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Helping Children and Adults Conquer Their Medical Challenges Through Revolutionary Neuro-Optometric methods

Vision Therapy and Speciality Care @ Eminence Family Eyecare
6300 Atlanta Hwy Ste 101A , Alpharetta, GA 30004
Phone: 678-825-4077 Fax: 678-585-3909
Email: info@eminencefamilyeyecare.com
www.eminencefamilyeyecare.com

Daniel D. Gottlieb O.D., F.A.A.O., F.C.O.V.D., N.A.P.
Neuro-Optometric Consultant
drdannygottlieb@gmail.com

Diagnosis and treatment	Vision Treatments	Innovative Treatment
Complex Vision Disorders	Visual Related Learning Problems	Convergence insufficiency
Oculo-Motor Disorders	Strabismus & Amblyopia	Brain & Spinal Cord Injury
Postural Abnormalities	Visual Perceptual Deficits	Cerebral Palsy
Autism & PDD	Developmental Disorders	Autism Glasses
Vision Loss & Recovery	Vision Rehabilitation	Rekindle Vision 1.0 & 2.0
Low Vision	Macular and Retinal Degeneration (RP)	Bioptic Cycling & Driving

Financial Policy for Consultations, Report writing, and Treatments

Welcome to Eminence Family Eyecare and thank you for choosing our practice !

Our commitment is to provide you the best vision care while recognizing that your time and dedication is valuable. To meet this commitment, we recognize the need for a definitive understanding and agreement concerning your vision care and the financial arrangement for that care. Your clear understanding of you financial policies is important to our professional relationship. Please contact our office regarding any question about your fees, financial policies, or your financial responsibilities.

Professional Fees: Our fees for specialized services are comparable to other similarly trained professionals and reflect the complexity of your specific needs, the physician time dedicated to your therapy, the specialized nature of the Doctor's education and training, and support costs associated with providing and coordinating your individualized care. Our professional fee for regular vision therapy session or other specialty care is $250.00 per hour and this payment need to be made upfront before the next scheduled session. ***They do not, however, cover the doctor's time to write a report or to provide consultation outside of the scheduled appointment time.***

Report Writing and consultations require a significant amount of time. This includes the time required to review materials such as records, notes, or other references in preparation for a consultation or a report. Additionally, this would include time spent discussing your case with other professionals or experts. As such, if the doctor's time is required in excess of the appointment time for report writing, consultation, preparation/review, or other special requests—the following hourly rate will apply:

Doctor Hourly rate: **$360.00 per hour**

Please note that if consultation with other professionals are required, they may have a consultation fee separate from Dr. Gottlieb, for which you would be responsible. Billable consultations should occur only with your knowledge and permission.

The Doctor's hourly rate for time spent in excess of the appointment time is an out-of-pocket expenses and is not billable to, nor reimbursable by, insurance.

Your signature below indicates you have read and accept the terms of this policy:

____ ____________________
Signature Date

____ ____________________
Print Name (Patient/Guardian) Relationship

Daniel D. Gottlieb O.D., F.A.A.O., F.C.O.V.D., N.A.P.

Distinguished member: National Academies of Practice (**NAP**)

Board Certifications: Fellow Academy of Optometry (**FAAO**) and Fellow College of Optometrists in Vision Development (**FCOVD**)

Founding Member: Neuro-Optometric Rehabilitation Association, (**NORA Int'l**)

Author, Lecturer, Inventor, Teacher and ***Grandfather***

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Authorization to release healthcare information

Patient's Name:________________________ **Date:**____________

Please release my records to Dr Gottlieb or Eminence Family Eyecare via email to drdannygottlieb@gmail.com or fax to 678-585-3909. If possible, please include copies of most recent visual field examinations.

Patient Signature:________________________ Date:____________

This Authorization expires 90 days after it is signed

Helping Children and Adults Conquer Their Medical Challenges Through Revolutionary Neuro-Optometric methods

Daniel D. Gottlieb O.D., F.A.A.O., F.C.O.V.D., N.A.P.
Low Vision Care
Vision Therapy & Rehabilitation
Neuro-Optometric Consultant

PHOTOGRAPHIC AND DATA RELEASE FORM

Eminence family Eyecare, LLC and Dr. Gottlieb has my permission to use Slides, Photographs and /or videos of myself for the purpose of teaching, lecturing. Publication in journals and other office publications, and for use in news releases, website, internet and other public possibilities.

