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New England Eye Low Vision Clinic at Perkins

Preparing for Your Appointment

We are looking forward to your visit to our clinic! Please carefully review the information contained in this packet prior to your appointment and send us the following information prior to the appointment:

- **Insurance Referral** – this is not a routine eye exam and often requires a referral from your Primary Care Physician or insurance company. In order to bill your insurance we must have a referral number prior to your appointment. Your doctor may call us with the number (617-972-7296) or it can be faxed to us at: 617-972-7297. If we have not received by the day of the appointment you will be responsible for full payment. Please be prepared to pay with cash, check or money order. Unfortunately, we cannot accept credit cards at this time.

- **Copies of the latest eye reports, medical records (incl. neuropsychology), available educational reports** (including I.E.P., OT, PT, Speech, Teacher of the Visually Impaired, Orientation and Mobility, etc)

Please bring with you to the appointment:

- **Medical Insurance Card** – please bring this with you to the appointment as we will need to make a copy when you arrive.

- **All eyeglasses and low vision devices used** – this helps us understand what has or has not been helpful in the past and enables us to compare these devices with new ones.

- **Favorite Toys/Examples of School Work** – having familiar objects can help make this a positive experience. Examples of school books, homework, or worksheets will help us identify the current size of print/symbols used and to recommend the most appropriate device(s).

- **Other Professionals or Caregivers**– this is a collaborative, team effort! Having other professionals or caregivers attend helps us to develop appropriate recommendations that address everyone's questions.

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If someone other than the parent or legal guardian will be attending the exam, the following additional information must be provided before the appointment.

1. Authorization To Release Identifying Health Information

- This form must be signed by the patient (if able and of legal age) or by a parent/legal guardian. It will identify the people/agency that should receive a copy of our report and gives permission for us to discuss with those listed regarding the information contained in our files.

2. Insurance Information and Patient Waiver

- This form must be signed by the patient (if able or of legal age) or their parent/guardian. We must have assurance that we will receive payment for the appointment. If possible, we will attempt to bill the medical insurance. However, in the event the insurance is denied or a referral is not receive, the person signing this form will be financially responsible for payment and will be billed by New England Eye Institute.

If you have any questions about completion of these forms, please don't hesitate to contact us at:

New England Eye Low Vision Clinic at Perkins
617-972-7296/617-972-9297 (fax)

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New England Eye Low Vision Clinic at Perkins
175 North Beacon Street
Watertown, MA 02472

Patient Name: DOB:
Address:

AUTHORIZATION TO RELEASE IDENTIFYING HEALTH INFORMATION

NEEI Inc. Director of Operations, Chief Compliance Officer and HIPAA Privacy Officer

I authorize the New England Eye Low Vision Clinic at Perkins to release health information identifying me under the following terms and conditions.

- Copy of New England Eye at Perkins Eye Report
- Name and Address of recipients of information
- Expiration Date: 3 years from dated signature below

It is your decision to sign this authorization form. We cannot refuse to treat you if you choose not to give authorization.

If you sign this form, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose this information as he/she wishes. Sometimes, state or federal law changes this possibility.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

______________________________ ________________
Patient's Signature Date

If you are the patient's representative, describe your relationship and the source of authority.

Relationship: ____________________ Name: ____________________

Source of Authority: ______________________________

I request to have a copy of the report from New England Eye Low Vision Clinic at Perkins to be sent directly to the people listed below.

Name: ______________________________
Address: ______________________________
City/State/Zip ______________________________

Name: ______________________________
Address: ______________________________
City/State/Zip ______________________________

Name: ______________________________
Address: ______________________________
City/State/Zip ______________________________

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New England Eye Low Vision Clinic at Perkins
175 North Beacon Street
Watertown, MA 02472
617-972-7296

Name: DOS:
DOB:
Address:

Phone:

NEEI Doctor:

INSURANCE INFORMATION (office use only)

PRIMARY INSURANCE:

Subscriber Name: Subscriber DOB:

__________ See copy of card __________ No copy of card available

__________ Referral Received __________ Referral Requested but not received

Referral Number: [ ]

__________ Patient reports no referral necessary

SECONDARY INSURANCE:

__________ See copy of card __________ No copy of card available

PATIENT WAIVER

x__________ I understand that I am responsible for payment for services that are not covered by my insurance company.

x__________ I understand that I am responsible for obtaining an insurance referral if my insurance company requires one. If I fail to obtain a referral, I may be responsible for payment on the day of the appointment.

__________ I understand that my insurance company will not pay for services rendered. Therefore, I waive my rights to use my insurance here at the New England Eye Low Vision Clinic at Perkins.

I agree in full with the selected statement(s) above by signing below.

______________________________ _______________
Patient/Guardian Signature Date

____
If Guardian, please give relationship to patient