

**PLEASE FILL OUT
EVERY PAGE IN THE
NEW PATIENT
PACKET. IF YOU
DON'T KNOW PLEASE
PUT N/A.YOUR
PRIMARY DOCTOR IS
NEEDED. ON THE LAST
PAGE PLEASE INITIAL
EACH LINE AND SIGN
AND DATE.**

EFFECTIVE 7/17/2025

Refraction* Fee: \$35

Dilation Reversal: \$15

* A refraction is a test performed by our staff to determine your need for glasses and to generate eyeglasses and contact lens prescriptions. A refraction is considered routine by most insurance companies which means **it is not covered** as part of your full medical eye exam.

Northlake Eye Center

Patient Information and Insurance Information

PATIENT INFORMATION: ***PLEASE FILL OUT EVERY SECTION, IF IT DOES NOT APPLY PLEASE FILL IN N/A***

| | |
|---|---|
| M F TITLE _____ RACE _____ | NAME _____ ADDRESS _____ ZIP _____ CITY/STATE _____ |
| PREFERRED PHONE _____ OTHER PHONE _____ EMAIL _____ EMERGENCY CONTACT _____ EMERGENCY CONTACT # _____ | MARITAL STATUS _____ BIRTHDATE _____ SSN# _____ Ethnicity HISPANIC or NON HISPANIC Preferred Language: _____ |
| EMPLOYER _____ PRIMARY DOCTOR _____ | |
| _____ | |
| HOW DID YOU LEARN ABOUT US? _____ | |

RESPONSIBLE PARTY: CHECK BOX IF SAME AS ABOVE

| | |
|--|--|
| NAME _____ ADDRESS _____ ZIP _____ CITY/STATE _____ PHONE _____ EMAIL _____ | M F TITLE _____ BIRTHDATE _____ SSN# _____ |
| EMPLOYER _____ EMPLOYMENT STATUS: FT PT RETIRED | |

| | |
|---|--|
| GUARANTOR _____ ADDRESS _____ ZIP _____ CITY/STATE _____ | SS# _____ DOB _____ RELATIONSHIP _____ |
|---|--|

ARE YOU ON HOSPICE Y OR N

If you require a REFERRAL, you must have it prior to seeing the doctor. We will submit your claims using the insurance information we have on file the day of service. If you want us to ONLY bill your vision insurance AND NOT your medical insurance you must let us know before you see the doctor. Once a claim is submitted it will not be resubmitted to a different insurance company.

FILL OUT ALL SPOTS. PUT N/A IF YOU DO NOT KNOW

Past Medical History (Please Circle All That Apply)

| | | | |
|--------------------------|----------------------|-------------------------|------------------------|
| Diabetes | Stroke | Sickle Cell | Epilepsy |
| Hypertension | Cancer-Type _____ | Ulcerative Colitis | Nutritional Deficiency |
| Heart Disease | | Depression/Anxiety | Headache/Migraines |
| Heart Stent or Pacemaker | HIV/AIDS | Skin Condition | Hearing Disorder |
| Heart Attack | Hepatitis | Lupus | Vocal Problem |
| High Cholesterol | Alcoholism | Rheumatoid Arthritis | Smelling Defect |
| Graves Disease | Asthma | Thyroid Disease/Graves | Tasting Defect |
| Blocked Carotid Artery | Lyme Disease | Organ Transplant | Liver Disease |
| Temporal Arteritis | Arthritis | Parkinson's | |
| Anemia | Gall Bladder Disease | Multiple Sclerosis | |
| A-fib | GERD | Kidney Failure/Dialysis | |
| Premature Birth | Dementia/Alzheimer's | COPD | |
| Birth Defect | Sleep Apnea/Machine | Myasthenia Gravis | |

Please List any Other Medical or Surgical History:

Do you drink alcohol? Y N How Often? _____

Do you smoke: Y N Former

When was your last comprehensive eye exam? _____

Past Ocular History

(Please Circle all that apply.)

| | | | |
|---|--------------------------|--------------------|-----------------------|
| Cataracts Surgery? Year _____ | Iritis/Uveitis | Double Vision | LASIK |
| Glaucoma Surgery? Year _____ | Eye Turns In/Out | Dry Eye Syndrome | Year _____ |
| Diabetic Retinopathy Laser/Surgery ? | Surgery? Year _____ | Retinal Detachment | PRK |
| Macular Degeneration Laser/Injects ? | Facial Palsy | Eye/Year _____ | Year _____ |
| Lazy Eye | Eyelid Tumor | Retinal Tear | RK |
| Retinal Vein Occlusion (stroke in eye) | Eyelid Cancer | Eye/Laser? _____ | Year _____ |
| Retinal Artery Occlusion | Droopy Eyelid | Tear Duct Disorder | Cosmetic Face Surgery |
| Severe Eye injury | Cancer in Eye | Floaters | Corneal Surgery |
| | Facial Pain | Flashes of Light | Eye/Year _____ |
| | Conjunctivitis(Pink Eye) | Night Blindness | |
| | Orbital Tumor/Disease | Total Blindness | |
| | Optic Neuritis | Color Blindness | |
| | Optic Nerve Damage | | |

NORTHLAKE EYE CENTER, APMC

2243 Gause Blvd E.
Slidell, LA 70461
(985) 643-6355
Terry Hemelt, MD
Martine Domangue, MD
Jessica Fawer, OD

DO YOU HAVE ROUTINE AND MEDICAL INSURANCE?

