagnosed:_____

_____

_____

Surgical History: Please include date(s) if known.

Cardiac Stent(s): _____ Colon: _____ Stomach: _____

Cardiac Bypass: _____ Thyroid: _____ Brain: _____

Carotid Artery: _____ Back: _____ Lung: _____

Prostate: _____ Gall Bladder: _____ Other: _____

Do you have any artificial joint(s): YES / NO

If yes, please list the date of the surgery.

Shoulder: _____ Hip: _____ Knee: _____

Eye History: Please circle all the apply.

Cataracts:	Right / Left	Macular Degeneration	Diabetic Retinopathy
Retinal Detachment:	Right / Left	Glaucoma	Dry Eye

List all previous eye surgeries. Include the dates and which eye(s): (Examples: LASIK, PRP, Cataract, Retinal Detachment, Lesion Excisions, Ptosis, Blepharoplasty, etc.)

_____

_____

_____

Is an antibiotic needed prior to surgery due to past surgical history? Yes / No

Family Eye History of:

Please indicate your relationship.

Glaucoma: _____ Cataracts: _____

Diabetic Eye Disease: _____ Macular Degeneration: _____

REFRACTION POLICY

Refraction is a measurement that is performed to establish a baseline of the patient's vision. It is the only way to determine whether or not the patient needs glasses. It is done at least once a year to monitor any changes. Refractions are required to establish the status of your vision. Your medical insurance will not cover this service. You can use your receipt to ask for reimbursement from your vision insurance. Our fee is $30 and is payable at the time of service.

In addition, please give your new eyeglass prescription 3-4 weeks to get adjusted to your eyes. Be sure to confirm the policies and procedures with the optical shop that you choose. Most optical shops give patients 30-60 days to make any needed changes. If you are having difficulty with new prescription, please call our office to be placed on the schedule for a specs check. However, if you have exceeded the time frame, we will not be responsible for any additional cost.

_____

Patient Signature or Person Authorized to Sign for Patient Date

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. If you do not have sunglasses, we will be happy to provide you with some.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Jane Kokinakis / Dr. Perin Diana, and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____

Patient Signature or Person Authorized to Sign for Patient Date

PLEASE TURN THIS PAGE OVER

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that it is the patient or parent (if minor) responsibility to supply Beaufort Eye Center with any current insurance information and/or any referral authorization forms that may be necessary for my insurance claim.

I authorize all payments of services from all insurance carriers to be made to Beaufort Eye Center. I agree that I am responsible for paying any amount not covered by my insurance plan.

I understand that most insurance carriers do NOT pay for all health care costs. Carriers only pay for covered benefits. Some items and services are not covered benefits and carriers will not pay for them. If I receive a service that is not a covered benefit, I will be financially responsible for payment. I also understand that I am responsible for all insurance deductibles, co-insurance, co-pays and any non-covered services at the time services are rendered.

Although our staff is very knowledgeable about insurance plans and policies, it is NOT our responsibility to know the details of individual plans. Your insurance is a contract between you and/or your employer and the insurance company; not with Beaufort Eye Center or our doctor(s). We do encourage you to speak with your insurance company BEFORE your scheduled appointment to review any specific details. We will do everything we can to be of assistance.

Medical insurance DOES NOT cover any vision-related services including refraction. I understand that Beaufort Eye Center only bills through medical insurance and not vision policies.

I AM AWARE THAT I AM RESPONSIBLE FOR ANY OVERDUE / UNPAID BALANCES. I understand that overdue balances must be paid prior to seeing the doctor or my appointment may be rescheduled.

_____

Patient Signature or Person Authorized to Sign for Patient Date

PLEASE TURN THIS PAGE OVER