Millbrook Family Eyecare

EXCELLENCE IN EYE CARE

REGISTRATION FORM

Welcome to our office. Thank you for taking the time to complete this form in its entirety.
PLEASE PRINT CLEARLY

TODAY'S DATE: _____ PATIENT'S NAME: _____

HOME PHONE#_____CELL PHONE: _____

AGE: _____ DATE OF BIRTH: _____ SEX: M__ F___ SOC. SEC# _____

STREET ADDRESS: _____

CITY:_____STATE: _____ZIP: _____

MAILING ADDRESS: (if different) _____

EMPLOYER: _____OCCUPATION: _____

ADDRESS: _____WORK PHONE: _____

EMERGENCY CONTACT: _____

ARE YOU A STUDENT? IF YES ____ SCHOOL/ COLLEGE _____

FINANCIAL INFORMATION

(Payment is expected at the time of service)

PERSON FINANCIALLY RESPONSIBLE: (i.e. patient is child) _____

RELATIONSHIP TO PATIENT: _____ADDRESS: (if different) _____

SOC. SEC. # _____DATE OF BIRTH: _____

EMPLOYER: _____OCCUPATION:_____

ADDRESS: _____WORK PHONE: _____

SPOUSE: (of patient/responsible party) _____

EMPLOYER: _____OCCUPATION: _____

ADDRESS: _____WORK PHONE: _____

MEDICAL INSURANCE INFORMATION

Is referral required for medical services? _____yes _____no We will need to make a copy of your current insurance card/cards

PRIMARY INSURANCE CO. _____POLICY# _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH:_____

SECONDARY INSURANCE:_____POLICY# _____

VISION CARE INSURANCE: _____

HAS ANY MEMBER OF YOUR FAMILY BEEN IN OUR OFFICE? YES _____ NO _____
IF YES, WHO? _____
REFERRED BY:_____

FAMILY DR. OR PEDIATRICIAN: _____PHONE # _____

SIGNATURE OF PERSON COMPLETING FORM: _____

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Thank you for completing this form. It will help your doctor to make an accurate diagnosis and begin treatment.

Today's date**:** _____Patient name**:** _____

Appointment date**:** _____ Date of birth**:** _____

CHIEF COMPLAINT: (REASON FOR APPOINTMENT) _____

HISTORY OF PRESENT EYE CONDITION: (When did symptoms begin? / What brings it on? How did it progress?

What makes it worse? What relieves symptoms?) _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury?_____

Are you pregnant and /or nursing? Yes____ No____
Do you wear glasses? Yes ____ No_____ If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? Yes _____ No _____ If yes, how old is your present pair of contacts? _____
Type of contact lenses: Rigid ____ Soft ____ Extended Wear ___ Other _____ Are they comfortable? Yes ____ No _____

ALLERGIES - : List your allergies including any medications that caused an allergic reaction:

Allergy to: _____Type of allergic reaction:_____

CURRENT MEDICATIONS – List all medications you are currently taking with dosage and frequency (include over the counter medications and vitamins):

Drug name (generic brand):_____Dosage:_____Frequency:_____

Drug name (generic brand):_____Dosage:_____Frequency:_____

Drug name (generic brand):_____Dosage:_____Frequency:_____

MEDICAL HISTORY

Please provide a complete history including all illness, injuries hospitalizations, operations and present medical conditions that you are being treated for now.

_____Date _____Treatment_____

_____Date _____Treatment_____

_____Date _____Treatment_____

_____Date _____Treatment_____

Do you have?
Diabetes ___ High blood pressure ___ Heart disease ___ Headaches ___ Pulmonary disease ___ Eye disease___ Other___
Explain_____

Date of last eye exam: _____ By whom: _____

Date of last physical: _____ By whom: _____

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SOCIAL HISTORY

This information is kept confidential. If you prefer you may discuss this portion directly with your Dr.
I would prefer to discuss my Social History information directly with my doctor. If so check box. _____.

