Charles A. Shaller, M.D. - Patient Information Sheet

Demographic Information

Today's Date: ___/___/___ Date of Birth ___/___/___ Sex: ☐ Male ☐ Female

Name _____ SS# ___-___-___

Mailing Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail address _____ May we contact you at this email? ☐ yes ☐ no

Employer _____
Name Address

Responsible Party/POA _____
Name Address and Phone# Relation

*If patient is under 18 years old *Responsible Party SS# ___-___-___ Responsible Party DOB ___/___/___

(*** If POA (Power of Attorney) please present documents so they may be copied for the patient's chart.)

Emergency Contact _____
Name Address and Phone# Relation

Is this your first visit to our office? Y N If yes, referred by _____

Insurance Information *** Please present insurance card(s) and a photo ID to be scanned for your chart. ***

Primary Insurance: Policy Holder Name _____ SS# _____ DOB _____ Relationship _____

Secondary Insurance: Policy Holder Name _____ SS# _____ DOB _____ Relationship _____

FINANCIAL POLICIES

1. Medicare: By my signature below and where applicable, I request that payment of authorized Medicare benefits be made on my behalf to Charles A. Shaller, M.D., for services furnished to me by Charles A. Shaller, M.D. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Charles A. Shaller, M.D. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. I understand that if a MediGap policy or other health insurance is indicated for my care, my signature authorizes payment of these secondary insurance benefits be made on my behalf to Charles A. Shaller, M.D., if possible or otherwise to me.

2. Other Insurance: I understand that Charles A. Shaller, M.D. maintains a list of health care service plans with which it contracts, such list being available from the business office. And that Charles A. Shaller, M.D. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Charles A. Shaller, M.D. if I belong to a plan that does not appear on the above mentioned list.

3. Non-covered services: I understand that Charles A. Shaller, M.D.'s contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are "covered" by the health service plan. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health insurance plan not to be covered. The undersigned agrees to cooperate with Charles A. Shaller, M.D. to obtain necessary health care service plan authorizations for services/treatments.

4. Release of Protected Health Information: I have received or was offered a copy of Charles A. Shaller, M.D.'s Notice of Privacy Practices and understand their policies as well as my rights as it applies to use and disclosure of my confidential medical information.

5. Financial Agreement: I agree that in return for services provided by Charles A. Shaller, M.D., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Charles A. Shaller, M.D. for payment. If an account is sent to an agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits under any health insurance policy insuring the patient are hereby assigned to Charles A. Shaller M.D. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Charles A. Shaller, M.D. I further understand and agree that failure to pay amounts owed in full at the time of service could result in an additional administrative processing fee being charged to my account. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I agree to pay, in a timely manner, for any and all charges for services rendered by Charles A. Shaller, M.D. that are denied for payment by my health insurance plan.

_____ _____
Beneficiary Signature or Authorized Party Date

(OVER)

Health History Form

Patient Name: _____ DOB: _____ Date Of Last Eye Exam: _____

Primary Care Physician: _____

Reason for your visit today: _____

Have you ever been diagnosed with any of the following in the past? (Do not leave any unanswered)

Yes	No		Yes	No	
☐	☐	Head or Spinal Injury	☐	☐	Psychiatric Disorders
☐	☐	Asthma or other breathing problems	☐	☐	Seizures, Convulsion or Fainting
☐	☐	Cancer (Type) _____	☐	☐	Sickle Cell Anemia
☐	☐	Carotid Artery Disease	☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes _____ # of yrs. /Insulin? Y N	☐	☐	Stroke or other Neurologic Disease
☐	☐	Gastrointestinal Disease/Ulcers	☐	☐	Temporal Arteritis
☐	☐	Heart Disease	☐	☐	Thyroid Trouble
☐	☐	Skin Disease	☐	☐	Tuberculosis
☐	☐	High Blood Pressure _____ # of years	☐	☐	(Women) Are you pregnant?
☐	☐	HIV Infection or AIDS	☐	☐	Do you smoke? ___Packs per day
☐	☐	Kidney Disease	☐	☐	Do you drink? ___ Drinks per day
☐	☐	Migraines	☐	☐	Other Diseases _____

Please explain any YES answers from above: _____

Your Ocular History- Have you ever been diagnosed with any of the following? (Do not leave any unanswered)

