EYEGAZE

Getting Started

Complete the Application Packet. All sections MUST be completed.

□ Intake Form: Patient and contact information. To purchase through insurance please include the contact information of your Physician and Speech Language Pathologist (SLP).

□ Pre-Screening Questionnaire: A brief questionnaire used to collect the medical details and history of the the patient's condition.

□ Eye Movement Video (If communicating with eye gaze access only): In order to determine the patient's candidacy for eye gaze access, we ask that you submit an eye movement video. Here is an example of the type of video we would like to see:

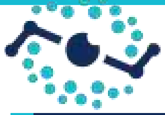
For Insurance Purchases:

□ Authorization for Release of Information: Designates whom Eyegaze Inc. can communicate with regarding your case.

□ Copy of all insurance cards: Please provide a copy of the front and back of the patient's insurance cards. Please ensure the copies are legible so all phone numbers on the back of the insurance cards are clear. Photo scans or smart phone photos can printed and faxed or mailed to:

Eyegaze Inc.
10363 Democracy
Lane Fairfax Virginia
22030 USA
FAX: 703-385-7137

For Medicare customers a copy of Medicare Supplier Standards can be found here, and our privacy practices can be found here.



Intake Form

Patient Information

Full Name First ______

Last ______

Date of Birth : ______ / ______ / ______

Mailing Address : ______

(include zip code) : ______

Phone Number : ______ E-Mail : ______

Diagnosis : ______

Preferred Language for Communication Device : ______

Notes : ______

Contact Details - Who is the main point of contact?

Contact Name : ______ Email Address : ______

Relationship : ______ Mobile Number : ______

Healthcare Provider Information (For Insurance Purchases Only)

Physician's Name (Who will write the prescription) : ______ Fax Number : ______

Phone Number : ______ Address : ______

Speech Language Pathologist : ______ Fax Number : ______

Phone Number : ______ Company/ School Name : ______

Address : ______

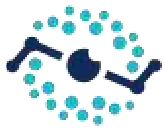
More Information :

10363 Democracy Lane, Fairfax Va 22030 (703)-385-8800 (Office)

(703)-385-7137 (Fax)

www.eyegaze.com

info@eyegaze.com

 EYEGAZE

Method of Payment (Check all that apply)

☐ Commercial/Private Insurance ☐ Insurance

Primary Payer : ______________________

Name as it appears on card : ______________________

Provider Services : ______________________

Phone # Member ID : ______________________

Group # : ______________________

Secondary Payer : ______________________

Name as it appears on card : ______________________

Provider Services : ______________________

Phone # Member ID : ______________________

Group # : ______________________

Tertiary Payer : ______________________

Name as it appears on card : ______________________

Provider Services : ______________________

Phone # Member ID : ______________________

Group # : ______________________

☐ Self Pay/Purchase Order

Contact Information (Buyer) ______________________

Name : ______________________

Phone : ______________________

Email : ______________________

Billing Address : ______________________

The information collected in this packet will remain confidential and will be used only for the purpose of providing assistance in obtaining insurance funding for an Eyegaze Edge®

EYEGAZE

Authorization for Release of Information

Identifying Information:

Patient Name: ______________________________Date of Birth: _________________________

Address: ____

Contact Person: __________________________________ Phone: ________________________

This authorizes the release of any medical or other information necessary to determine and obtain benefits payable for an Eyegaze Edge to Eyegaze, Inc., my insurance carrier or other medical entity. A copy of this authorization will be sent to the Centers for Medicare and Medicaid Services (CMS), my insurance company or other entity of requested. The original authorization will be kept on file by the organization.

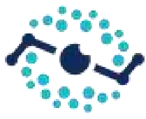
The following is a listing of the person(s) and/or organization(s) that I authorize to receive my personal health information pertaining to the acquisition of the Eyegaze Edge. I understand if the person(s) and/or organization(s) listed below are not health care providers, a health plan or a health care clearinghouse, they are not subject to the same Federal privacy rules and they may disclose my health care information without obtaining my permission.

Eyegaze Inc.	Relationship to the patient	DME Provider
Contact 1:	Relationship to the patient	
Contact 2:	Relationship to the patient	
Contact 3:	Relationship to the patient	
Contact 4:	Relationship to the patient	

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices and a copy of the DMEPOS Standards. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

This authorization may be revoked in writing by the above individual at any time.

Printed Name of Parent/Guardian/Patient: ____ Signature of Parent/Guardian/Patient: ____________________________ Date: ___________________________________ Relationship to Patient: ____________________________________ Authority: ______________________________



EYEGAZE

Tell us more about the patient. An Eyegaze Representative will use these details to prepare for a demonstration.

Clinical Details			
	Explain		Explain
Name		Gender	
Age		Location/Zip	
How are they currently communicating?			
Have they tried any other devices? Which ones?		Have they ever used a communication keyboard?	
Is the patient working with a speech pathologist?		Tell us about their body movements, positioning, and seating	
Can they answer yes/no somehow?		Are they able to look up, down, left, right?	
Previous eye surgeries/conditions		Do they wear glasses? What kind of lenses?	
Do they use eyedrops?		Where will they be using the device? (In bed, sitting in a wheelchair or recliner, outside)	
Who in the family will be trained to assist with the device?		Would they like to control an external computer (PC, Mac, Linux, IPad)?	
Are they or will they be on hospice? If so, when?		Notes/Comments	