DATE:_____ **If you are a new patient- when was your last eye exam?** _____

First Name:_____ **Last Name**_____ **M** ☐ **F** ☐
Date of Birth:_____ **Age:**_____ **Occupation:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Cell Phone:_____ **May we text you?**___ **2nd Phone:**_____**Home/Office(Circle)**

Email Address:_____
If you provide an email address, we will only use it to send patient appointment reminders, recalls, a patient survey after your visit. We will not give your email address to any other entity.

Reason for visit today:_____
If your visit is of a medical eye problem in nature, your vision coverage will not cover this visit. Please let the staff know so we may properly direct your care and determine your eligibility for medical insurance coverage which may differ from your vision coverage.

Personal History/Social History **Existing Patients**
Past history of ocular injury and/or surgery:_____ no change ☐
Current or previous eye conditions: _____ no change ☐
Current or previous medical conditions: _____ no change ☐
Current Medications:_____ no change ☐
Medication Allergies:_____ no change ☐
Primary Physician**:** _____ Phone:_____
Are you pregnant?_____ If yes, what trimester?
Do you: Smoke?N☐ Y☐ packs per week.
Drink alcohol? N☐ Y☐ drinks per week.

Family History: Is there a member of your family who has/had any ocular issues, including glaucoma, cataracts, macular degeneration, blindness, etc.? Y☐ N☐

If yes, check: Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐ Grand Parent ☐ Aunt/Uncle ☐
Condition and when: _____

Information about your medical history:

Eyes	**Y**	**N**
Burning eyes	☐	☐
Constant tearing	☐	☐
Dry eyes	☐	☐
Eye pain	☐	☐
Flashes of light	☐	☐
Floaters	☐	☐
Fluctuating vision	☐	☐
Foreign body sensation	☐	☐
Glare	☐	☐
Glaucoma	☐	☐
Halos	☐	☐
Itching	☐	☐
Lid Infection	☐	☐
Light sensitivity	☐	☐
Mucus in eyes	☐	☐
Redness	☐	☐
Sandy eyes	☐	☐
Sudden vision loss	☐	☐
Tired eyes	☐	☐
Visual disturbances	☐	☐
Watery eyes	☐	☐

Allergic / Immunologic	**Y**	**N**
Hay Fever	☐	☐
Medicine Allergies	☐	☐
Cardiovascular		
Heart Problems	☐	☐
High Blood Pressure	☐	☐
Constitutional		
Fevers	☐	☐
Weight Loss	☐	☐
Problems Sleeping	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid	☐	☐
Gastrointestinal		
Constipation	☐	☐
Diarrhea	☐	☐
Genitourinary		
Bladder infections	☐	☐
Frequent urinations	☐	☐
Kidney infections	☐	☐
Head		
Allergies/Hay Fever	☐	☐
Sinus problems	☐	☐
Dry throat / mouth	☐	☐

Hematological/Lymphatic	**Y**	**N**
Anemia	☐	☐
Bleeding problems	☐	☐
Swelling	☐	☐
Immunologic		
Herpes Simplex	☐	☐
Sjogren's Syndrome	☐	☐
Rheumatoid Arthritis	☐	☐
Crohns / Celiac	☐	☐
Integumentary		
Breast Cancer	☐	☐
Dry Skin	☐	☐
Musculoskeletal		
Arthritis	☐	☐
Fibromyalgia	☐	☐
Joint Pain	☐	☐
Muscle pain	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Psychiatric		
Compulsive behaviors	☐	☐
Respiratory		
Asthma	☐	☐

Contact Lenses

Are you here to update your contact lens Rx or would you like to try contact lenses? ( ) Yes ( ) No

If you would like a prescription for contact lenses, the doctor will need to evaluate the lenses on your eyes. There are additional fees for contact lens evaluations separate and in addition to your comprehensive eye exam. This annual fee for contact lens evaluation is applicable to both existing and to new contact lens patients. Our fees vary depending on complexity of fit and prescription. **This fee is NOT COVERED by medical insurance**. Please see staff with any questions. See schedule below for general pricing of contact lens fees:

Spherical Lens Evaluation ($95)
For patients wearing single vision spherical lenses in both eyes or an update of an established Rx requiring no change and no follow up visits.

Toric Lens Evaluation ($120)
For patients wearing lenses to correct astigmatism in at least one eye.

Multifocal and/or Monovision Evaluation ($145)
For patients wearing lenses to correct distance and near (bifocal Rx)

Rigid Gas Permeable Lens Evaluation ($160)
For patients requiring rigid gas permeable lens for vision correction.

Specialty Contact Lens Prescription ($260)
For patients who present with more complex contact lens prescriptions and need more customized care.

Ortho-K ~ Overnight Vision Correction for Myopia (Starts at $2200)
Primarily meant for children to see clearly during daytime without use of glasses or contacts. It has also been known to slow down myopic progression. Corrects myopia using custom corneal molds worn overnight. See staff for details.

Regarding Contact Lenses and Contact Lens Evaluations:

- Contact lens patients have follow up care for a period of 3 months after their initial contact lens evaluation. Any visits after the three months will be billed at $45 per visit. After six months, we will need to perform a new annual evaluation billed at the applicable fees.
- Contact lenses may be returned for full credit if unopened, unmarked, unexpired, and if purchased from our office. They must not have an expiration date within two calendar years of the return date.
- All contact lens orders must be paid in full at the time of order placement.

Initial:_____ **Date:**_____

Eye Care Associates of Princeton Financial Policy (Not Using Insurance)

- **Annual Eye Exam**
  Our annual eye exam fee for patients **not using insurance** and paying at the time of service is $124.00 which includes our ClarifEye Exam and an Optomap Retinal Exam. Additional fees apply to patients who are receiving a contact lens evaluation, and/or those choosing the optional Ocular Wellness Screening.

- **Ocular Wellness Screening**
  The wellness screening is highly recommended for those over the age of 18 and if you have family history of Glaucoma and or Macular Degeneration.

  Utilizing an Optical Coherence Tomographer (OCT), we can provide a detailed structural analysis on your retinal health. This analysis provides information regarding thickness of both retinal nerve fiber layer and macular thickness and compares them to an age related normative database. Such information is useful in detecting early glaucoma and as well as macular integrity.

  The wellness screening is highly recommended for those over the age of 18 and if you have family history of Glaucoma and or Macular Degeneration.

  The fee for this screening is $40. ☐ Accept ☐ Decline

- All fees are due at the time of service. All contact lens orders must be paid in full at the time of order placement.

- Patients who are seen for an eye exam in our office, resulting in a glasses prescription, are entitled to come in for one prescription check visit within 30 days of the initial exam. Any visits to check the glasses prescription after 30 days will be billed at $45 per visit.

Please Read and Sign Below

I have read the Financial Policy. I understand I can ask questions if any part is not clear. My signature below indicates I agree to the terms of this document.

_____	_____
Signature of Patient or Responsible Party	Print Name of Patient
_____	_____
Relationship/Authority of Responsible Party	Date

Eye Care Associates of Princeton Financial Policy (For Patients Using Insurance)

Insurance Information

Patient Name: _____ Patient date of birth: _____
Subscriber's name: _____ Subscriber's date of birth:_____
Name of insurance: _____ Member #:_____

- **Annual Eye Exam** Our annual eye exam fee for **patients using insurance** is comprised of their Co-pay as directed by their individual coverage **and** the fee for the Optomap which is $29.00. In our office, the Optomap Retinal Exam is now performed on every patient who is receiving an annual eye exam unless they specifically ask to decline the service. Additional fees apply to patients who are receiving a contact lens evaluation, and/or those choosing the optional Ocular Wellness Screening. The Optomap differs from the Ocular Wellness Screening.