Please check all that apply:
Do you drive? Yes _____ No_____

Smoking: Current ___ Previous____ No. of years____ Quit year ____ # per day ____Other ____None_____

Miscellaneous Drugs: Vitamins ___ Pain pills ____ Marijuana ____ Laxatives ____ Sleeping pills _____
Cocaine ____ Antacids ____ NutraSweet _____ Amphetamines _____ Diet pills _____
Saccharin ____Other _____ Please list _____

Do you drink alcohol? Yes_____ No _____ I yes, type/amount/ how long? _____

Have you ever been exposed to or infected with: Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis _____

Do you use illegal drugs? Yes_____ No_____ If yes, type/amount/how long?_____

Marital Status: Married _____ Single _____ Widowed _____ Divorced ____ Other _____

FAMILY HISTORY

Please <u>circle</u> if there is any family history (parents, grandparents, siblings, children;(living or deceased) for the following conditions: **Relationship to You**

Diabetes _____
Glaucoma _____
Macular degeneration _____
Blindness _____
Cataracts _____
Crossed Eyes _____
Retinal Detachment/disease _____
High blood pressure _____
Cancer _____
Kidney Disease _____
Arthritis _____
Lupus _____
Thyroid Disease _____

OCULAR HISTORY

Do you have any problems with your present spectacle/contact lens prescription? Yes _____ No_____

Do you experience any: Itching_____ Pain _____ Double vision _____ Spots _____ Light flashes _____

Have you ever worn contact lenses? Yes _____ No _____

Eye color _____ Has your color vision been tested? Yes _____ No _____

Is there a family history of an eye turn or "lazy" eye? Yes _____ No _____

Have you ever had an eye injury? Yes _____ No _____Have you ever had eye surgery? Yes_____ No _____

If so please describe? _____

Have you ever had vision training, eye exercises, or worn a patch over an eye? Yes _____ No _____

Print patient name: _____DOB:_____

Patient/Guardian signature: _____Date: _____

Review of Systems Do you currently, or have you ever had any problems in the following areas? If yes, please explain and list medications.

System	No	Yes	?	Explain/List Medications
Constitutional (fever, weight loss/gain)				
Integumentary (skin)				
Neurological				
Headaches				
Migraines				
Seizures				
Eyes				
Loss of vision				
Blurred Vision				
Distorted Vision/Halos				
Loss of Side Vision				
Double Vision				
Dryness				
Mucous Discharge				
Redness				
Sandy or Gritty Feeling				
Itching				
Burning				
Foreign Body Sensation				
Excess Tearing/Watering				
Glare/Light Sensitivity				
Eye Pain or Soreness				
Chronic infection of Eye Lid				
Sties or Chalazion				
Flashes/Floaters in Vision				
Tired Eyes				
Ears, Nose, Mouth, Throat				
Allergies/Hay Fever				
Sinus Congestion				
Runny Nose/ Post Nasal Drip				
Chronic Cough				
Dry Throat/ Mouth				
Respiratory				
Asthma				
Chronic Bronchitis				
Emphysema				
Vascular/Cardiovascular				
Diabetes				
Heart Pain				
High Blood Pressure				
Vascular Disease				
Gastro-intestinal				
Diarrhea				
Constipation				
Genitourinary(genital/kidney/bladder**)**				
Bones/Joints/Muscles				
Rheumatoid Arthritis				
Muscle Pain				
Joint Pain				
Lymphatic/Hematologic				
Anemia				
Bleeding Problems				
Endocrine (thyroid/other glands)				
Allergic/immunologic				
Psychiatric				

Doctor's Signature_____Date_____

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OUR VISION/HEALTH INSURANCE POLICY:

Our office accepts payment from various insurance companies and third party carriers for the convenience of our patients. Our policy is to bill your insurance carrier first. You will be responsible for whatever portion of your bill that is not paid by your insurance carrier.

