EYE CENTERS OF AMERICA
Excellence in Eyecare

Stephen A. Gollance, MD
Scott W. Silodor, MD
Joel D. Pakett, MD
James Kirszrot, MD
Linda L. Hogan, OD

968 Hamburg Turnpike, Wayne, NJ 07470 Tel. 973-696-0300 • Fax. 973-696-0465

Dear Patient,

Attached is paperwork for you to complete and bring with you when you arrive for your appointment.

Please arrive 20 minutes prior to your appointment with your completed paperwork, allowing us time to enter your information.

Please be sure to complete each page and sign where required and please bring your driver's license and current insurance card (s) as we'll need to scan and enter all information into our computer system.

If you arrive at your scheduled time without completed paperwork, your appointment may need to be rescheduled.

Thank you very much for your cooperation.

Enjoy the day.

The Doctors and Staff of Eye Centers of America, LLC.

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PATIENT REGISTRATION FORM

First Name	**MI**	**Last Name**	**DOB**	**Sex: M / F**
Home Address			**Social Security #**	
City	**State**	**Zip Code**	Marital Status ☐ S ☐ M ☐ D ☐ W	
Preferred Language		Race ☐ Native American (Indian) ☐ Black/African American ☐ Asian		
Ethnicity ☐ Hispanic Origin. ☐ Not of Hispanic Origin		☐ Native Hawaiian/Pacific Islander ☐ Hispanic or Latino ☐ White		
Home Phone # ☐	Ok to text? Yes ☐ No ☐	**PLEASE PRINT CLEARLY**		
Cell Phone # ☐		E-mail:		
Please check preferred number to call				
Emergency Contact Name	Phone #	Relationship		
Referring Physician	Phone #	City		
Primary Care Physician	Phone #	City		
Financially responsible person (if different from patient)				
Responsible person's address:		Phone #		
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?		☐ Yes ☐ No		
Is this visit related to an automobile accident or Workers' Compensation?		☐ Yes ☐ No		

INSURANCE INFORMATION

Primary Insurance:	**Policy Holder Name:**	**DOB:**	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
ID #:			
VSP Vision Service Plan ☐ Yes ☐ No	Policy Holder Name:	DOB:	Policy #:

FINANCIAL POLICY STATEMENT

Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You will be responsible for any balances not covered by your insurance. A return check fee of $35.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, patient will be charged a $25.00 fee. Second occurrence, patient will be charged a $35 fee. Third occurrence, patient will be charged a $50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

If you have any questions regarding billing, please contact our billing office Monday - Friday 8am - 5pm at (973) 707-7057

PATIENT AUTHORIZATION

I hereby authorize Eye Centers of America, LLC to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and/or any other insurance company be made directly to Eye Centers of America, LLC. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare Part B benefits.

I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature_____ **Date** _____

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HIPAA NOTICE OF PRIVACY PRACTICE

Privacy Consent

I understand that Eye Centers of America, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy. I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Eye Centers of America, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Eye Centers of America, LLC has already made in reliance prior to my consent. Eye Centers of America, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

I acknowledge that by signing this form, I permit Eye Centers of America, LLC, to release any information to the physician(s) involved in my care. I consent that Eye Centers of America, LLC, may call my house or designated locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Eye Centers of America LLC, may mail to my home appointment reminders and patient statements.

I designate the following representative(s) as being legally authorized to communicate with Eye Centers of America, LLC, on my behalf. If you do not designate anyone below, the Doctor/Eye Centers of America, LLC, will not be able to speak with anyone besides the patient regarding your medical condition.

Please let us know if there is anyone else we can speak with on your behalf.

Name_____**Relationship**_____**Phone**_____

Name_____**Relationship**_____**Phone**_____

Signature on file

I request that the payment of authorized benefits be made on my behalf to Eye Centers of America, LLC.
I authorize any holder of medical information about me be release to Novitas Medicare Solutions or any other of my medical carriers and any information needed to determine benefits or benefits payable for related services.

