Robert A. Kitei, MD | Pediatric Ophthalmology

Bethlehem Eye Associates PC

Please answer questions as best as you can.

Name _____ Date _____

Date of Birth_____ Gender ❑ M ❑ F Name of Referring Physician_____

What is Wrong with the Patient's eyes?

❑ No known problem, routine check

❑ Failed a vision test: ❑ School ❑ Doctor's ❑ Other_____

❑ Poor vision suspected: ❑ by patient ❑ by:_____

❑ Needs new glasses

❑ Trouble reading in school

❑ Headaches

❑ Eyes are red

❑ One eye drifts in or out

❑ Head in abnormal position

❑ Eyes shake or jiggle

❑ Other _____

When did the problem start? _____

What treatment has been given?

❑ Glasses Worn happily? ❑ Yes ❑ No

❑ Patching

❑ Medicine

❑ Eye Surgery When _____ By Whom_____

For Children under 5 years of age:

Birth Weight_____ ❑ Full Term ❑ Premature: How Early?_____

For all other patients:

Other medical history: _____

Current Medications: _____

Allergies to Medications: _____

Other previous surgery: When:_____ Where: _____

What serious eye problems (glaucoma, retinal detachment, eye tumors, blindness) runs in your family?

_____

Patient/Parent Guardian signature:_____ **Date:** _____

Bethlehem Eye Associates PC

INSURANCE INFORMATION

Patient

Name _____

Address _____

City/State/Zip _____

Ph#_____ Work#_____

Email _____ Cell#_____

Sex: ❑ F ❑ M DOB_____ SS#_____

Policy Holder (if same as patient skip)

Name _____

Address _____

City/State/Zip _____

Ph#_____ Work#_____

Email _____ Cell#_____

Sex: ❑ F ❑ M DOB_____ SS#_____

INSURANCE SUBMISSION: A copy of your insurance cards is required if you would like our office to submit for services rendered. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts. See our complete financial policy for details.

A copy of our *HIPPA Privacy Policy* is posted in our waiting room and a copy is available upon request. Please take a moment and review this policy then sign below.

HIPPA Privacy Policy reviewed by: _____ Date:_____

I hereby authorize Bethlehem Eye Associates PC to submit a claim to my insurance company or its intermediaries for all services rendered. Any information needed by my insurance company to make payment directly to Bethlehem Eye Assoc. PC is also authorized.

Name of Patient/Responsible Party: _____ Date:_____

If Medicare patient:

Name of Medicare Beneficiary: _____ HIC#: _____

Emergency Contact

Name _____ Relationship _____ Phone# _____

If patient is under the age of 18, name of parent/guardian accompanying patient to today's visit.

Name:_____ Relationship: _____

ANYONE UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY AN ADULT IN ORDER TO RECEIVE TREATMENT.

Patient Communication Consent

To preserve your privacy as a patient of Bethlehem Eye Assoc. PC, we need your permission to allow us to contact you or someone you might designate, outside of your office visits.

In the event that you are not able to answer your telephone, we need permission to leave certain types of information on your answering machine or with another person. Without specific permission specified below, we will not release any of your medical or billing information.

- ❑ Do not leave medical information pertaining to my care on my home answering machine or with any other person.
- ❑ I authorize the physicians and/or staff at Bethlehem Eye Assoc. PC to leave messages regarding appointment reminders and insurance coverage/benefits issues on a telephone answering machine, Email or with the person/people indicated below.

The following is a list of people who I authorize to receive information regarding all aspects of my care with Bethlehem Eye Assoc. PC:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

I am aware that it is my responsibility to inform Bethlehem Eye Assoc. PC of any changes in my phone number, address or insurance information as well as any changes to the above privacy authorizations.

Signature of Patient/Parent or Guardian: _____ Date: _____

Workmen's Compensation Patients

Your employer may request information regarding your condition if you are being treated for a workmen's compensation injury. This information is provided to the Insurance carrier by law. Please sign below to authorize release of this information to your employer.

Signature of Patient:_____ Date: _____

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Bethlehem Eye Associates PC

PATIENT HISTORY

Name _____ Date _____ Acct. # _____

Date of Birth _____ Name of Referring Physician _____

Primary Care Physician _____ Date of last eye exam _____

Reason for today's visit _____

Is this due to an injury? ❑ Yes ❑ No If **yes**, date of injury _____

Were you hurt at work? ❑ Yes ❑ No Auto Accident? ❑ Yes ❑ No

Employer Name _____

Address _____ Phone _____

Past Ocular History:

Previous History of Eye Treatment or Exams: _____

_____

What Problems are you having with your eyes? _____

Medical History (MARK ALL CURRENT AS WELL AS PREVIOUS ILLNESSES.)

Asthma	❑ Yes	❑ No	Cardiac Problems	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Nature of _____		
Stroke(s)	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Seizure/Convulsions	❑ Yes	❑ No	Type I _____ Type II _____		
Bleeding Tendency	❑ Yes	❑ No	History of Cancer	❑ Yes	❑ No
Thyroid Disorder	❑ Yes	❑ No	Rheumatologic Disease	❑ Yes	❑ No
Mental Illness	❑ Yes	❑ No	Are you Pregnant?	❑ Yes	❑ No

Do you have any other medical conditions that affect your eyes? ❑ Yes ❑ No

List all Surgeries: _____ Date _____

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

List all serious Illnesses/Accidents: _____ Date _____

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

List all Current Medications (Including eye drops):