Signature______________________ Date ______________________

Eminence Family Eyecare, LLC

(Center for Specialty Care and Vision Therapy)

6300 Atlanta Hwy Suite 101A
Alpharetta GA 30004

Phone: 678-825-4077
Fax: 678-585-3909
www.eminencefamilyeyecare.com

Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date: ____________________

Patient Information

Last: ______________________________

First: ________________ MI: __________

Date of Birth____________ Age ___________

Street: ______________________________

City: ____________________State: _________

Zip Code: ____________________________

Gender: Male Female

Preferred Phone (Circle one): Home Cell Work

Home Phone: __________________________

Work Phone: __________________________

Cell Phone: ___________________________

Email Address: ________________________

Employer (or School): ___________________

Occupation (or Grade): __________________

Emergency Contact______________________

Emergency Phone_______________________

Referred By ___________________________

If not referred, how did you hear about our office?

☐ Friend or Relative Name:________________
☐ Another Doctor
☐ Insurance List
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Yellow Pages: Which directory? ___________
☐ Website
☐ Online Search. If yes, where did you find us? ________
____
☐ Other: ______________________________

Insurance Information

Vision Insurance:_________________________

Subscriber Name:_________________________

Subscriber SSN/ID#:_______________________

Subscriber Birth Date:_____________________

Primary Medical Insurance:__________________
Subscriber Name:_________________________
Subscriber SSN/ID #:______________________
Subscriber Birth Date:_____________________

ASSIGNMENT OF BENEIFTS/ FINANCIAL RESPONSIBILITY

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Eminence Family Eyecare unless payment is made in full at time of service. I agree to bear full responsibility for co-pays, deductibles, non-covered or denied services by my insurance.

Signature: __________________ Date____________

Relationship to Patient (If minor): ________________

Lifestyle Questions

Do you...(check all that apply):

☐ ...use digital devices on a regular basis? If yes, how many hours per day? ______hrs/day

☐ ...think you might benefit from thinner, lighter lenses?

☐ ...prefer NOT to wear glasses at times?

☐ ...spend time outdoors? How often? ____hrs/week

☐ ...participate in vision-related sports or other activities? If yes, please specify:_____________________________

Consent to Procedures

➢ Dilated Pupil Examination

Pupil dilation is part of your complete eye examination. Dilating the pupil with eye drops allows the doctor to better examine the inside of your eyes and detect vision threatening eye diseases such as glaucoma, retinal detachment, macular degeneration or malignant growths.

- ✓ Eyes will be dilated with eye drops. Mild burning sensation with drops for few seconds.
- ✓ After dilation, there will be blurry vision up-close and eyes will be unable to focus well to read at near.
- ✓ Driving should be fine but care must be taken when driving, as eyes will be highly sensitive to sunlight. There may also be some decrease in visual quality when driving.
- ✓ Side effects generally last 4-6 hours
- ✓ Temporary sunglasses will be provided
- ✓ **No Extra cost for this procedure**

☐ **I want dilation today (no extra cost)**

➢ Fundus Photos (Picture of your Retina which is the back of your eye)

An annual fundus photo is an important part of a comprehensive eye exam. The doctor will take a picture of the inside of your eye to detect vision threatening eye diseases such as glaucoma, retinal detachment, macular degeneration or malignant growths.

- ✓ Fast, easy and comfortable
- ✓ Non-invasive procedure, No eye drops
- ✓ A permanent medical record to store and compare with subsequent photos to track potential eye disease
- ✓ Your eyes will not be dilated so no blurry vision or light sensitivity afterwards
- ✓ An in depth view of nearly the whole retina
- ✓ Educational tool for your doctor to discuss your eye health and wellness with you
- ✓ **Covered by most insurance with a copay of $39**

☐ **I want fundus photos today ($39)**

☐ **"NO" I DO NOT want both fundus photos and dilation.** I release Eminence Family Eyecare, LLC from any liability related to the failure to treat or diagnose any eye condition due to lack of diagnosis information which could have been obtained by these tests.

By signing below, you understand and agree with the above statements:
Patient/Guardian Signature: ____________________________ Date: ______/______/________

Office Policy /Financial Information/privacy practices

1. **Prescription Re-check:** Glasses re-checks will be performed and are subject to no charge within 30 days of original date of eye exam. All glasses re-checks after 30 days are subject to an Office visit charge.