Patients who do not have coverage for materials must pay a deposit when the initial order is placed and the balance upon dispensing. Medicare patients are responsible for their annual deductible and 20% of the Medicare approved charges.

FINANCIAL POLICY:

Our office accepts cash, checks and most major credit cards. Full payment is due at the time of service. *There will be a $25 service charge for a returned check*. If you have major medical insurance, *you may be* entitled to reimbursement or coverage if your eye care involved a medical diagnosis, or the exam was necessary to rule out either a medical eye problem based on medical eye symptoms like headaches or double vision, or if you have a general health problem which can cause eye problems (like diabetes or high blood pressure). A 50% deposit is required for all eyewear, contact lenses and low vision orders. The balance is due when dispensed. *We may require full payment prior to ordering materials through certain vision care plans.* All quoted fees are approximate, because eye problems revealed by the exam may be more complex, requiring,, more comprehensive testing, diagnosis and/or consultation. This cannot be predicted in advance.

I understand that I will be financially responsible for all charges incurred for services rendered to me or my dependents, not covered by my insurance company, including, but not limited to, deductible, co-pays, coinsurance obligations and denials (after exhausting every measure possible to have your insurance pay). I also understand that once I have been seen and examined, I cannot request retro-active insurance claim submission.

I request that payment of authorized Medicare benefits or other insurance be made to Dr. Vernon A. Peryea for any services furnished. I authorize any holder of medical information about me to release to the Healthcare Financing Administration (HCFA) and its agents (my insurance), any information needed to determine these benefits payable for related services. The signature below is valid for my lifetime. I may however rescind my signature anytime I wish.

Print patient name: _____DOB:_____

Patient/Guardian signature: _____Date: _____

DO I NEED TO HAVE MY EYES DILATED?

On the patient's first visit, a comprehensive eye exam many times will include papillary dilations. This is used not only to determine the health of the eyes but the health of the patient. Pupillary dilation allows viewing the internal eye in great detail and permits the doctor to discover early detection of potentially serious eye health problems such as glaucoma, cataracts, and vascular disease. The procedure can also reveal any potentially damaging diseases such as diabetes, hypertention, drug toxicity, tumors and neurological disease. The eye drops will dilate the pupils and cause sensitivity to light and some mild blurring of vision. The symptoms typically last 3-4 hours. You will be given a tinted shield to wear when you leave to help you cope with the light.

It is extremely important to inform us of your medical history and ocular symptoms. Some insurance plans cover this procedure while others may not. We may be able to inform you of this after we review your coverage and your file.

ABOUT THE "GLAUCOMA TEST"

This office does not use an air-puff tonometer to determine the eye's pressure, so you can relax. We use the Goldman tonometer which is the standard by which all others are made. A yellow drop will be instilled which not only contains the fluorescein dye but also a topical anesthetic, so you will not feel anything…….**as long as you keep your eyes open during the actual measurement.** We normally begin testing at age 18 unless the family history suggests otherwise.

I HAVE READ THE ABOVE AND WISH ____ DO NOT WISH____ TO HAVE MY EYES DILATED.

Print patient name: _____DOB:_____

Patient/Guardian signature: _____Date: _____

Millbrook Family Eyecare
EXCELLENCE IN EYE CARE
Dr. Vernon A. Peryea
Optometrist

Tel: 845-677-5012
Fax: 845-677-5024
61 Front Street
Millbrook, NY 12545

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control how your healthcare information is used. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary, information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment of your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use of disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your doctor or the doctor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights the following is a statement of your rights with respect to your protected health information. **You have the right to inspect and copy your protected health information.** Under federal law, your may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of , or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. Your may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your doctor is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i. e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Notice effective June 10,2002.

Signature below is the only acknowledgement that you have received the Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Please list the names of any persons you authorize our office to speak with regarding your medical condition: