Historial y examen físico del paciente

Nombre del paciente: _____ **Fecha de nacimiento:** _____ **ID del paciente:** _____

SALUD GENERAL

Altura _____ ft _____ in
PESO _____ lbs
Enfermedades, lesiones, accidentes recientes/actuales: _____

Contacto de emergencia/Divulgación de información

_____

_____

_____

Nombre / Relación / Número de teléfono

HISTORIA QUIRURGICA

			Lado / Ubicación
Extirpación de la vesícula biliar	☐ NO	☐ SÍ	
Apendectomía	☐ NO	☐ SÍ	
Cirugía Ortopédica	☐ NO	☐ SÍ	
Cirugía Oral	☐ NO	☐ SÍ	
Hernia	☐ NO	☐ SÍ	
Amigdalectomía	☐ NO	☐ SÍ	
Cirugía de la columna	☐ NO	☐ SÍ	
Histerectomía	☐ NO	☐ SÍ	
Mastectomía	☐ NO	☐ SÍ	
Aamputaciones	☐ NO	☐ SÍ	

Otro _____

ANTECEDENTES QUIRÚRGICOS OCULARES

Cirugía PK	☐ NO	☐ SÍ	
Cirugía LASIK	☐ NO	☐ SÍ	
Cirugía PRK	☐ NO	☐ SÍ	
Cirugía de cataratas	☐ NO	☐ SÍ	
Cirugía de pterigión	☐ NO	☐ SÍ	
Láser para glaucoma	☐ NO	☐ SÍ	
Colocación de derivación de tubo de glaucoma	☐ NO	☐ SÍ	
Trabeculectomía por glaucoma	☐ NO	☐ SÍ	
Inyecciones retinales (para el degenerador macular)	☐ NO	☐ SÍ	
Inyecciones retinales (para retinopat. diabético)	☐ NO	☐ SÍ	
Láser de retina	☐ NO	☐ SÍ	
Reparación de desprendimiento de retina	☐ NO	☐ SÍ	
Cirugía Oculoplástica (seleccione/encierre	☐ NO	☐ SÍ	

Blefaroplastia / Ptosis / Ectropión / Entropión / DCR / MOHS

Otro _____

DISPOSITIVO DE ASISTENCIA

Capaz de posicionarse con asistencia mínima ☐ NO ☐ SÍ Otro _____

Alguna vez ha utilizado o está utilizando actualmente:

Silla de ruedas	☐ NO	☐ SÍ
Caminante	☐ NO	☐ SÍ
Caña	☐ NO	☐ SÍ
Dentadura postiza	☐ NO	☐ SÍ
Audífonos	☐ NO	☐ SÍ

Otro: _____

HISTORIA OCULAR

Último examen de la vista: ☐ Nunca ☐ Fecha: _____
Último examen dilatado: ☐ Nunca ☐ Fecha: _____

☐ Usa anteojos ☐ NO ☐ SÍ
☐ Usa lentes de contacto ☐ NO ☐ SÍ ☐ Contactos blandos ☐ Contactos duros Solución para lentes de contacto: _____

Patient Conditions: ☐ Ninguno ☐ Catarata ☐ Trastorno corneal ☐ Ojos secos ☐ Inflamación ocular ☐ Giro de ojos ☐ Glaucoma
☐ Ojo vago ☐ Degeneración macular ☐ Ángulos estrechos ☐ Trastorno de la retina ☐ Trauma

Prótesis Ocular: ☐ Ninguno ☐ Ojo derecho ☐ Ojo izquierdo ☐ Los dos ojos Nota: _____

HISTORIA CARDIOVASCULAR

Infarto de miocardio ^	☐ NO	☐ SÍ	
Cateterismo cardíaco ^	☐ NO	☐ SÍ	
Stent cardíaco ^	☐ NO	☐ SÍ	
Derivación/CABG ^	☐ NO	☐ SÍ	
Marcapasos ^	☐ NO	☐ SÍ	
Desfibrilador Interno Automático ^	☐ NO	☐ SÍ	
Insuficiencia cardíaca congestiva ^	☐ NO	☐ SÍ	
Arritmia (Afib, Aflutter, etc) ^	☐ NO	☐ SÍ	
Arteriopatía coronaria	☐ NO	☐ SÍ	
Enfermedad cardíaca valvular	☐ NO	☐ SÍ	
Hipertensión/Presión Arterial Alta	☐ NO	☐ SÍ	
Colesterol alto	☐ NO	☐ SÍ	

