THANK YOU FOR CHOOSING

EYE DOCTORS OF CHESTER COUNTY

WELCOME TO OUR PRACTICE. WE LOOK FORWARD TO SERVING YOU.

LAST____________________________________FIRST________________________MI______

ADDRESS ____

CITY_______________________________________ STATE______ ZIP___________________

EMAIL ADDRESS_________________________________ DATE OF BIRTH_________________

PHONE(S) Home __________________ Work __________________Cell __________________

Please circle the number you wish us to use as your primary phone

SS#______________________ OCCUPATION____

RACE ☐American Indian ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Pacific Islander ☐Other

ETHNICITY ☐Hispanic/Latino ☐Not Hispanic/Latino

FAMILY PHYSICIAN NAME____

CONTACT PERSON (Relative/Friend)__________________________ PHONE________________

How did you hear about our practice? Relative/Friend Family Physician Optometrist Internet Other __________________

In an effort to serve our patients in a more timely and efficient manner, Eye Doctors of Chester County, through Levin Luminais Chronister Eye Associates, has an online patient portal with Follow My Health.

As part of our commitment to quality of care and in compliance with new federal regulations, the patient portal can provide you with timely access to a current report of your eye health. You can also communicate securely with your doctor regarding your vision care, office visits and medications.

To receive an invitation to join our portal, please email your name and date of birth to info@lleaeyes.com. You must use the email invitation to join; you cannot sign up independently.

All copays are due at the time of service.

Medical History Form

Patient name: ______________________________**Occupation:** ______________________________
Email Address: ____
Family Physician (Name and Phone): ____

Drug allergies:☐ None ☐Other:____

Do you have now or have you ever had:		**Comment:**
Skin problems like eczema or psoriasis	YES ____NO ____	_______________________
Problems with your hearing	YES ____NO ____	_______________________
Breathing problems like asthma or emphysema	YES ____NO ____	_______________________
High blood pressure/heart problems	YES ____NO ____	_______________________
Heart problems/surgery	YES ____NO ____	_______________________
Stomach or acid reflux problems	YES ____NO ____	_______________________
Kidney/bladder/prostate problems	YES ____NO ____	_______________________
Muscle or joint pain/arthritis	YES ____NO ____	_______________________
Neurological/headache	YES ____NO ____	_______________________
Headaches/migraines	YES ____NO ____	_______________________
Diabetes – date of onset: _____	YES ____NO ____	_______________________
Treatment: Diet Controlled _____ Oral medications ____ Insulin ____		
Thyroid problems	YES ____NO ____	_______________________
Blood problems like anemia	YES ____NO ____	_______________________
High cholesterol	YES ____NO ____	_______________________
Depression or anxiety	YES ____NO ____	_______________________
Seasonal/environmental allergies	YES ____NO ____	_______________________
Infectious disease like HIV or Hepatitis	YES ____NO ____	_______________________
Cancer -location: _____________ year: _____	YES ____NO ____	_______________________
Treatment: Chemotherapy ____ Surgery ____ Radiation _____		
Head/eye trauma	YES ____NO ____	_______________________
Major surgeries or hospitalizations	YES ____NO ____	_______________________

Please explain: ____
____

Do you smoke? Never Former Current **Drink alcohol?** Yes No Social

Current Medications (name and dosages): ***please use other side for additional medications***

1. ________________________________ 6. ________________________________
2. ________________________________ 7. ________________________________
3. ________________________________ 8. ________________________________
4. ________________________________ 9. ________________________________
5. ________________________________ 10. _______________________________

Current Eye Medications:

1. _________________________________ 3. ____________________________
2. _________________________________ 4. ____________________________

Over the Counter Preparations (vitamins etc)

1. _________________________________ 3. _____________________________
2. _________________________________ 4. _____________________________

Preferred Pharmacy Name and Address ____

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

I have received and/or been given the opportunity to review Eye Doctors of Chester County's Notice of Privacy Practices.

____________________________________	______________________________	___________
Printed Patient Name (and Guardian Name if applicable)	Signature	Date

____

Eye Doctors of CC Witness

Our office does not make the rules. They are determined by your specific medical insurance or vision plan.

It is important that you read and acknowledge our Policies and Procedures in full.

Policies and Procedures

Payment in full for services and products are due at the time services are performed or products are ordered. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services or products you receive from our office. This includes any medical service or visit, routine examination, testing, contact lens services and any other screening ordered by the doctor or staff.

Co-payments will be collected at the time of service. Professional fees, services fees, co-payments and deductibles are NOT refundable. There will be a $20 fee for returned checks.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient. If you miss two appointments without prior cancellation, you will be required to pay a $35 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this $35 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable.

Medical vs. Vision Insurance

Medical Insurance: when a medical condition exists such as (but not limited to) cataracts, glaucoma, dry eyes, diabetes, high blood pressure, or any other condition related to the health of the eye, it will be necessary for the doctor to perform a full and comprehensive ocular health exam. This exam may include further testing beyond the scope of a routine eye exam. With a medical diagnosis, your exam and testing will be billed to your medical insurance and you will be responsible for any co-pays, deductibles and/or co-insurance as dictated by your specific plan. If you are diabetic, your exam will be billed to your medical insurance without exception.

Vision Care Insurance: vision coverage for a routine examination is designed to provide a screening evaluation of the eye to determine a prescription for glasses only. This evaluation is not a comprehensive ocular health examination and excludes any testing to diagnose, evaluate and follow medical issues. This evaluation also does not include a contact lens evaluation or any fees associated with contact lenses.

Refractions: a refraction is the portion of the examination process wherein the doctor or technician places various lenses in front of your eyes to determine your best corrected vision for your spectacle prescription. This service is considered to be a non-covered service by Medicare and most secondary insurance plans. The fee for this service is $40 and is collected when a refraction is performed whether or not you have had a change in your prescription. A spectacle prescription is valid for two years from the date of the refraction; you will need to have refractions as part of your exam in order to maintain a current prescription.

Contact Lenses: contact lens services are considered to be elective and therefore not covered by medical insurance, and often not covered by vision insurance. A contact lens prescription is valid for one year from the date of issue. In order to maintain a current contact lens prescription, you must have annual contact lens evaluations with your doctor. Payment for a contact lens evaluation, whether performed independently or as part of your comprehensive eye exam, is expected at the time of service. A separate contact lens agreement will be signed prior to a contact lens fitting or refitting.

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Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name ___________________________________ Date of Birth ________ SSN (last four digits)_______

Entity Requested to Release information: __LLCEA __Other _______________________________________

Purpose of request (who will be authorized to receive information): I authorize the entity identified above to disclose or provide protected health information about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual entity who is to receive your PHI):

Individual/Entity Name and Relationship ____

Individual/Entity Name and Relationship ____

Individual/Entity Name and Relationship ____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity or person(s) identified above:

__ **Entire patient record**; or, check only those items of the record to be disclosed:

__ office notes from ________ to ________

__ test results

__ financial history report (previous 3 years)

__ nursing home/home health/hospice/other physician records

__ record of HIV and communicable disease testing

__ record of mental health or substance abuse treatment

__ only the following ____

Purpose of disclosure

__ Patient request __ Other (please specify) ____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year ______________________.
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected healthcare information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

____ ___________

Patient or Representative Signature Date

____ ___________

Patient or Representative Signature Date

____ ___________

Patient or Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.

Limited Patient Authorization for Disclosure of Protected Health Information

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print the name of the patient for whom the form is being filled out.

Social Security Number and Date of Birth - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information.

Purpose of Request- To disclose your protected health information to an individual.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Expiration or Termination - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on the use of the authorization.

Redisclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.