Patient Information - Child

Please complete all questions on this form

Patient Name: ______________________________ Today's Date: ____/____/____

Date of Birth: ____/____/____ Birth Weight: __________ Full Term / Premature (circle one)

Sex: M / F (circle one) Ethnicity __________ If premature, how may weeks early ________

What problem(s) is your child currently having with their eyes? ______________________________

____

General Medical History (Please check all that apply)

☐ Arthritis	☐ Genetic Syndrome	☐ Psychiatric Disorder
☐ Asthma	☐ Hearing Impairment	☐ Diabetes
☐ Autism Spectrum	☐ Neurologic Disorder	☐ Kidney Disease
☐ Cancer	☐ Seizures	☐ Thyroid Problems
☐ Cerebral Palsy	☐ Learning Difficulty	☐ ADD/ ADHD
☐ Developmental Delay	☐ Headache/ Migraine	☐ Other ______________

List all medications currently being taken: ______________________________

____

List all previous surgery / hospitalizations: ______________________________

____

List all allergies to medications: ______________________________

Ocular History

Does your child wear glasses? (circle one): no / yes If yes, for how long?__________

Does or has your child ever had?

- ☐ Strabismus (crossed or wandering eyes)
- ☐ Amblyopia (Lazy Eye) Which eye? ____________________
- ☐ Worn an eye patch Which eye? ____________________
- ☐ Eye Surgery If yes, what kind? ____________________
- ☐ Other ______________________________

Family History (Please list any eye conditions present in relatives, such as "lazy eye," crossed eyes, thick glasses, cataracts at birth, etc.):______________________________

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Patient Registration

Patient's Name: ______________________ DOB: __________ ☐ MALE ☐ FEMALE
Address: ______________________
City/State/Zip: ______________________ Phone #: ______________________
Place of employment/Occupation: ______________________
Email: ______________________

Parent / Guardian Information (if patient is a minor)

Mother		Father	
Name		Name	
Date of Birth		Date of Birth	
Address (if different from above)		Address (if different from above)	
Phone	Email	Phone	Email

Emergency Contact Information

Name: ______________________ Phone #: ______________________
Address: ______________________
City/State/Zip: ______________________ Relationship to Patient: ______________________

Insurance Information

Primary Insurance: ______________________
Name of Policy Holder: ______________________ Relationship to Patient: ______________________
DOB Of Policy Holder: ______________________ Policy #: ______________________

Secondary Insurance: ______________________
Name of Policy Holder: ______________________ Relationship to Patient: ______________________
DOB Of Policy Holder: ______________________ Policy #: ______________________

Primary Doctor		Referring Doctor (if different from primary doctor)	
Name		Name	
Address		Address	
Phone	Fax	Phone	Fax

Please provide your insurance card to copy for our records. Insurance co-pay/deductible and referral (if applicable) are due at the time of service. By signing below, you agree to these terms and authorize Pediatric Ophthalmology & Strabismus Associates to bill your insurance.

______________________ ______________________
Patient/Parent/Guardian Signature Date

Revised 9/2020

Pediatric Ophthalmology & Strabismus Associates

Patient Privacy Notice

We are required by Federal Law under HIPAA (Health Insurance Portability and Accountability Act) to notify you of our Patient Health Information Privacy Policy. A copy of the policy is available at our front desk, and also on our website. You may review it there at any time, or request a copy to take with you. We are also required to obtain your signature indicating that we have offered you a copy of our Policy.

By signing below, you are confirming that you understand that a copy of our Patient Health Information Privacy Policy is available any time upon request or on our website, www.posa-pa.com.

Patient Name____

Signature ____
(Parent or Guardian signature if patient is a minor)

Relationship to Patient _________________________ Date____________

Authorization to Disclose Medical Information

It is the policy of our office to send a summary with the pertinent information to your/your child's primary care physician, or other physicians involved in your care, after each visit, or periodically for three reasons:

1. To document the visit for referrals which may be required by your insurance company
2. To keep your primary care physician updated as to the diagnosis and treatment of your eye condition
3. In response to consultation requests by your primary care physician or another physician who referred you to this office for consultation, second opinions or treatments

☐ I AGREE to the release of medical information to my/my child's primary care physician or other physicians involved in my/my child's medical care as outlined above.

☐ I DO NOT AGREE to the above release of medical information, with the exception of:

____

Signature: ____

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BRING TO YOUR FIRST APPOINTMENT

- Cash, check or credit card (MasterCard, Visa or Discover) for copays and any services not covered by your insurance company.
- All medical insurance cards (even if we don't participate)
- Driver's license or state identification.
- Completed New Patient Forms
- If applicable: Glasses, contact lenses, contact lens box and/or contact lens information.
- A referral from your primary doctor, if required by your insurance company.
- Authorization for child to be accompanied by adult other than parent (if applicable)

YOU AND YOUR INSURANCE

MEDICAL vs VISION INSURANCE Our doctors will be providing you with a very thorough and comprehensive medical eye exam. Therefore, our services will be billed through your medical insurance. We do not accept vision insurance plans. If you choose to pay out of pocket for a routine exam, we will provide you with a detailed receipt that you can submit to your vision insurance for reimbursement based on your vision plan allowance. Please be aware that some plans have clauses in their policies about some eye problems and classify them as non-payable. We will make every effort to appeal these types of rejections and educate your plans about ocular pathology and needed evaluation/treatment. However, we can't guarantee success in every scenario and you will be responsible for the bill if we can't obtain appropriate payment. Please remember that we didn't choose your plan for you and it is impossible for us to know every detail and clause in your plan.

CO-PAYS AND DEDUCTIBLES Our contract with your insurance company requires that we collect any known co-pays and/or deductibles. We are in violation of our contract if we don't collect these fees. We will be collecting these fees at your visit. Please be prepared to pay at this time.

REFRACTIONS A refraction is a specialized service performed to determine the prescription for glasses. Many eye conditions require a refraction for proper diagnosis and treatment. If a refraction is required, we will bill your insurance company for the service. Some insurance companies may not pay for refractions; therefore, it could be an out-of-pocket cost to patients. Our current fee for refraction is $40.00.

INSURANCE REFERRALS If your insurance company requires that you obtain referrals or authorizations from your primary care physician (i.e. pediatrician, internist), it is your responsibility to request the referral prior to your visit. You may need to pick the referral up from their office - check with your primary care physician. Also, please remember you will need a referral for every visit. If we do not have your referral at the time of your appointment, you will be asked to reschedule.

I have read the above and understand that none of the Doctors of Pediatric Ophthalmology & Strabismus Associates participate with vision plans. Instead, my medical plan will be billed, unless I choose to pay out of pocket. I also recognize that some insurance companies will not pay for an exam for every ocular diagnosis, and some insurances may not pay for refractions. I understand that I am responsible to pay for services not covered by my insurance. I also understand that it is my responsibility to request a referral from my doctor prior to my scheduled appointment, if required by my insurance company.

________________________________ ________________
Signature Date

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Authorization for Examination of Minors
When Parent/ Legal Guardian is Not Present

If someone other than a parent or legal guardian will be accompanying your child to their appointment, WE MUST HAVE written authorization from you in order to examine your child. Please complete the following information to authorize us to examine your child in your absence. The accompanying adult must show a valid ID when they arrive with your child.

I, the parent/legal guardian of the below named patient(s), give the doctors and staff of Pediatric Ophthalmology & Strabismus Associates permission to examine and treat my child(ren), and to instill dilating eye drops if necessary, for the exam. I authorize the adult(s) listed below to accompany and make decisions regarding my child(ren):

Patient(s)

1. Name: ______________________ DOB: ______________________
2. Name: ______________________ DOB: ______________________
3. Name: ______________________ DOB: ______________________

Appointment Date: ______________________

Accompanying Adult(s)

1. Name: ______________________ Relationship to patient: ______________________
2. Name: ______________________ Relationship to patient: ______________________

This authorization is for:

- ☐ This appointment only (we will need a new authorization for future appointments)
- ☐ This appointment and future appointments (we will keep this authorization in effect until you notify us in writing that it is no longer in effect)

Parent/Legal Guardian

Mobile/Work Phone: ______________________ Home Phone: ______________________

Name: ______________________ Signature: ______________________

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At Pediatric Ophthalmology & Strabismus Associates we strive to adhere to our appointment schedule to minimize waiting times for our patients. Sometimes unforeseen circumstances (emergencies, patients with complex conditions requiring more time, etc.) may cause us to fall behind. If we are running behind schedule, we will attempt to notify you when you check in for your appointment.

In order to help minimize disruptions in our schedule, we have enacted the following policies:

1. If you arrive more than 15 minutes after your scheduled appointment time, you may be asked to reschedule. In that case, you are still responsible for the $25.00 no-show fee.

2. If your insurance requires a referral, the referral must be received by our office prior to your scheduled appointment. If your referral has not been received by 15 minutes after your scheduled appointment time, you will be asked to reschedule. In this case, you are still responsible for the $25.00 no-show fee.

3. If you choose to be seen without a referral (in anticipation of a referral being submitted at a later time), we require a $75.00 deposit prior to being seen. If we are able to obtain a referral, you will be refunded the $75.00 deposit. If we are unable to obtain a referral, you will be billed for the balance of the appointment fee.

4. All no-show fees must be paid in full prior to scheduling another appointment.

Thank you for your cooperation!