2. **Contact Lens Patients:** Please be aware that certain lens fitting types (Sclerals, RGP, Soft Toric, Multifocal, Monovision etc.) require more time and measurement on the part of the doctor and extra fitting fees apply. Contact lens follow-ups are often indicated and will be provided to address contact lens fitting issues at no additional charge for 60 days from the initial fitting date. This includes 3 follow-ups. After 60 days or after 3 follow-ups an office visit fee will be charged.
   By Georgia Law, a contact lens prescription is valid for one year. No contact lens can be given by the doctor or sold by the optical after the one-year expiration date. New contact lens wearers will need to demonstrate the technique of proper insertion and removal of contact lenses before the lenses can be released by the office. If further time or instruction for insertion and removal is needed, the patient may return at NO additional charge for up to 30 days

3. **Refunds:** All eyewear purchases are final sale but patients seeking refunds can receive store credit which can be used for future eyewear purchase. All fees for professional services rendered by the doctor are **non-refundable**. Patients can request re-checks at no additional cost.

4. **Insurance Patients:** While we make every effort to verify and confirm your insurance benefits, it your responsibility to understand the terms and conditions of your insurance plan. Please be aware that some services provided may not be covered by your insurance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old will be subject to collection fees. There will be a service charge of $25 on all returned checks.

Payment from my insurance is to be paid directly to Eminence Family Eyecare and I understand that (name of vision or medical insurance) ____________________________________ will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made once the claim is processed. Patients are responsible for all charges their insurance carrier does not cover with applicable co-pays due at the time of service. I understand that any cost (such as collection fees, mailing cost, court and legal fees) will be added to my bill if these procedures are required to secure payments.

HIPAA / PRIVACY PRATICES: All doctor's offices must keep your personal information confidential due to a law known as **HIPAA**. I understand that the privacy rights are posted and a copy is available to read at any time. I also understand that I may request a copy for my personal records. I consent to the release of my health information for treatment, Insurance payments and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices. Furthermore, I **DO** authorize Eminence Family Eyecare to release my records to any other physician or third party participating in my care. I have received, read, and understand your Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization any time to obtain a current copy. I understand that I may request in writing that the office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the office is not required to agree to my requested restrictions, but if they do agree, they are bound to abide by such restrictions.

By signing below, you understand and agree with the above statements:

Printed Patient Name:____

Patient/Guardian Signature: ___________________________ Date: _______/________/_______________

Patient Medical History Form

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

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FAMILY EYECARE

Patient Name: ______________________

Date: ______________________

Patient Eye History

Date of Last Eye Exam: ______________________

By Whom? ______________________

Have you had any eye-related surgeries of any kind?
☐ Yes ☐ No

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision	☐ Burning
☐ Cataracts	☐ Corneal Abrasions
☐ Crossed eye/Eye turn	☐ Double Vision
☐ Eye Infections	☐ Eye Injury
☐ Flash of light	☐ Floaters/Spots
☐ Glaucoma	☐ Grittiness
☐ Headaches	☐ Iritis/Uveitis
☐ Itchiness	☐ Lazy Eye
☐ Macular Degeneration	☐ Occasional dryness
☐ Retinal Detachment	☐ Sunlight Sensitivity
☐ Tearing	☐ Trouble seeing at night
☐ Uncomfortable glasses	

☐ Other eye disorders: ______________________

Family Medical/Eye History

Do you have a family medical history of any of the following? (check all that apply and indicate mother or father's side):

	Relationship (Mother's or Father's side)
Blindness	☐ ______________
Cataracts	☐ ______________
Corneal Problems	☐ ______________
Diabetes	☐ ______________
Glaucoma	☐ ______________
Heart Disease	☐ ______________
Lazy Eye	☐ ______________
Macular Degeneration	☐ ______________
Retinal Problems	☐ ______________

Continued on next page...

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FAMILY EYECARE

Patient Medical History Form, Continued

Patient Medical History

Name of Family Physician: ______________________

____

Address: ______________________

Date of Last Physical Check-Up: ______________________

Height: ______________ Weight: ______________

Current Medications (Rx or Over-The-Counter)

(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency. Please bring a list if possible!): ______________________

____

____

____

____

____

Allergies to medications? ☐ Yes ☐ No

If so, what medications? ______________________

____

____

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No

Patient Medical History, Cont.

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