Dedicated to Excellence in Eye Care Since 1977

Eye Doctors of Chester County

A division of Levin Luminais Chronister Eye Associates

3000 C.G. Zinn Road
Thorndale, PA 19372

Phone (610) 384-9100 • Fax (610) 384-EYES (3937)

1175 Lancaster Ave
Berwyn, PA 19312

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

Last_______________________________

First______________________________

Mi_______________________________

Date of Birth________________________

SS#______________________________

Address ___________________________

City________________________________

State_________

Zip__________

Preferred Phone___________________________

Secondary Phone__________________________

Email_________________________________

Ethnicity ______________________________

Family Physician__________________________

Family Physician Phone____________________

Emergency Contact________________________

Phone _________________________________

Relationship ____________________________

How did you hear about our practice?

Relative	Internet	Physician
Friend	Family	Optometrist
	Other_______________	

Our office is implementing some exciting new changes with regard to patient communication! We are working with Luma Health to make your interactions with the office easier and more convenient.

This new program will allow us to seamlessly communicate through multiple modes, which include text messages, phone calls, and emails.

To make sure you are getting our office communications, be sure to verify that all of your information is current, and please let us know if there are any changes to your phone number or email address.

For Office Use Only: Pt Number___________ Doctor______

Medical History Form

Patient name:______________________________**Occupation:**______________________________

Email Address: ____

Family Physician (Name and Phone): ____

Drug allergies: ____

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 on set:______	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/eyetrauma	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____

For Office Use Only: Pt Number___________ Doctor______

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

Co-payments and self-pay services that are not covered by insurance will be collected at the time of service. The cost of any returned check fees are considered patient responsibility.

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 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.

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

Office Communication Practices
We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by call, text, email, or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

I have received and/or been given the opportunity to review Levin Luminais Chronister Eye Associates' Notice of Privacy Practices.

____
Printed Patient Name (and Guardian Name if applicable)

____
Signature

____
Date

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The completion of this form allows anyone listed to obtain information regarding your office visits, test results, appointment dates/times, and financial information. Please do not list other physicians' offices. For additional information, please refer to the next page.

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 current calendar year, unless you specify an earlier termination. You must 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 current 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

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

For Office Use Only: Pt Number___________ Doctor______

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.

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your eye care to Levin Luminais Chronister Eye Associates. When you schedule an appointment with Levin Luminais Chronister Eye Associates we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Effective January 1, 2021 any patient who fails to show or cancels an appointment and has not contacted our office with at least **24 hours notice** will be considered a No Show and charged a **$50.00 fee**.

- The fee is charged to the patient, not the insurance company, and is due at the time of the next scheduled appointment.

- If a third No Show or cancellation occurs with no 24 hour notice the patient will be dismissed from our practice.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show/cancellation fee. You may contact Levin Luminais Chronister Eye Associates Monday through Friday. Should it be after regular business hours you may leave a message.

Levin Luminais Chronister Eye Associates: 610 384 9100

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

______________________________	______________________________
Signature (Parent/Legal Guardian)	Relationship to Patient
______________________________	______________________________
Printed Name	Date

For Office Use Only: Pt Number__________ Doctor_____