PLEASE READ VERY IMPORTANT

****PLEASE READ THIS CAREFULLY SO THAT WE WILL FILE YOUR CLAIM WITH THE CORRECT INSURANCE COMPANY****

Many patients have both routine and medical insurance plans. At Northlake Eye Center, we can accept and file to either your routine or medical insurance plan, but not both. It is **EXTREMELY** important that you inform us which insurance plan you would like us to file your claim with. It is also important to understand that there are some potentially vision threatening eye conditions that may be identified during your eye exam. Most of these conditions require additional testing that can be done on today's visit. These additional tests **ARE NOT** covered by your vision insurance plan, **HOWEVER**, they **ARE** covered by your medical insurance. Therefore, if you plan to have us file to your vision plan and you don't want us to do any additional testing you must let us know in advance below. Please read the three choices below and place your initials in the box to indicate how you would like us to proceed.

CHOOSE ONLY 1 BOX!!!!

- I DON'T HAVE VISION INSURANCE. USE MY **MEDICAL INSURANCE** TODAY.
- USE MY ROUTINE EYE INSURANCE **UNLESS** THE DOCTOR NEEDS TO DO ADDITIONAL TESTING THEN **USE MY MEDICAL INSURANCE ONLY.**
- FILE ROUTINE FOR EXAM AND MEDICAL FOR TESTING.
- FILE ROUTINE ONLY, I DON'T HAVE MEDICAL INSURANCE
- I DON'T HAVE ANY INSURANCE; I WILL PAY FOR MY EXAM MYSELF.

PLEASE FILL IN THE **MAIN REASON FOR YOUR VISIT** WITH US TODAY:

NAME

SIGNATURE

DATE

NORTHLAKE EYE CENTER / SURGICAL EYE ASSOCIATES
IMPORTANT POLICIES

*****PLEASE READ AND INITIAL EVERY LINE ITEM. THESE POLICIES MAY AFFECT THE AMOUNT YOU OWE AT THE
END OF YOUR VISIT*****

_____ 3% CONVENIENCE FEE for all credit card transactions.

_____ REFRACTION FEE (\$35) this fee will be collected at the end of your visit if you receive a prescription for eyeglasses. If we have experience with your insurer that they will cover this fee, we will file the claim, and you will not be expected to pay this fee at the time of your visit. You will be billed later if your insurance company denies coverage for any reason.

_____ CONTACT LENS UPDATE FEE (\$100) if you wear contact lenses that are managed by our doctors, you will be charged this fee no more than once a year. This fee is for the service provided by your doctor to ensure that you have the correct prescription and the proper fit. This fee is waived for initial fittings. See the contact lens pricing sheet for further details. If you wear contact lenses and you are having them updated elsewhere please let us know so we do not charge you and please remove them from your eyes prior to your visit. If you plan to take advantage of this service, you may leave your contact lenses in.

_____ NSF Check fee (\$30) this fee and the amount of the check must be paid in cash. Future payments will require payment by cash, debit or credit card.

_____ PAYMENT FOR SERVICES PROVIDED IS EXPECTED AT TIME OF SERVICE. We will collect all co-pays, coinsurance, deductibles and non-covered services at the time of your visit. We will file your claim with your insurance company on your behalf. IT IS YOUR RESPONSIBILITY: 1. To provide accurate insurance information to our staff 2. Provide accurate secondary insurance information for our staff 3. Provide us with any vision insurance plan information. 4. Inform us which insurers you would like us to file with or not file with. 5. If required, know the status of your referral and provide us with an up-to-date referral for the date of your service. Failure to provide this information will result in you having to pay for your visit in full if your claim is denied by your insurance company. 6. Pay any outstanding balances in a timely manner.

_____ FAILURE TO PAY your bill in a timely manner will result in us turning your past due account over to a third-party collection agency. We do not have the resources to run our own collection agency.

_____ SPECIALTY CATARACT SURGERY LENSES have additional costs which your surgeon will discuss with you. If you choose one of these lenses, payment is expected prior to surgery. Standard cataract surgery lenses do not incur additional fees.

