Thank you for choosing Pediatric Ophthalmology & Strabismus Associates for your eye care needs. We are committed to providing you with the best possible care in a friendly, comfortable environment. In order to help minimize disruptions in our schedule, please be aware of the following policies.

Please review and initial where indicated.

_________ We require at least 24 hours' notice if you need to cancel your appointment. **If you fail to show up for your appointment, or cancel with less than 24 hours' notice, you will be charged a $25.00 cancellation fee, which must be paid prior to scheduling your next appointment.**

_________ If you arrive more than 15 minutes after your scheduled appointment time, you may be asked to reschedule. **If you are rescheduled because you arrived more than 15 minutes after your scheduled appointment time, you will be charged a $25.00 cancellation fee which must be paid prior to scheduling your next appointment.**

_________ If your insurance requires a referral, you are responsible for obtaining the referral from your primary care provider. The referral must be received by our office prior to your scheduled appointment. **If your appointment needs to be rescheduled because we did not receive your referral in time, you will be charged a $25.00 cancellation fee which must be paid prior to scheduling your next appointment.**

_________ If someone other than a parent or legal guardian is bringing a minor to the appointment, please send a note stating the name of the person who will be bringing your child, and that it's OK for us to instill dilating drops. The person bringing your child should be prepared to present us with a Driver's License or State ID to prove his/her identity.

_________ The initial appointment, and subsequent appointments that include dilation of the eyes, will last approximately 2 hours. Dilation may last up to 24 hours. The patient may be light sensitive and have some difficulty seeing small details up close (usually within arms distance) during that time.

_________ **MEDICAL vs VISION INSURANCE** Our services will be billed through your medical insurance**. We do not accept vision insurance plans**. Please be aware that some medical plans have clauses in their policies that classify some eye problems as non-payable. We will make every effort to appeal these types of rejections and educate your plan about ocular pathology and needed evaluation/treatment. However, we can't guarantee success in every scenario. You will be responsible for the bill if we can't obtain appropriate payment.

__________ **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 this service is $40.00.

____   ____

Patient Name (Parent's Name if patient is a minor)   Signature

Date: ____________________

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: ____

Patient Registration

Patient's Name :______________________ DOB: __________ ☐ MALE ☐ FEMALE
Address:______________________
City/State/Zip:______________________ Phone #: ______________________

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

Patient Information - Adult

Please complete all questions on this form

Name: ____ Today's Date: _____/_____/______

Date of Birth: _____/_____/_____ Sex: M / F (circle one)

Do you wear glasses or contact lenses? ☐ Yes ☐ No How old is your current prescription? _______________

Reason for today's visit:____

____

When was the approximate onset of the problem? ____

Are you **currently** experiencing any of the following? Please check all that apply.

☐ Abnormal Head Position	☐ Droopy Eyelid	☐ Eye Misalignment
☐ Double Vision	☐ Dry Eyes	☐ Headaches
☐ Blurry/ Decreased Vision	☐ Eye Injury	☐ Other____________________

General Medical History (Please check all that apply)

☐ High Blood Pressure	☐ Brain Tumor	☐ Hearing Loss
☐ Diabetes	☐ TIA/ Stroke	☐ Bell's Palsy
☐ COPD/ Emphysema/ Asthma	☐ Neurologic Disorder	☐ Myasthenia Gravis
☐ Arthritis	☐ Seizures	☐ Thyroid Problems
☐ Heart Disease	☐ Parkinson's Disease	☐ Multiple Sclerosis
☐ Bleeding Disorder	☐ Headache/ Migraine	☐ Sjogren's Syndrome
☐ Cancer	☐ Psychiatric Disorder	☐ Genetic Disease
☐ Kidney Disease	☐ Drug/ Alcohol Addiction	☐ Other _____________________

List all medications currently being taken: ____

____

Are you allergic to any medications? ☐ No ☐ Yes Please List: ____________________________________

Previous Surgery: ____

Ocular History (Please check all that apply)

☐ Amblyopia (Lazy Eye)	☐ Macular Degeneration	☐ Glaucoma Surgery
☐ Strabismus (eye misalignment)	☐ Retinal Detachment	☐ Keratoconus
☐ Eye Muscle Surgery	☐ Diabetic Retinopathy	☐ Corneal Transplant
☐ Cataracts	☐ Retinal Surgery	☐ LASIK / PRK
☐ Cataract Surgery	☐ Glaucoma	☐ Other _____________________