S I G H T L I N E

Laser Eye Center & Ophthalmic Associates

2100 CORPORATE DRIVE, SUITE 400 WEXFORD, PA 15090 P (724) 933-5588 F (724) 933-6051

Thank you so much for scheduling an appointment in our office. We are honored that your doctor has selected us to participate in your care. Our role is to deliver excellent patient care and to meet the high expectations of you and your doctor. Your doctor is in a unique position to evaluate our services. This is a strong motivating force for us and should be a source of comfort for you.

Please complete both pages of the HEALTH HISTORY FORM. Completely filled out forms will expedite the organization of your chart and have you seen by the doctor in a timely manner.

We also ask that you bring a photo identification and your most current health insurance card(s) to include in your chart. If you have an insurance plan that requires a referral from your primary care provider, you must contact their office in advance of your appointment. Co-pays must be paid at the time of service. If you have any questions regarding your health insurance coverage, please contact your insurance company prior to your visit.

FOR CATARACT AND REFRACTIVE SURGERY EVALUATIONS, WE ASK THAT YOU REMOVE CONTACT LENSES AT LEAST 48 HOURS BEFORE YOUR VISIT (THE LONGER THE BETTER).

Your eyes may be dilated at your appointment in order for us to examine the back of your eyes. The necessary drops may cause temporary blurred vision or light sensitivity; therefore, you may need to bring a friend or family member to drive you home. Please plan to be at the office for 2 hours.

Please call your insurance carrier prior to your visit to determine what surgery center or hospital is in network with your insurance to help facilitate scheduling your surgery. You will need the NPI number of the surgery center or hospital you would like to go to when calling your insurance company. Below is the list of NPI numbers of the locations Sightline is affiliated with:

Armstrong Hospital	1568577724	SW Ambulatory Surgery Center	1912933680
Gamma Surgery Center	1821036138	The Surgery Center at Cranberry	1902876212
Heritage Valley Beaver	1063422053	UPMC Cranberry Passavant	1225047699
Jameson Memorial Hospital	1477538312	Western PA Surgery Center	1447220082

Once again, we welcome you as a patient, and hope your experience with us is a pleasant one. Please feel free to contact the office with questions you may have.

Sincerely,

The Sightline Doctors and Staff

SightLine Laser and Ophthalmic Associates
ADVANCE NOTICE & ACKNOWLEDGEMENT OF POLICIES

HIPAA PRIVACY POLICY

A copy of our Notice of Privacy Practices is posted at the front desk and can be found in our 'Privacy Binder'. You have the right to have a copy of this policy. Please see a staff member to request a copy of our HIPAA policy for your records. Signing below acknowledges that you have had the opportunity to review the Notice of Privacy Practices and have been offered a copy.

REFRACTIONS

A refraction may be performed at your evaluation and/or subsequent follow-up visits. This is a test to determine the best possible vision. This test is a separate component to the medical exam and is NOT COVERED BY INSURANCE PLANS. Our current fee for this service is $45.00. If you choose to pay for the refraction on the day of service, a $10 cash discount will be extended.

ASSIGNMENT OF BENEFITS

Signing below authorizes and directs your insurance carrier(s), including Medicare and private insurance plans, to issue payment check(s) directly to SightLine Ophthalmic Associates for medical services rendered to you and/or your dependents. You also authorize the release of any information needed to determine benefits and submit claims for these services.

FINANCIAL RESPONSIBILITY

Fees (including co-pays) are due and payable on the date that services are rendered. You have requested medical services from SightLine Ophthalmic Associates, and by making this request, you become fully financially responsible for any and all charges (including co-insurance, deductibles and non-covered services) incurred in the course of the treatment authorized.

By signing below, I am confirming that I have read and understand this notice and confirm that I have been given the opportunity to ask whatever questions that I might have and that they have been answered to my satisfaction.

_____
Patient Name (print)

_____ _____
Signature Date