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Iritis
☐	☐	Corneal Disease	☐	☐	Macular Degeneration
☐	☐	Crossed Eyes, Lazy Eye (Amblyopia)	☐	☐	Retina Disease
☐	☐	Eye Infections	☐	☐	Other Eye Disorders:
☐	☐	Floaters or Flashing Lights	☐	☐	Have you ever had eye surgery?
☐	☐	Double Vision	☐	☐	Have you ever had an eye injury?
☐	☐	Glaucoma			

Please explain any YES answers from above: _____

Please list any medications you are ALLERGIC to: _____

List ALL medications – prescription and non-prescription- you are currently taking or bring a list:

1) _____ 4) _____ 7) _____

2) _____ 5) _____ 8) _____

3) _____ 6) _____ 9) _____

Family History - Has anyone in your family (blood relative) had any of the following? (Do not leave any unanswered)

Yes	No		Yes	No	
☐	☐	Glaucoma	☐	☐	Diabetes
☐	☐	Cataracts	☐	☐	Heart Diseases
☐	☐	Crossed Eyes/Lazy Eye	☐	☐	Diabetic Retinopathy
☐	☐	Stroke	☐	☐	Other Eye Problems:
☐	☐	Corneal Disease	☐	☐	other diseases
☐	☐	Macular Degeneration	☐	☐	Rheumatoid Arthritis/Autoimmune disease

Please explain any YES answers from above: * Please Note Relation to Patient using F-Father, M-Mother, S-Sister, B-Brother, GF-Grandfather, GM-Grandmother, U-Uncle, or A-Aunt (for example: F-Diabetes, GM-Macular Degeneration)**

Surgical History (All Surgeries)

_____

_____

Patient Signature: _____

CHARLES A. SHALLER, M.D.

BOARD CERTIFIED PHYSICIAN AND SURGEON

36 WESTGATE PLAZA, FRANKLIN, NC 28734

CORONAVIRUS – COVID 19 SCREENING QUESTIONNAIRE

PATIENT'S NAME: _____

DATE OF BIRTH: _____

In the last 14 days have you traveled outside of Macon County? _____

Do you have new or worsening onset of any of the following symptoms: fever, cough, shortness of breath, runny nose, sore throat, chills, body aches, fatigue, headache, loss of taste or smell, red, goopy, painful eyes or congestion? _____

If yes – please list your symptoms:

Have you been exposed to someone being tested for Covid 19 or who has symptoms compatible with Covid 19? _____

Are any members of your household a close contact of someone who is currently under quarantine for exposure to Covid 19? _____

Sign _____ **date** _____

Charles A. Shaller, M.D.

Board Certified Physician and Surgeon

36 Westgate Plaza Franklin, NC 28734

(828) 369-4236

WHAT IS A REFRACTION TEST?

A refraction test is given during your complete eye exam. This test not only will tell your doctor what glasses or prescription you need – but it also will tell him what your best possible vision is as well as any eye diseases you may have including cataracts, astigmatism, glaucoma, macular degeneration, diabetic retinopathy, myopia, hyperopia and presbyopia which names only a few of the many eye diseases that DR. Shaller will be checking for today. It is a vital component of the eye examination but it is not covered by Medicare and most commercial insurances – therefore we collect the $50.00 fee for this service from the patient at the time of his or her visit. Regular eye examinations are crucial for maintaining the health of your vision. Healthy adults should have this test yearly.

CHARLES A. SHALLER, M.D.

BOARD CERTIFIED PHYSICIAN AND SURGEON

36 WESTGATE PLAZA, FRANKLIN, NC 28734

DETERMINATION OF THE REFRACTIVE STATE OF THE EYES

Per Medicare Jurisdiction II Part B – Medicare statutorily excludes payment for determination of the refractive state of the eyes during an eye examination. The majority of supplemental insurances and commercial insurances follow Medicare guidelines. Because the refraction test is NON-COVERED – NOT PAYABLE BY YOUR INSURANCE PROVIDER – my office does not submit a claim for the test.

The refraction fee is $50 and is due at the time you check in for your appointment.

By signing this notice I acknowledge that Dr. Shaller's office staff has informed me the refraction fee is a NON-COVERED test and it is my full responsibility for full payment at the time of my appointment.

Patient's signature _____

Date: _____