- **OptoMap Digital Retinal Screening** For your eye exam we will be using the Optomap digital retinal camera to view your retina. Your Optomap retinal exam will give the doctor a thorough retinal exam without the use of dilating drops, blurry vision and requires no additional time. The digital scan assists in detecting and measuring subtle changes in your retina during your annual eye exam. The digital scan becomes part of your electronic health records and is stored permanently for physician referrals if needed. Although it is a part of our annual comprehensive eye exam it is **not a covered service by your health insurance and therefore has a fee of $29.00.**

- **Ocular Wellness Screening** The wellness screening is highly recommended for those over the age of 18 and if you have family history of Glaucoma and or Macular Degeneration.
    - Utilizing an Optical Coherence Tomographer (OCT), we can provide a detailed structural analysis on your retinal health. This analysis provides information regarding thickness of both retinal nerve fiber layer and macular thickness and compares them to an age related normative database. Such information is useful in detecting early glaucoma and as well as macular integrity.
    - **The fee for this screening is $40.** ☐ **Accept** ☐ **Decline**

- All fees are due at the time of service. All contact lens orders must be paid in full at the time of order placement.
- Patients who are seen for an eye exam in our office, resulting in a glasses prescription, are entitled to come in for one prescription check visit within 30 days of the initial exam. Any visits to check the glasses prescription after 30 days will be billed at $45 per visit.

Regarding Insurance

- Our office is a provider for Aetna, Horizon Blue Cross/ Blue Shield, Medicare, and United Health Care for medical coverage. We are providers for EyeMed, Humana, and Superior Vision for vision coverage. We can also bill to VSP as an out of network provider.
- Medicare patients should provide their Medicare card and their card for supplemental or other insurance. You will be required to satisfy your annual deductible and pay your 20% copayment plus and other non-covered services provided. Additionally, all fees for any service which are not covered by Medicare will be due at the time of service.
- If you are using insurance, you must present your insurance card when you check in or you will be personally responsible for all charges and for obtaining any reimbursements due from your insurance carrier. No claims will be filed with insurance if presented after the service date, including to secondary insurance. Our policy is to make every effort to bill your insurance but no claim is guaranteed, even with a pre-authorization.

Please Read and Sign Below

I have read the Financial Policy. I understand that I can ask questions if any part is not clear. My signature below indicates I agree to the terms of this document.

_____ _____
Signature of Patient or Responsible Party Print Name of Patient

_____ _____
Relationship/Authority of Responsible Party Date

Notice of Privacy Practices Eye Care Associates of Princeton, P.C.

Effective Date of this Notice: May 1, 2016

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting our Compliancy Officer, Suzanne Mullarney.
- You can file a complaint with the U.S. Department of Health and Human Services OfT1ce for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling I -877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if vve believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes, sale of your information, most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

- We can share health information about you for certain situations such as: Preventing disease / Helping with product recalls / Reporting adverse reactions to medications /Reporting suspected abuse, neglect, or domestic violence and preventing or reducing a serious threat to anyone's health or safety

- Do research- We can use or share your information for health research.

- Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- Respond to organ and tissue donation requests -We can share health information about you with organ procurement organizations.

- Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

- Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health intörmation.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

I authorize the following people to have access to my health records:

Name_____ Relationship:_____ Date:_____
Name_____ Relationship:_____ Date:_____
Name_____ Relationship:_____ Date:_____

Acknowledgement of Receipt of HIPAA Privacy Practices

I acknowledge that I read and received a copy Eye Care Associates of Princeton, P.C. Notice of Privacy Practices.

Patient Name: (Please Print) Signature: Date:

_____ _____ _____

For Office Use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual declined to sign.

- Communication barriers prohibited obtaining the acknowledgment.

- An emergency situation prevented us from obtaining acknowledgement.

- Other:_____