Lehigh Valley Eye Care Associa

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth_____ Date_____

List any **medication** you currently take (Rx and over-the-counter):	Do you have **allergies** to any medications? ❑ YES ❑ NO If YES, list the medications:

Contact Lenses: ❑ No ❑ Yes Type _____

List any **surgeries** you have had (cataract, appendectomy, etc.): _____

_____

_____

Do you or your immediate family have any problems in the following areas? If YES, check all that apply and provide additional information.	You		Family		Details
	Yes	No	Yes	No	
EYES (blurry vision, dry eyes, watery eyes, pain, flashes, floaters, halos, headaches)					
Cataract					
Glaucoma					
Macular Degeneration					
Retina Detachment					
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)					
EARS, NOSE, THROAT (hard of hearing, stuffy nose, seasonal allergies, ear ache, cough, dry mouth, etc.)					
CARDIOVASCULAR (heart attack, high blood pressure, racing pulse, dizziness, etc.)					
RESPIRATORY (congestion, wheezing, short of breath, asthma, bronchitis, emphysema, etc.)					
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)					
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)					
FEMALES Are you pregnant? Nursing?					
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)					
SKIN (pimples, warts, growths, rash, etc.)					
NEUROLOGICAL (numbness, headache, seizures, paralysis, epilepsy, etc.)					
PSYCHIATRIC (anxiety, depression, insomnia)					
ENDOCRINE (diabetes, hypothyroid, etc.)					Diabetes controlled by: ❑ Insulin ❑ Medication ❑ Diet
BLOOD/LYMPH (bleeding, high cholesterol, anemia, problems related to blood transfusion, etc.)					
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)					
OTHER (Cancer, AIDS, HIV+, Hepatitis, etc.)					

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ❑ **YES** ❑ **NO**

Have you ever had a blood transfusion? ❑ **YES** ❑ **NO** Date of last tetanus shot: _____

Do you drink alcohol? ❑ **YES** ❑ **NO** How much_____ Do you smoke? ❑ **YES** ❑ **NO** How much_____

SIGNATURE _____

OFFICE USE ONLY

Reviewed Date	Tech	Physician	Reviewed Date	Tech	Physician	Reviewed Date	Tech	Physician

Lehigh Valley Eye Care Associates

WELCOME TO OUR OFFICE

Today's Date _____ Age _____

Patient _____ Date of Birth _____

Name of Person Legally Responsible *(If patient is a Minor, Name of Parent, Guardian, etc.)* _____

Home Address _____
Street *City* *Zip*

Home Phone _____ Cell Phone _____

Email _____ Preferred Pharmacy & Location _____

Patient Employed by _____ Occupation _____
(Or Responsible Person)

Business Address _____
Street *City* *Zip*

Business Phone _____ Social Security Number _____

Name of Spouse _____
First Name *Middle Name* *Maiden Name* *Last Name*

Spouse Employed by _____ Occupation _____

Business Address _____
Street *City* *Zip*

Business Phone _____ Social Security Number _____

How did you find out about our office? _____

Relative or friend not living with you *(for emergency purposes)* _____ Phone (w) _____ (h) _____

Name of Family Physician _____

Do you have Medical or Vision Insurance? ☐ No ☐ Yes Medicare No. _____

Insurance Company _____

Group and Membership Number _____

COMMUNICATION CONSENT

It is the office policy of Lehigh Valley Eye Care Associates and staff not to release confidential and/or unauthorized information by home telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the patient. Also, information will not be left with an unauthorized person who may answer the telephone.

This authorizes Lehigh Valley Eye Care Associates and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home / Answering Machine _____ ☐ Yes ☐ No

Work _____ ☐ Yes ☐ No Cell _____ ☐ Yes ☐ No

If you would like to have information released to someone other than yourself, please list the names and relationship of authorized people:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I, the undersigned, verify that the above information is correct. I give permission to Lehigh Valley Eye Care Associates to file my medical insurance claims for me and to release any medical records necessary to accomplish this filing process. I will be responsible for any non-covered service by my insurance.