Patient Name:_____ **Date of Birth:** _____

Signature (Patient or Legal Guardian): _____ **Date:** _____

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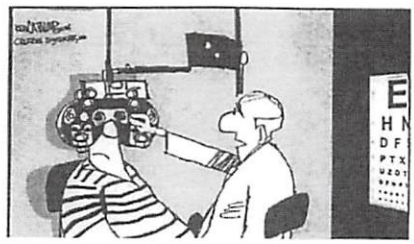

REFRACTION SERVICE AND FEE

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eyes, which is essential medical information for us to have, as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider a refraction a "vision" service, not a "medical" service. Unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Please check your Explanation of Benefits to see if your insurance plan paid for the refraction. If your plan did pay for the refraction, please let us know and we will reimburse you accordingly. Our fee for a refraction is $60.00.

If you do not have the refraction on the day of your exam, you will not be able to receive your current eye glass prescription.

PATIENT ACKNOWLEDGEMENT

I have read the above information and understand that the refraction may be a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

(By signing this you acknowledge that you understand our policy.)

_____
Patient Printed Name

_____
Date

_____
Patient Signature

We now offer an alternative for dilation when having your eye exam.

We have a High Speed Camera (OPTOS) that takes a picture of the back of your eyes in several seconds, that will give the doctors the information they will need to complete your eye exam in half the time. Your vision will not be affected.

Not all patients are a candidate for this procedure. **If you have a medical condition such as cataracts, glaucoma, diabetes, retinal issues, etc, you are NOT a candidate for the Optos.** If you are able to choose this option, there is an out-of-pocket expense of $39.00 (this is not covered under insurance).

___Yes ___No

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The Eye Institute • 968 Hamburg Turnpike Wayne, NJ 07470

IF YOU CURRENTLY WEAR CONTACT LENSES:

You have the option of having your contact lenses evaluation during your complete eye exam today. This service is not included in the exam but is a very important step in maintaining your eye health. One of our doctors will evaluate the fit of the lens, the condition of the lens and the change in the power of the lens, if needed. The power is usually different than that of your glasses. Improper fit of the lens can cause various problems including damage to your cornea. We will check to see if your lenses have any rips or tears and will check the cleanliness of the lenses.

If you do not have your contact lenses with you, we will be happy to re-schedule this evaluation for you at the check-out desk today.

The cost of this contact lens evaluation is $50.00 and is not covered by most insurance companies.

_____ Yes, I do want a contact lens evaluation.

_____ No, I do not want a contact lens evaluation; therefore, I will not receive an updated Contact lens prescription.

_____ If interested in a contact lens fitting, please be advised that this requires a separate appointment and fee.

VISION SERVICE PLAN MEMBERS

If you do not advise us of your VSP coverage prior to service, we are not obligated to submit your services after rendered as they require prior authorization.

As a Vision Service Plan (VSP) member, this contact lens evaluation fee is discounted at 15%.

Do you wish to have a contact lens evaluation today? ____ Yes _____ No

_____ _____
Patient Printed Name Date

_____
Patient Signature

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PATIENT MEDICAL HISTORY FORM

Name: _____ Date of Birth: ___/____/_____ Height: _____ Weight: _____

Most Recent Blood Pressure _____
Last A1C _____

REASON FOR REFERRAL / VISIT (TELL US WHY YOU ARE HERE):

_____

_____

_____

Last Eye Exam _____

CHIEF COMPLAINTS (TELL US WHAT IS BOTHERING YOU):