Name Dose Condition

_____

_____

_____

_____

Allergies to Medications? ❑ Yes ❑ No

If yes, please list: _____

_____

_____

Latex Sensitivity? ❑ Yes ❑ No

❑ **No Known Allergies?**

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Family History

Disease		Relationship	Disease		Relationship
Blindness	❑ Yes ❑ No	_____	High blood pressure	❑ Yes ❑ No	_____
Cataract	❑ Yes ❑ No	_____	Kidney disease	❑ Yes ❑ No	_____
Glaucoma	❑ Yes ❑ No	_____	Lupus	❑ Yes ❑ No	_____
Macular degeneration	❑ Yes ❑ No	_____	Sjogrens Syndrome	❑ Yes ❑ No	_____
Retinal detachment	❑ Yes ❑ No	_____	Stroke	❑ Yes ❑ No	_____
Arthritis	❑ Yes ❑ No	_____	Thyroid disease	❑ Yes ❑ No	_____
Cancer	❑ Yes ❑ No	_____	Tuberculosis	❑ Yes ❑ No	_____
Diabetes	❑ Yes ❑ No	_____	Other	❑ Yes ❑ No	_____
Heart attacks	❑ Yes ❑ No	_____			

Social History

Current occupation _____

Do you drive? ❑ Yes ❑ No _____

Do you have visual difficulty when driving? ❑ Yes ❑ No

Do you have problems with night vision? ❑ Yes ❑ No

Have you ever tried to wear contacts? ❑ Yes ❑ No

Do you currently wear glasses? ❑ Yes ❑ No If yes, how long have you had the current pair? _____

Do (did) you Smoke? ❑ Yes ❑ No ❑ Former How much per day? _____ For how many years?_____

Do (did) you Drink? ❑ Yes ❑ No ❑ Former How much per day? _____

Do (did) you use Drugs recreationally? ❑ Yes ❑ No ❑ Former How much per day? _____

Review of Systems

Do you currently have any problems in the following areas? If "yes," circle condition and explain.

❑ Yes ❑ No **Skin:** Psoriasis Rash Shingles _____

❑ Yes ❑ No **Head:** Headache Migraine Temporal Arteritis _____

❑ Yes ❑ No **Eyes:** Cataract Glaucoma Retina _____

❑ Yes ❑ No **Ears:** Hearing Loss Aids _____

❑ Yes ❑ No **Nose/Mouth/Throat:** Dentures Sinus _____

❑ Yes ❑ No **Neck:** Restriction of Movement Difficulty swallowing _____

❑ Yes ❑ No **Pulmonary:** Cough Shortness of Breath Wheeze _____

❑ Yes ❑ No **CV:** Chest pain Palpitations _____

❑ Yes ❑ No **GI:** Ulcers Pain _____

❑ Yes ❑ No **MS:** Leg Cramps Swelling _____

❑ Yes ❑ No **Neuro:** Tremor Speech Problems _____

❑ Yes ❑ No **Psych:** Anxiety Depression Insomnia Panic Attacks _____

History Reviewed ❑ No changes ❑ Additions as noted above

Physician's Signature _____ Date _____

Bethlehem Eye Associates PC

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Address _____

City/State/Zip _____

Ph#_____ Work#_____

Email _____ Cell#_____

Sex: ❑ F ❑ M DOB_____ SS#_____

Policy Holder (if same as patient skip)

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City/State/Zip _____

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Patient Financial Policy

Co-Pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made. Medicare patients with no secondary insurance are expected to pay the 20% co-insurance at checkout. We accept cash, check or credit cards.

Self-Pay accounts

Self-pay accounts are patients without insurance coverage, patients with insurance plans the office does not participate in or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise demonstrated. Self-pay patients will be expected to make payment at the time of service. A minumum of $150 will be required unless other arrangements are made in advance.

Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Patient refunds

In order for our office to issue a patient refund, there can be no outstanding insurance claims or open balances on the account. A refund will be issued within approximately 30 days of the request.

Referrals

If your insurance has designated a primary care physician (PCP), you are most likely required to have prior authorization from your PCP prior to your office visit. If this authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Workmen's Compensation and Automobile Accidents

In the case of a workmen's compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Outstanding Balance Policy

Patients with ongoing balances will be billed monthly. A billing fee will be assessed each month after the second billing statement. After the third statement, a courtesy telephone call will be attempted. If the account cannot be resolved, the outstanding balance will be turned over to a collection agency, and the costs associated with collection will be added to the account.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and are receiving treatment, you are responsible for payment of the service. Our office will not bill any other personal party. This also applies to minor patients with parental financial agreements; whoever accompanies the patient, is responsible for presenting appropriate payment of the services.

Missed Appointments

Our office fully understands that emergencies come up that require changes in schedules. If you need to cancel or reschedule your appointment, a 24-hour notice is required or a "no show" fee of $25 will be added to your account. The account will then be frozen. No further appointments will be made or kept until this fee is paid in full.

Refractions

"Refraction" is a procedure necessary for our physicians to evaluate your vision and/or write you a prescription for glasses. If you are experiencing blurred vision or decreased visual acuity as measured by the eye chart, a refraction would help determine whether the difficulty is associated with a medical problem or a need for glasses. During the refraction, the physician or technician offers you a series of lens choices until you reach the best corrected vision. Unfortunately, not all insurance plans cover this service and Medicare specifically excludes refractions as a covered benefit. The cost of the refraction is due at the time of service.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Release of Medical Records

If for any reason you need a copy of your medical record we will be happy to mail or fax a copy to your doctor upon presentation of a signed release. If you require a copy for personal use, legal documentation, or disability, a record copying fee will be calculated according to PA law. A signed record release form and pre-payment will be required before any records will be copied and/or supplied.

I understand and agree to these policies.

Signature of Patient/Parent or Guardian: _____ Date: _____