COHN EYE CENTER

Richard A. Cohn, MD
Diplomate American Board of Ophthalmology
Diseases and Surgery of the Eye
Glaucoma Specialist

As a new patient to our practice, we would like to extend you a very warm welcome. The Cohn Eye Center is committed to doing everything possible to provide you with caring, quality and customized eye care. We hope to make not only your *first* visit, but *all* visits to our office as pleasant and comfortable as possible.

New patient exams usually take a minimum of 90 minutes. Generally, in the course of your first visit, you will be dilated as an important part of your complete eye examination. Most people are able to drive following dilation. However if you have never been dilated before, or have previously experienced problems driving after dilation, you may want to bring sunglasses and/or arrange a driver to drive you home after your appointment. Parents of children under 18 should plan to stay with their child during appointments.

- At the time of your visit, **please bring your completed forms, insurance cards, and a list of your current medications and dosages prescribed. If you wear contact lenses or glasses, please remember to bring them with you as well.** If you do not bring your completed forms with you, you will be asked to fill them out again before being seen

- Please arrive 15 minutes prior to your scheduled appointment time so that we may process your paperwork and scan your insurance cards.

- If you wear **contact lenses**, you will be scheduled for a separate appointment for a contact lens evaluation and prescription with our licensed optician (this will be a separate fee).

- Please be aware that we allow a 20 minute window for late arrivals. If you arrive beyond that window, your appointment will have to be rescheduled to a later date.

If you have any questions, please feel free to contact us at 407-647-7227 or via email at info@cohneyecenter.com and our staff members will be glad to help. Thank you again for choosing the Cohn Eye Center and we look forward to assisting you with all your eye care needs.

Sincerely,

Dr. Richard Cohn and the Staff of the Cohn Eye Center

COHN EYE CENTER
RICHARD COHN, MD
Ophthalmologist
Glaucoma Specialist

(407) 647-7227
260 Lookout Place, Suite 105
Maitland, FL 32751
info@cohneyecenter.com
www.cohneyecenter.com
FAX: (407) 647-5744

Your next appointment is on

_____

at

_____

Dilation: Yes No

COHN EYE CENTER

PATIENT INFORMATION

Today's Date: _____

Last Name:_____ First Name: _____ Middle:_____ DOB: _____
Address: _____
City, State, ZIP: _____

Cell phone: _____ Home phone: _____
Email: _____ Gender: _____ Marital Status: _____

Emergency contact name: _____ Phone: _____ Relationship: _____

Patient Employer: _____ Occupation: _____
Employer address: _____
Employer phone: _____

Referring Physician: _____ Phone: _____
General/Family Physician: _____ Phone: _____

Do you have Medicare? (Circle one) YES / NO Is Medicare Primary? YES / NO

Primary Insurance Company: _____
Member ID#: _____
Group#:_____
Policy holder name: _____
Policy holder DOB: _____
Pt relationship to policy holder: _____

Secondary Insurance Company: _____
Member ID#: _____
Group#:_____
Policy holder name: _____
Policy holder DOB: _____
Pt relationship to policy holder: _____

Pharmacy: _____
Pharmacy address: _____
Pharmacy phone: _____

I hereby authorize the Physicians and staff of The Cohn Eye Center to perform such treatments to me as may be prescribed by my physician during my visits to the Cohn Eye Center. I understand that I am financially responsible for all charges arising from services rendered to me by the Cohn Eye Center. I hereby authorize the Cohn Eye Center to file to my insurance companies for any charges that I incur. I request that all payments for any of these insurance companies be sent directly to the Cohn Eye Center. I authorize the holder of medical information about me to release this information to The Centers for Medicare & Medicaid Services, or any other insurance company, to determine benefits payable for related services.

Patient signature: _____

Date: _____

PLEASE BRING TO APPOINTMENT

- **Insurance cards and copays**
- **Photo ID**
- **Medication list/dosages**

MEDICAL HISTORY

Name: _____ Date: _____

General physician: _____ Referring Doctor: _____

List any known ***drug allergies***: _____

_____

Have you ever been treated or informed that you have any of the below?