_____ SELF PAY/FEES NOT COVERED BY INSURANCE. These fees are expected to be paid prior to surgery or at the time of service.

_____ OUTSTANDING BALANCES. These must be paid in full before being seen by the doctor. No contact lenses will be ordered until these obligations have been met.

_____ HIPPA ACKNOWLEDGEMENT. You have been given an opportunity to review/receive a copy of these privacy policy practices.

NAME: _____ WITNESS: _____

SIGNATURE: _____ SIGNATURE: _____

DATE: _____

NORTHLAKE EYE CENTER, APMC

Terry Hemelt, MD

Martine Domangue, MD

Ross Kelt, OD

Cindy Tran, OD

1120 N. Hwy 190 Covington, LA 70433

985-893-5777

CONTACT LENS FITTING INFORMATION

Please fill in "N/A" if not interested _____

CONTACT LENS EVALUATION/FITTING FEE

| | NEW (First Time Wearer) | ESTABLISHED (Current Wearer) |
|----------------------------|----------------------------|---------------------------------|
| Soft Spherical/Toric | \$150 | \$100 |
| Soft Multifocal/Monovision | \$200 | \$100 |
| RGP (hard lens) | \$250 | \$100 |

THESE ARE FITTING FEES ONLY AND DO NOT INCLUDE THE COST OF THE LENSES.
COST OF LENSES VARY BY TYPE AND BRAND.

FITTING INCLUDES:

- Initial evaluation with trial lenses
- Unlimited trial lenses during the fitting period up to 90 days
- Unlimited Contact Lens follow-ups for 90 days
- 45 min – 1 hour of instruction time (insertion, removal, and cleaning)

REFUND POLICY

- If the patient is unsuccessful with contact lens fitting and the patient decides to discontinue contact lenses, patient is eligible for \$100 refund from contact lens fitting fee if within 90-day trial period.

***Contact Lens prescriptions **not finalized** within the 90-day trial period may require a **new** contact lens exam.

***Contact Lens prescriptions expire after 12 months. A **comprehensive eye exam** is required annually. A **contact lens exam** must be completed yearly to update contact lens prescriptions. See above for contact lens follow up exam fitting fee. Both the comprehensive and contact lens exams may be performed at the same visit and will incur separate charges.

I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICY:

PRINT

SIGN

DATE

*This policy will be superseded by the benefits of your vision plan if applicable.

VER 1/2/26



NORTHLAKE EYE CENTER

SURGICAL EYE ASSOCIATES

1120 N. Hwy 190 Covington, LA 70433

Phone 985-893-5777

Fax 985-871-0609

Terrell Hemelt M.D.

Martine Domangue M.D.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI):

I, _____, AUTHORIZE SURGICAL EYE ASSOCIATES TO RELEASE/OBTAIN MY ENTIRE MEDICAL RECORD FOR ALL DATES OF SERVICE. THIS IS TO INCLUDE CHART NOTES, TEST RESULTS, VISUAL FIELDS, LABORATORY RESULTS, AND THE MOST RECENT CONTACT AND/OR GLASSES PRESCRIPTIONS.

OTHER: _____

NAME OF FACILITY/DOCTOR: _____

PHONE/FAX NUMBER(S): _____

ADDRESS: _____

CITY/STATE/ZIP: _____

IF THE PHI NOT BEING RELEASED TO A FACILITY/DOCTOR'S OFFICE, I AUTHORIZE SURGICAL EYE ASSOCIATES TO RELEASE MY ENTIRE MEDICAL RECORD FOR ALL DATES OF SERVICE TO:

SPOUSE'S NAME

OTHER'S NAME

WHEN MY PHI IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT OF REDISCULOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY THE FEDERAL HIPPA PRIVACY RULE. THE USE OF DISCULOSURE OF THE INFORMATION IDENTIFIED ABOVE IS VOLUNTARY. I HAVE READ AND UNDERSTAND THE NATURE OF THIS AUTHORIZATION AND UNDERSTAND THAT IT MAY BE REVOKED UPON MY WRITTEN REQUEST TO THE PRIVACY OFFICER, EXCEPT TO THE EXTENT THAT ACTIONS HAS ALREADY BEEN TAKEN ON THIS AUTHORIZATION. THE RELEASER AND ITS AGENTS AND EMPLOYEES ARE HEREBY AUTHORIZED TO OBTAIN, INSPECT, AND REPRODUCE SUCH RECORDS AND/OR INFORMATION AND RELIEVED OF ANY RESPONSIBILITY OF LIABILITY THAT MAY ARISE FROM THE RELEASE OR REPRODUCTION OF SUCH RECORDS AND/OR INFORMATION.

PATIENT'S/GUARDIAN'S SIGNATURE

DATE: _____

WITNESS'S SIGNATURE

DATE: _____