PEDIATRIC EYE MD

Welcome!

Our mission is to provide outstanding care in a pleasant and efficient setting. We respect your time and appreciate the privilege of participating in your health care. These are our office policies:

1. If you make an appointment with us and do not show up for the visit or call more than 24 hours in advance to cancel/reschedule the visit, then you will be charged **$50** for the administrative cost of making the appointment. **You will not be rescheduled/seen before this is paid. THIS IS NOT COVERED BY INSURANCE**.

I understand and consent to this policy. x _____

2. I, _____(please print your name), assign insurance payment to be made to PediatricEyeMD for services rendered to Fname Lname.

a. If the insurance plan that covers Fname Lname requires that I obtain a **referral** from his/her primary care doctor (pediatrician, internist, or family practitioner), then **it is my responsibility** to obtain this referral. If I do not have a referral and I pay for the visit, I will be refunded for the visit **only** if I bring in a valid referral.

b. I understand that I am responsible for non-covered services, co-payments, unmet deductibles, co-insurance fees. In the event that my insurance company reclaims monies at any time for a visit because I was not eligible or had other insurance, I am responsible for the billed amount.

c. If I default on the above responsibilities, I understand that I will be held responsible for *any and all* costs associated with collecting my debt, including court costs, collection fees and a **$200** administration fee if a court action is commenced. **I understand and consent to this policy. x _____**

3. **Important Insurance Information (so we can bill properly)**

Is this insurance policy held in the name of the patient being seen? Yes/No

IF NO, then what is the **name** of the **insurance policy holder**? _____

What is the **birthdate** of the **policy holder**? _____

What is the **social security number** of the **policy holder**? _____-_____-_____

Consent for ePrescribing

Our practice uses ePrescribing software. This allows us to send your prescriptions over the internet to your pharmacy. It also lets us see information such as drug interactions and your prescription history. The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors and less chance of adverse drug reactions
- No need to drop off a prescription at the pharmacy

I agree that PediatricEyeMD may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This consent will remain in effect until I revoke it.

Signature x

HIPAA Acknowledgement

I have received a copy of PediatricEyeMD's notice of privacy practices.

Signed: _x_____

□ Refused to sign □ Reason for refusal:

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New Strabismus Patient Demographics

Name:
Date of birth:
Today's date:

Patient's Address:

Home phone:
Work phone:
Other phone numbers where we might reach you:

Your primary insurance is:

Occupation:

How did you learn about our practice?

Who is the referring ophthalmologist/optometrist?

What is this the doctor's phone number?

Are there any other doctors to whom we should send a report?

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New Strabismus Patient
History and Review of Systems

History of eye problems: □ **None of the things in this section**

Eye injury
Eye surgery
Glasses
Other:

Social History:

What things can you no longer do because of the double vision?
Do you smoke? If so, how many packs per day?
What do you do most of the day?

Some questions about your DOUBLE VISION:

Are the double images side-by-side or up-and-down (or both)?
Is the double vision worse far away or up close?
Do you suffer from this all the time or just sometimes?
Is the double vision worse when you are tired?
Have you ever had vision training?
Did you ever wear a patch as a child?

Review of Systems: □ **None of the things in this section**

Arthritis/joint problems
Fever or weight loss
Frequent ear infections
Other ear, nose, or throat problems
Heart problems
Kidney or urinary disease
Lung disease
Mental illness
Neurologic problems
Sickle cell disease or trait
Skin problems
Other:

I have: □ **no known drug allergies (NKDA)** □ **allergies to the following medications:**
Please list ANY and ALL surgeries, hospitalizations, major illnesses, and injuries:

Please list ANY and ALL medications that you are currently taking, INCLUDING EYE DROPS:

Family History – as pertains to "blood" relatives □ **None of the things in this section**

Amblyopia ("lazy eye")
Blindness at an early age
Cataracts in childhood
Eye muscle surgery
Glasses before age 6 years
Glaucoma in childhood
Other types of serious eye disease
Patching treatment
Strabismus ("crossed eye")
Complications from anesthesia
Genetic diseases