	Y	N	Eye	When
Glasses/Contacts	☐	☐	R / L	_____
Glaucoma	☐	☐	R / L	_____
Cataract	☐	☐	R / L	_____
Macular Degeneration	☐	☐	R / L	_____
Dry Eyes	☐	☐	R / L	_____
Lazy Eye	☐	☐	R / L	_____
Retinal Detachment	☐	☐	R / L	_____
Eye Inflammation/Iritis	☐	☐	R / L	_____
Herpes of the Eye	☐	☐	R / L	_____
Shingles on your face	☐	☐	R / L	_____
Eye Injury	☐	☐	R / L	_____

	Y	N	When
Diabetes	☐	☐	_____
High blood pressure	☐	☐	_____
High cholesterol	☐	☐	_____
Heart disease	☐	☐	_____
Stroke	☐	☐	_____
Asthma/Emphysema	☐	☐	_____
Arthritis	☐	☐	_____
Thyroid disease	☐	☐	_____
Kidney disease	☐	☐	_____
Seasonal allergies	☐	☐	_____
Migraine headaches	☐	☐	_____
Autoimmune disease	☐	☐	_____

If yes, type: _____

If yes, name of doctor: _____

Has anyone in your immediate family ever had:

	Y	N	Relative
Glaucoma	☐	☐	_____
Retinal detachment	☐	☐	_____
Macular degeneration	☐	☐	_____
Lazy eye	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Blindness	☐	☐	_____
Heart disease	☐	☐	_____
Other eye problems (explain)	☐	☐	_____

_____

List other MEDICAL conditions that apply to you:

_____

_____

_____

Approx. date of last eye exam: _____

How old are your glasses? _____

Have you ever worn contact lenses? Y / N

If Yes, what type? _____

List any eye surgery (cataract, glaucoma, refractive)	Date
R / L	
R / L	
R / L	
R / L	

List any general surgery	Date

Names of EYE Medications	Eye	Dosage	Frequency	Start date
	R / L			
	R / L			
	R / L			
	R / L			
	R / L			
	R / L			
Names of GENERAL Medications				

REASON FOR VISIT

Name: _____ Date: _____

Please circle the MAIN REASON for your visit today

Blurred vision (with glasses)

Eye pain

Dryness/Itching

Floaters

Evaluation for possible glaucoma

Evaluation for possible cataracts

Other: _____

Do you wear glasses? YES / NO

Do you wear contacts? YES / NO

Are you considering purchasing ☐ glasses ☐ contacts

Note: a contact lens exam is not the same as a routine eye exam and requires a separate appointment with the optical staff.

COHN EYE CENTER

260 Lookout Place, Ste. 105
Maitland, FL 32751
(407) 647-7227
www.cohneyecenter.com

PATIENT FINANCIAL POLICIES

Billing / Insurance Information

You must provide all your insurance information at each visit. Payment of your required co-pay and any non-covered services are required at time of service. We may also request payment for deductibles and co-insurance if provided by your insurance carrier at time of service.

We participate or contract with most major insurance carriers, including Medicare, but it is your responsibility to confirm benefits and coverage prior to services provided. We will submit claims to your insurance carrier, but you remain responsible for any charges incurred regardless of your insurance coverage. All unpaid balances will be billed to you as self pay and are due and payable within 30 days of the statement date. Past due balances may be subject to outsourcing to a third party agency for collection.

Your insurance carrier can tell you whether we are contracted with them. For any insurance plans that we do not participate or contract with, you are responsible for any unpaid balance, and if unable to pay in full you must make payment arrangements with our billing staff.

Cohn Eye Center only sends claims for primary and secondary insurances. You are responsible for any additional insurance claims.

It is your responsibility to

- **Know your insurance benefits and coverage.**
- **Know whether a referral is required.**
- **Know whether pre-certification for a procedure or surgery is required.**
- **Notify us of changes to your insurance plan or coverage at the time of service.**

Credit Cards

We accept Visa, Mastercard, Discover and American Express credit cards. You may pay in person, on the phone or securely and conveniently online on our website www.cohneyecenter.com under “Pay Bill”.

Refractions

Routine eye exams for glasses prescription are usually NOT covered by most medical insurance plans. This exam must be paid at time of service.