Otro: _____

HISTORIA RESPIRATORIA

COPD ^	☐ NO	☐ SÍ	Saturación de O2:
Tuberculosis ^	☐ NO	☐ SÍ	AÑO:
Apnea del sueño	☐ NO	☐ SÍ	☐ **CPAP ^** ☐ **BIPAP ^**
Enfisema ^	☐ NO	☐ SÍ	
Oxígeno continuo ^	☐ NO	☐ SÍ	Saturación de O2:
			# L/min:
			☐ Posición supina tolerada por encima de la saturación de O_2 90
Asma	☐ NO	☐ SÍ	
Dificultad para respirar	☐ NO	☐ SÍ	
Tos crónica	☐ NO	☐ SÍ	

Otro: _____

Nombre del paciente: _____ **Fecha de nacimiento:** _____ **ID del paciente:** _____

HISTORIA NEUROLÓGICA

Accidente cerebrovascular/AIT	☐ NO	☐ SÍ
Alzheimer	☐ NO	☐ SÍ
Parkinson	☐ NO	☐ SÍ
Demencia	☐ NO	☐ SÍ
Esclerosis múltiple	☐ NO	☐ SÍ
Epilepsia/Convulsiones	☐ NO	☐ SÍ
Sindrome de la pierna inquieta	☐ NO	☐ SÍ
Dolores de cabeza	☐ NO	☐ SÍ
Migrañas	☐ NO	☐ SÍ
Vértigo	☐ NO	☐ SÍ
Entumecimiento	☐ NO	☐ SÍ
Desmayo	☐ NO	☐ SÍ

Otro: _____

HISTORIA ENDOCRINA

Diabetes	☐ NO	☐ SÍ
Tipo: _____		
Año diagnosticado: _____		
HbA1c _____		
Último nivel de azúcar en la sangre _____		
Hipotiroidismo	☐ NO	☐ SÍ
Hipertiroidismo	☐ NO	☐ SÍ

Otro: _____

HISTORIA DE LA PIEL/INTEGUMENTARIA

Herpes	☐ NO	☐ SÍ	Ubicación: _____ Último brote: _____
Eczema	☐ NO	☐ SÍ	
Erupciones	☐ NO	☐ SÍ	
Heridas	☐ NO	☐ SÍ	

Otro: _____

HISTORIA PSIQUIÁTRICA

Ansiedad	☐ NO	☐ SÍ
Depresión	☐ NO	☐ SÍ
Pérdida de memoria	☐ NO	☐ SÍ

Otro: _____

HISTORIA GASTROINTESTINAL

Sangrado gastrointestinal	☐ NO	☐ SÍ
Ictericia	☐ NO	☐ SÍ
Enfermedad del higado	☐ NO	☐ SÍ
ERGE	☐ NO	☐ SÍ
Úlceras	☐ NO	☐ SÍ
Náuseas vómitos	☐ NO	☐ SÍ

Otro: _____

HISTORIAL DE SALUD DE LA MUJER

Último ciclo menstrual _____		☐ No aplica	
o posmenopáusicas	☐ NO	☐ SÍ	
o histerectomía	☐ NO	☐ SÍ	

Otro: _____

HISTORIA HEMATOLÓGICA

Hepatitis C ^	☐ NO	☐ SÍ	Tipo: _____
Coágulos de sangre ^	☐ NO	☐ SÍ	
Tendencias de sangrado ^	☐ NO	☐ SÍ	
Anticoagulantes ^	☐ NO	☐ SÍ	_____
Anemia	☐ NO	☐ SÍ	
Transfusiones de sangre	☐ NO	☐ SÍ	Año: _____

Otro: _____

HISTORIAL DE ENFERMEDADES AUTOINMUNE

Sjogren's Syndrome	☐ NO	☐ SÍ
Artritis reumatoide	☐ NO	☐ SÍ
Lupus	☐ NO	☐ SÍ

Otro: _____

HISTORIAL DE INFECCIONES

HIV/AIDS ^	☐ NO	☐ SÍ	
MRSA	☐ NO	☐ SÍ	
			Año diagnosticado: _____ Año resuelto: _____
Infección por estafilococos	☐ NO	☐ SÍ	
Pseudomonas	☐ NO	☐ SÍ	
			Año diagnosticado: _____ Año resuelto: _____

Otro: _____

HISTORIA MUSCULOESQUELÉTICA

Implante de metal/prótesis	☐ NO	☐ SÍ	Ubicación: _____
Artritis	☐ NO	☐ SÍ	
Dolores en las articulaciones, dolor, hinchazón	☐ NO	☐ SÍ	
Rigidez/Contracturas	☐ NO	☐ SÍ	
Parálisis	☐ NO	☐ SÍ	_____

Otro: _____

ANTECEDENTES DE OIDO, NARIZ Y GARGANTA

Personas con discapacidad auditiva	☐ NO	☐ SÍ
Boca seca	☐ NO	☐ SÍ
Problemas sinusales	☐ NO	☐ SÍ

Otro: _____

HISTORIA DEL RIÑÓN (RENAL)

Diálisis ^	☐ NO	☐ SÍ	_____
Derivación/Fístula	☐ NO	☐ SÍ	Ubicación _____
Cálculos renales	☐ NO	☐ SÍ	
Nefropatía	☐ NO	☐ SÍ	
Problema de próstata	☐ NO	☐ SÍ	
Incontinencia	☐ NO	☐ SÍ	

Otro: _____

Embarazada	☐ NO	☐ SÍ
Amamantamiento	☐ NO	☐ SÍ

Nombre del paciente: _____ **Fecha de nacimiento:** _____ **ID del paciente:** _____

HISTORIA MISCELÁNEA

Hipertermia maligna ^ ☐ NO ☐ SÍ Año: _____

- ☐ Orina de color oscuro/chocolate
- ☐ Antecedentes familiares de muerte(s) inesperada(s) después de la anestesia general o el ejercicio
- ☐ Antecedentes personales de espasmo muscular
- ☐ Antecedentes familiares/personales de Hipertermia maligna
- ☐ Alta temperatura después del ejercicio
- ☐ Trastorno muscular/neuromuscular
- ☐ Fiebre imprevista inmediatamente después de la anestesia

Trasplante de organo ^ ☐ NO ☐ SÍ Tipo: _____

Reacción a la anestesia local/sedación intravenosa ☐ NO ☐ SÍ ☐ Náuseas ☐ Vómitos ☐ Fiebre ☐ Hinchazón ☐ Anafilaxia ☐ Dificultad para despertarse después de la sedación.

Historia del cáncer ☐ NO ☐ SÍ Año: _____ Tipo: _____ Donde: _____ Año resuelto: _____

Alergia al latex ☐ NO ☐ SÍ

Otro: _____

HISTORIA FAMILIAR

Heart Trouble	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Hipertensión	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Problemas hepáticos	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Problemas de riñon	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Trastornos hemorrágicos	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Cáncer	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Ataque	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Problemas pulmonares	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Ceguera	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Catarata	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Trastornos de la córnea	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Desordenes genéticos	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Giro de ojo	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Glaucoma	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Ojo vago	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Degeneración macular	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Trastorno retinal	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____
Diabetes	☐ No aplica	☐ Madre	☐ Padre	☐ Abuelos	☐ Hermanos	Nota: _____

Otro: _____

HISTORIA SOCIAL

Ocupación ☐ Empleado ☐ Desempleados ☐ Jubilado ☐ Desactivado Nota: _____

De fumar ☐ nunca fumé ☐ fumador de cigarrillos ☐ fumador de cigarros ☐ fumador de tabaco ☐ fumador de vape ☐ Ex fumador Tipo: _____ Frecuencia: _____ Nota: _____

Alcohol ☐ Nunca bebió alcohol or Tipo: _____ Frecuencia: _____ edad de inicio: _____ detener la edad: _____ Nota: _____

Uso de drogas recreativa ☐ NO or Tipo de droga: _____ Metodo de uso: _____ edad de inicio: _____ detener la edad: _____ Nota: _____

