Pediatric Ophthalmology & Strabismus Associates

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: _____

3855 West Chester Pike ● Suite 335 ● Newtown Square, PA 19073 ● P: 610-347-7672 ● F: 610-347-7673
www.posa-pa.com

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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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) 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.):_____

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