Self Pay

Payment is expected at time of service. Payments may be made by cash, check, money order or credit card.

Surgery

We will provide an estimate of expected physician fees at your request, excluding anesthesia and facility fees (Please contact Orlando Ophthalmology Surgery Center at 407-428-0040). You may also receive a statement due from Cohn Eye Center after insurance has paid their portion. Please refer to the explanation of benefits for patient responsibility.

COHN EYE CENTER PATIENT FINANCIAL POLICIES (page 2)

48 Hour Cancellation & "No Show" Fee

Each time a patient misses a surgery, doctor visit or visual field test appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Cohn Eye Center requires 48 hours of advance notice for all surgery or appointment cancellations. The Cohn Eye Center reserves the right to charge a fee of $50 for missed doctor visits or visual field tests and $200 for missed surgery ("no shows").

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice. You have the right to appeal the "no show" fee by contacting our office manager at 407-647-7227 (x103).

Please contact our billing staff to assist with any questions regarding insurance coverage, pre-authorization, or financial arrangements.
Phone us at 407-647-7227 (x103), Monday–Thursday 7:30 am to 4:00 pm, Friday 7:30 am to 12:00 pm.

Your signature will serve for any and all of the following:

I have read and understand The Cohn Eye Center patient financial policies and I accept responsibility for payment of any fees associated with my care.

I hereby give consent to The Cohn Eye Center, PA to provide the necessary treatment Dr. Cohn and I have discussed.

I am aware that payment is expected at the time service is rendered as explained in Patient Financial Policies.

Authorization of Medical Release: I authorize Dr. Cohn to release to any third party (acting as an insurance company or government agency) any medical information requested for use in determining claim payment. I request payment benefits either to myself or to the party who accepts assignment.

Lifetime Signature Authorization for Medicare: I authorize the release of any medical information necessary to process my claim. I also request payment benefits either to myself or to the party that takes assignment.

Insurance Authorization (applies only as stated above): I authorize payment of medical benefits to the attending physician.

I permit a copy of these authorizations and assignments to be used in place of this original, which is on file at the physician's office.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name (printed): _____ Date: _____

Patient Signature: _____

COHN EYE CENTER

260 Lookout Place, Ste. 105
Maitland, FL 32751
(407) 647-7227
www.cohneyecenter.com

HIPAA ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

By signing this, I acknowledge that I have received a copy of the Cohn Eye Center Notice of Privacy Practices.

Patient Signature: _____ Date: _____

If the signature above is not the patient's, please state your relationship to the patient

Relationship: _____ Date: _____

Communication with your family and others involved in your care

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing Insurance
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐
_____	_____	☐	☐	☐	☐

Specific Instructions or Limitations: _____

Validation Code: _____ Please provide this code to any individual who may be involved in coordinating your care or payment for care. They will be asked for this code before information will be released over the phone.

We will continue to rely on the information on this form when communicating with family members or other involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/Legal Representative: _____ Date: _____

Relationship to Patient: _____

COHN EYE CENTER

“Which is better? 1 or 2?”

What's a refraction and why do I have to pay for it?

A refraction (vision test for glasses) is an important part of an annual eye exam. It determines:

- if your vision has changed and if you can be helped by a new glasses prescription.
- why your vision is changing, which is essential information we need to assess your eye’s health

Our office fee for a refraction is $60 and this fee 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.

A refraction is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a “vision” service not a “medical” service.

In certain circumstances, the refraction is REQUIRED:

- Prior to cataract surgery or a YAG laser procedure
- Every year for contact lens patients

A refraction is highly recommended (but not required) every 1-2 years to keep eyeglasses updated.

Would you like to have a refraction (vision test for glasses)?

□ Yes, I wish to have a refraction to test my vision. I understand that this may be a non-covered service and I accept full financial responsibility for the cost.

□ No, I do not wish to have a refraction today

Name: _____
Signature: _____
Date: _____

Note: A contact lens fitting will be an additional charge. To schedule your contact lens fitting, or to inquire about fees for lens fittings, please contact our optician at 407-647-7227 (option 4) or email alice@cohneyecenter.com

Revised 1-2022