Longview Ophthalmology Associates
3209 N 4th Street; Suite 100
Longview, Texas 75605

Appointment Day: _____
Appointment Date: _____
Appointment Time: _____

Dr. Michael Guillory, MD
Dr. Craig King, MD
Dr. Jonathan Walgama, MD

Welcome back to our office!

It's been a while since your last appointment and we appreciate you continuing to choose us for your eye care needs.

There are a few things we'd like to ask of you to ensure a smooth check-in, work-up, & exam process during your upcoming appointment.

Check-In Process

- Bring a photo ID and insurance card(s) to your appointment – this is mutually beneficial. We want to be sure we are providing services to the correct patient & that we are filing to the correct insurance company on your behalf.
- Complete the enclosed Demographics half-sheet – this allows us to update any incorrect information that we may have on file (old phone numbers, old addresses, old employers, etc.).
- Review/complete our Refraction Policy – you may not be coming in specifically for a refraction, but in the event that you'd ever want us to perform a refraction (or your doctor deems it necessary) we will keep this acknowledgement on file.
- Review/complete our Acknowledgement of Review of Notice of Privacy Practices – protecting your health information is very important to us and we would like you to know how your information may be used. Our Summary of Privacy Practices is posted above our water fountain in the main waiting area near the reception desk - please review it upon your arrival. Also, at your request, you may obtain a printed copy of our Summary of Privacy Practices.

Work-Up & Exam Process

- Complete enclosed medical history paperwork – this helps us gather your most recent health information and any information that may have changed since your last appointment. (new surgeries, new health issues, etc.).
- Bring a list of current medications & vitamins (prescriptions and/or over the counter) – this is a crucial part of your exam and record.
- Bring your current eye glasses (prescription and/or over the counter) – this allows us to record what glasses you were wearing at the time of the exam.
- If you are going to have your eyes dilated or if you are going to have an in-office procedure – we do recommend bringing someone with you to drive you home.

Additional Information:

- **If your insurance requires an authorization for us to provide services** – it is very important for you to contact your primary care physician and ask them to send it to our office. *some can take 10-14 days to process*
  Appointments will not be scheduled unless an authorization is already approved/on file.
- All payments (including co-pays, deductibles, and/or previous balances) are due at time of service – unless prior arrangements have been made. If you are uninsured or "self-pay" – your payment is expected at time of check-in. If you are unable to meet this financial obligation, your current and any future appointment may be cancelled or rescheduled.
- There will be a $50 payment required for unkept, rescheduled, or cancelled appointments.
  This fee will not be applied to any co-pay, co-insurances, or deductibles.

We look forward to seeing you!
Please don't hesitate to contact our office for any questions you might have about your upcoming appointment.

Michael B. Guillory, MD | Craig K. King, MD | Jonathan P. Walgama, MD

Title: Mr | Mrs | Miss | Dr | Rev. Gender: Male/Female/Other

First Name:_____Middle Initial:_____

Last Name:_____Jr | Sr |_____

Date of Birth:_____ SSN:_____-_____-_____

Race: □ American Indian or Alaska Native □ Asian □ Black
□ Native Hawaiian or Pacific Islander □ White □ Other

Mailing Address:_____

City:_____ State:_____Zip:_____

Cell Phone#:_____(will be listed as primary)

Alternate Phone#:_____(will be contacted 2nd)

Email Address:_____

Emergency Contact Name:
_____

Their Relationship To You: Spouse | Other:
_____

Employer Name:
_____

Employer Phone:
_____

Primary Care Doctor:
_____

Who Recommended Our Office To You: Another Patient | Optometrist | Other Doctor | Insurance | Other_____

I understand that payment is expected at time of service except where there is no patient responsibility. I authorize the release of any medical or other relevant information necessary to process insurance claims on my behalf. I authorize payment of medical benefits to any of the providers listed above.

Signed:_____Date: _____

WE DO NOT FIT FOR CONTACT LENSES

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REFRACTION POLICY

One of the most important parts of an eye exam is the refraction. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. This test is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. **It is NOT a covered service by Medicare and/or most insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $35.00.** This fee is collected at the time of service in addition to any co-payment, coinsurance, or deductible your insurance plan may require. In the event your insurance plan pays us for the refraction we will reimburse you accordingly.

I acknowledge that I have read the above information and understand that the refraction is a noncovered service. I accept full financial responsibility for the cost of service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_____ _____
Signature of Patient or Patient Representative/Guardian Date

_____
Printed Name of Patient or Patient Representative/Guardian

Acknowledgement of Review of Notice of Privacy Practices

A copy of this Notice is located above the water fountain in the reception area for your review.

Our Notice of Privacy Policies provides information about how we may use and disclose protected health information (PHI) about you. By signing this receipt, you acknowledge that you have reviewed [or have been given the opportunity to review] our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. You may obtain a current or revised copy of this Notice by contacting the Office Manager.

Additionally, I authorize Dr. Michael Guillory, Dr. Craig King, and/or Dr. Jonathan Walgama's office/staff (d/b/a Longview Ophthalmology Associates) to release my PHI to the following persons or companies:

Name	Relationship	Phone Number

_____ _____
Signature of Patient or Patient Representative/Guardian Date

_____
Printed Name of Patient or Patient Representative/Guardian