○ Loss of Central Vision	○ Glare from Bright Lights	○ Swollen Eyelids
○ Loss of Peripheral Vision	○ Glare from Car Headlights	○ Droopy Eyelids
○ Loss of Night Vision	○ Glare from the Sun	○ Twitching of Eyelids
○ Loss of Distance Vision	○ Tearing from Bright Lights	○ Floppy Eyelids
○ Loss of Reading Vision	○ Tearing from the Sun	○ Poor Eyelid Closure
○ Loss of Color Vision	○ Headaches	○ Bumps on Eyelid
○ Flashes of Light - How long?	○ Watery Discharge	○ Growth on Eyelid
○ Floaters - How long?	○ Mucous Discharge	○ Itchiness of Eyelids
○ Shadow in Peripheral Vision	○ Crusty Discharge	○ Rash on Eyelids
○ Distortion (of Straight Lines)	○ Sand-Like Discharge	○ Redness of Eyelids
○ Objects Appear Smaller	○ Aching Eye Pain	○ Other:
○ Sensitivity to Bright Lights	○ Burning Eye Pain	○
○ Sensitivity to Car Headlights	○ Pinching Eye Pain	○
○ Sensitivity to the Sun	○ Stabbing Eye Pain	○
○ Halos Around Car Headlights	○ Foreign Body Sensation	○

Location: What is the site of the problem/which eye? ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Quality: What is the nature of the pain? ☐ Constant ☐ Intermittent ☐ Improving ☐ Worsening

Severity: Describe the severity of your pain/problem (on a scale of 1 to 10, with 10 being the worst) _____

Duration: When did the pain/problem start?_____

How long has the pain/problem been an issue?_____

Timing: Is the pain/problem worse in the morning, evening, or is it constant?_____

Context: Is the pain/problem associated with an activity? _____

Modifiers: What efforts has the patient made to improve the pain/problem (i.e. heat, artificial tears, other, etc.)?

_____

History: Is this visit related to an automobile accident or Workers' Compensation?_____

Do you take any eye drops? ☐Yes ☐No

Name of eye drops?_____

PAST MEDICAL HISTORY

List All Medical Conditions_____ Year of Onset

Hypertension ☐Yes ☐No _____

Diabetes Type I or Type II ☐Yes ☐No _____

Heart Disease ☐Yes ☐No _____

Cancer ☐Yes ☐No _____
Type- _____

Thyroid ☐Yes ☐No _____

Prostate ☐Yes ☐No _____

Cholesterol ☐Yes ☐No _____

CURRENT MEDICATIONS

Name	Dosage

Do you take any of these medications?

Hydroxychloroquine? ☐Yes ☐No

Plaquenil? ☐Yes ☐No

Blood thinners? ☐Yes ☐No

Aspirin? ☐Yes ☐No

Flomax? ☐Yes ☐No

AIDS/HIV ☐ Yes ☐No Sleep Apnea ☐ Yes ☐No Asthma/COPD ☐ Yes ☐No

PAST SURGICAL HISTORY

Surgeries	Date

Anesthesia Complications ☐Yes ☐No

If yes, explain:

_____

_____

PATIENT SOCIAL HISTORY

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Use of Tobacco
- ☐ Never
- ☐ Previous but Quit
- ☐ Currently
- _____ Packs Daily

Use of Illicit Drugs
- ☐ Never
- ☐ Type & Frequency
- _____
- _____

Use of Alcohol
- ☐ Never
- ☐ Rarely
- ☐ Moderate
- ☐ Daily

Excessive Exposure at Home or Work to:
- ☐ Fumes_____
- ☐ Solvents_____
- ☐ Chemicals_____
- ☐ Other_____

Living Conditions
- ☐ Lives with Family/ Caretaker
- ☐ Lives Alone
- ☐ Lives in Assisted Living/ Nursing Home

Driving
- ☐ Yes
- ☐ No
- ☐ Daytime only
- ☐ Locally

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Spouse			
Children			

Living Will/Advance Directive ☐Yes ☐No ☐Would Like Information

LIST ALL ALLERGIES

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current Pharmacy: _____

Phone:_____Address:_____

Primary Doctor_____Last visit _____

Endocrinologist_____Last visit _____

Retina Doctor_____ Last visit _____