Signature: _____ Date: _____

Lehigh Valley Eye Care Associates
2030 W. Tilghman Street, Allentown, PA 18104
Phone: 610-432-3258 Fax: 610-289-2100

FINANCIAL PAYMENT POLICY

Lehigh Valley Eye Care Associates is committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for all services provided by Lehigh Valley Eye Care Associates is due in full at the time of service. Our office participates with Medicare and other insurance companies. Should your coverage be with one or more of these companies, we will bill your insurance company along with the guidelines of our contract. However, co-payments, co-insurances, deductibles and non-covered services that have not been satisfied, are the responsibility of the patient and payment is expected at the time of service.

If you have any questions regarding your insurance coverage, it is your responsibility to contact your insurance carrier. **Your insurance is a contract between you and the insurance company.** If your insurance company requires a referral, this must be present at the time of service. If there is not a referral at the time of your visit:

1. You may be asked to reschedule.
2. You may sign a financial liability form stating that if the referral is not received by the end that business day, you will be responsible for the cost of the visit.

There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our staff prior to your appointment. Co-pays are exempt from this because your insurance requires you to pay your co-pay at the time services are rendered.

We accept cash, checks, MasterCard, Visa and Discover. There is a $50 returned check fee.

Lehigh Valley Eye Care Associates reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations. In the event your account is turned over to our collection agency, all appropriate collection fees will be added to your outstanding balance.

By signing below, the undersigned authorizes treatment by the providers of Lehigh Valley Eye Care Associates. The undersigned also authorizes the release of any information requested by insurance companies or liable third parties and assigns any insurance benefits or injury benefits to Lehigh Valley Eye Care Associates.

Signature _____ Date:_____

Patient's Name: _____

ADVANCE BENEFICIARY NOTICE

We expect that your Insurance may not pay for the service that is described below. Your Insurance Company does not pay for all of your health care costs. That fact that your Insurance may not pay for a particular service does not mean that you should not receive it. Right now, in your case, Insurance may not pay for-

REFRACTION:

Refraction is the portion of the examination that determines your spectacle prescription. Some Insurance companies, including Medicare, consider this routine and non-medical.

(Estimated Cost: $50.00)

PLEASE CHOOSE ONE OPTION. CHECK ONE. SIGN AND DATE YOUR CHOICE

____Option 1. **YES . I want to receive this service.**
Please submit my claim to Insurance. I understand that you may bill me for this service and that I may have to pay the bill while insurance is making its decision **(Medicare will NOT pay for this service).** If Insurance denies payment, I agree to be personally and fully responsible for payment.

____Option 2. **NO. I have decided not to receive this service.**

_____ _____

Date **Signature of patient or person acting on patient's behalf**

Lehigh Valley Eye Care Associates

Lehigh Valley Eye Care Associates is pleased to offer Optomap ultra-wide digital retinal imaging to our patients. Optomap is the latest in eye care technology and is the recommended method for retinal screening by our doctors.

The benefits of the Optomap system are:

- ✓ Testing is fast, easy, and comfortable
- ✓ Provides a more complete view of the retina (back of the eye) than has previously been possible. It provides a 200° view and 82% of the retina with a single image.
- ✓ A study showed that 1/3 more pathology was found with the Optomap than dilated exam alone
- ✓ Provides a digital record of your retina which becomes part of your permanent file
- ✓ Enables us to better monitor the health of your eyes over time
- ✓ Continues our commitment to offer all of our patients the highest standard of care available

If pathology or unusual anatomy is documented with this testing, these image studies can be billed to your medical insurance as part of your treatment plan. If the scans do not detect any unusual condition, then the photos will not be covered by insurance, and you are responsible for a fee of $39.

☐ I elect to have the Optomap ultra-wide digital retinal imaging test performed today.

☐ I would like to talk to my doctor and get more information first.

Patient Signature: _____

Date: _____