Otro: _____

Firma del Paciente: _____ **Fecha:** _____

Firma del Médico: _____ Fecha: _____

Nombre del Técnico: _____ Fecha: _____

Persona responsable de transferir el historial médico a la computadora

---

After reviewing on DOS, health changes in the past 30 days noted ☐ NO ☐ YES See note in EMR

Physician Signature / Date & Time _____ **Nurse Signature / Date & Time** _____

After reviewing on DOS, health changes in the past 30 days noted ☐ NO ☐ YES See note in EMR

Physician Signature / Date & Time _____ **Nurse Signature / Date & Time** _____

Nombre del paciente: _____ **Fecha de nacimiento:** _____ **ID del paciente:** _____

TABLA DE MEDICAMENTOS Y ALERGIAS DEL PACIENTE

La enfermera revisará esta información con usted durante el proceso de admisión.

✻ - Tomada HOY (SOLO Personal del Centro de Cirugía)

¿Tomas alguno de estos medicamentos? En caso afirmativo, utilice la casilla de verificación e indique EL DÍA DE LA SEMANA.

Agonistas de GLP-1 más comunes:

☐ NO	☐ SÍ	Dulaglutide (Trulicity) - ***semanalmente***	_____
☐ NO	☐ SÍ	Exenatide (Byetta) - dos veces al día	_____
☐ NO	☐ SÍ	Exenatide Extended Release (**Bydureon BCise**) - ***semanalmente***	_____
☐ NO	☐ SÍ	Liraglutide (**Victoza, Saxenda**) - diario	_____
☐ NO	☐ SÍ	Lixisenatide (**Adlyxin**) - diario	_____
☐ NO	☐ SÍ	Semaglutide (**Ozempic**) - ***semanalmente***	_____
☐ NO	☐ SÍ	Semaglutide (**Rybelus**), oral - diario	_____
☐ NO	☐ SÍ	Semaglutide (**Wegovy**) - ***semanalmente***	_____
☐ NO	☐ SÍ	Tirzepatide (**Mounjaro**) - ***semanalmente***	_____

Most Common SGLT2 agonists:

☐ NO	☐ SÍ	Canagliflozin (**Invokana**)
☐ NO	☐ SÍ	Dapagliflozin (**Farxiga**)
☐ NO	☐ SÍ	Empagliflozin (**Jardiance**)
☐ NO	☐ SÍ	Empagliflozin / linagliptin (**Glyxambi**)
☐ NO	☐ SÍ	Canagliflozin / metformin (**Invokamet, Invokamet XR**)
☐ NO	☐ SÍ	Dapagliflozin / saxagliptin (**Qtern**)
☐ NO	☐ SÍ	Empagliflozin / metformin (**Synjardy**)
☐ NO	☐ SÍ	Empagliflozin / linagliptin / metformin (**Trijardy XR**)
☐ NO	☐ SÍ	Dapagliflozin / metformin (**Xigduo**)
☐ NO	☐ SÍ	Ertugliflozin (**Stegltro**)
☐ NO	☐ SÍ	Ertugliflozin / metformin (**Segluromet**)
☐ NO	☐ SÍ	Ertugliflozin / sitagliptin (**Steglujan**)

MEDICAMENTOS / SUPLEMENTOS	DOSIS	FRECUENCIA

☐ **Ver lista adjunta**

ALERGIAS

Enumere TODAS LAS ALERGIAS, incluidos medicamentos, alimentos y látex, y la reacción que causan

ALÉRGENO	REACCIÓN

FARMACIA PREFERIDA: _____

Nombre

_____

Dirección (calle, ciudad, código postal)

FIRMA DEL PACIENTE: _____ **FECHA:** _____

MILAN EYE CENTER

OFFICE: 678.381.2020 FAX: 678.381.2015

ALPHARETTA | BUFORD | CANTON | CUMMING | DAWSONVILLE | JOHNS CREEK | MARIETTA | SNELLVILLE

PREFERRED EYE CARE PARTNER OF THE ATLANTA BRAVES

New Patient Consents and General Information

I. Consent for Treatment

I hereby voluntarily consent to receive outpatient medical care from Milan Eye, LLC d/b/a Milan Eye Center, and its affiliated entities (collectively and henceforth, "Milan EC") providers and medical staff, including routine examinations, diagnostic procedures, and medical treatment such as laboratory work and the administration of prescribed medications. In connection with such treatment, I understand and agree to each of the following:

(1) Health care workers in general are at risk for exposure to blood and/or bodily fluids thereby increasing their risk of contracting Hepatitis B, Hepatitis C, HIV, and other viral diseases. In the event an exposure occurs during my medical treatment, I understand the need to test me for these diseases and I hereby agree to such testing, both for my own health and safety and that of the Milan EC staff. I understand that this consent will be valid and remain in effect as long as I remain a patient of Milan EC or until I revoke my consent in writing.

(2) Milan EC contracts with certain laboratories (the "Lab Companies") and I am entitled to know which specific Lab Companies it uses. If my condition warrants cultures to be taken for treatment purposes, Milan EC utilizes a third-party facility for processing such cultures (the "Culture Processing Facility"). My healthcare insurer may not cover healthcare claims, in whole or in part, from the Lab Companies and/or the Culture Processing Facility. I fully understand and will adhere to Milan EC's financial policy and will be solely responsible for any costs not otherwise covered by my insurance. Any billing questions I may have for the Culture Processing Facility are my responsibility to address directly with the Culture Processing Facility.

(3) No guarantees have been made to me as to the effect of such examinations or treatment to my condition.

(4) My pupils may be dilated during my appointment. Dilation and other eye drops used during the visit may cause short-term light sensitivity and blurry vision.

Consent for Treatment of Minors

A minor child needs a Patient Agreement signed by a parent or legal guardian. By signing the Agreement, the parent or guardian assumes responsibility for information on behalf of the patient. Milan EC requires a parent or guardian to accompany a minor to all appointments. If, however, a parent or guardian is unable to accompany a minor to an appointment, they must provide verbal consent for treatment beforehand and designate an individual(s) to make financial arrangements/payments on the minor child's behalf. Milan EC reserves the right to request identification of any individual accompanying a minor.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

II. Communication

(1) Personal communications
I authorize Milan EC to call, leave voicemails, and/or send text messages to the phone number(s) I have provided.

(2) Power of Attorney
Patients who elect to utilize a duly authorized legal representative pursuant to a Power of Attorney at their medical visit (the "POA Representative") must provide the appropriate documentation. For patient safety and compliance regarding patient care, the POA Representative will need to provide a copy of the requisite POA document for Milan EC to keep on file. This documentation is required for the POA Representative to make any medical decisions on behalf of the patient and to sign any documents on behalf of the patient. We require any patient who is seen at our facility through a nursing home, rehab center, or assisted living facility to have their POA Representative present for their visit. Without a POA Representative present, we will not be able to see you at your scheduled appointment.

Any patient that elects to utilize a Power of Attorney during their medical visit must provide the appropriate documentation. We require any patient who is seen at our facility through a nursing home, rehab center, or assisted living facility to have their Power of Attorney present for their visit. Without a POA present, we will not be able to see you at your scheduled appointment.

(3) Disclosure of Protected Health Information (PHI) to Specific Individuals
I authorize disclosure of my health information, including appointment and billing information, to the following individual(s) involved in my care and the coordination of my care.

Spouse / Significant Other: _____ Phone Number(s): _____

Parent / Guardian: _____ Phone Number(s): _____

Child / Children: _____ Phone Number(s): _____

Other: _____ Phone Number(s): _____

(4) Release of Protected Health Information to Third Party Agents
I authorize Milan EC and any third party agent debt collector working on behalf of Milan EC, and their respective vendors and business associates including but not limited to third party mailing companies, to utilize all contact information I have provided to communicate with me. This includes, but not limited to, home

telephone, cellular telephone, and employment telephone. I grant consent for Milan Eye Center and third-party collection agents working on behalf of Milan EC, to leave voice and/or text messages on my home telephone, cellular telephone, and employment telephone.

A release may be revoked by me in writing at any time. For medical records questions, please contact Milan EC at (678) 381-2020.

Notice of Privacy Practices

I acknowledge receipt of Milan Eye Center's privacy practices (the "Notice of Privacy Practices"), a copy of which is also available on its website and upon request at the front desk.

_____ _____

Signature of Patient/Authorized Representative *Date*

Photo Consent

Medical photographs may be taken before, during or after a surgical procedure or treatment and consent is required to take such photographs. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images. I authorize Milan Eye Center, and/or associates or licensees to take pre-operative, intra-operative, and post-operative photographs, as well as consent to photographs of my interview and authorize Milan Eye Center, and/or associates or licensees to use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate, including but not limited to submission to my insurance company, medical education, patient education, lay publication, or lectures to medical or lay groups.

Payment for Services

I authorize that payment of authorized Medicare, Medigap, Medicaid or any other insurance be made on my behalf to Milan EC for any services furnished to me by a provider. I authorize any holder of medical information about me to release such information to the Centers for Medicare and Medicaid Services (CMS) and other insurers and their agents to the extent necessary to determine benefits payable for related services. I authorize Milan EC to share my debt-related data with any third-party debt collector and/or letter preparation vendor with respect to any outstanding debt owed to Milan EC.

I understand that it is my responsibility to confirm specific health plan coverage and benefit levels and that I am personally responsible for and agree to pay any charges for care rendered to me not covered by insurance. I agree that for services rendered to me by Milan EC, I will pay my account at the time of service or when invoiced secondary to insurance claim processing. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Milan EC at the time of service. If my account is sent to a collection agency, I agree to pay collection expenses. I also understand that a $25.00 fee may be applied for any returned checks.

I understand that if my health care plan requires an insurance referral to see an ophthalmology specialist, I (i) am responsible for obtaining the documentation prior to my appointment at Milan EC, and (ii) coordinate all required referrals with my primary care physician and submit same to Milan EC at least 48 hours prior to my scheduled appointment.

I understand that if surgical intervention and corresponding anesthesia services are recommended through a Milan EC affiliated ambulatory surgery center, my network status, benefits, and/or out-of-pocket expenses may change.

(1) Minor Patients
The adult accompanying a minor and/or the parents or guardians are responsible for the full payment when services are rendered. For unaccompanied minors, non-emergency treatment will be denied.

(2) Self Pay Patients
For patients who do not have insurance, we do offer a self-pay rate for services. We require a minimum of $300.00 upon check-in at your visit. Any additional cost for the visit will be due at time of check-out. I understand that a Good Faith Estimate ("GFE") of expected charges is available upon scheduling an item or service or upon my request.

(3) Financing Options
We have several financing options available. Such options include Care Credit, Wells Fargo, and Alphaeon. Please contact our business office for details.

(4) No-shows
A "No-Show" is someone who misses an appointment without notice. No-Shows inconvenience
patients that are in need of our services. If you fail to be present for your scheduled appointment you will be charged a "No-Show" fee of $25.00. All fees will be due prior to any future visits. Two or more No-Shows may result in the termination of care with Milan Eye Center.

(5) Tardiness
A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while traveling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their appointment, the patient will be given the option of either being seen that day as a walk-in (schedule permitting), or rescheduled for a later date. This process will ensure that patients who arrive on time are seen in a timely manner.

(6) Refraction Charges
Refraction is a procedure necessary for our physicians to evaluate your vision. We are dedicated to providing our patients with the very best medical and surgical eye care. If you are experiencing blurred vision or decreased acuity as measured by the eye chart, a refraction would help determine whether the difficulty is associated with a medical problem or a need for glasses.

However, refraction is not covered by Medicare. As a result, we are required by the Centers for Medicare and Medicaid Services ("CMS") to charge for this service. Also, other insurance companies follow Medicare's payor guidelines and consider refraction a "vision" service, not a "medical" service. Milan EC does not accept vision insurance, we only file medical insurance. Therefore, if you request a written refraction prescription at the time

of service, a $45 fee will be charged. If you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

By signing below, you acknowledge that you have read and understand the above New Patient Consent. This consent and authorization does not expire unless/until canceled in writing by me at any time.

_____ _____

Signature of Patient/Authorized Representative *Date*

_____ _____

Name of Authorized Representative *Relationship to Patient*