PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

New Patient Forms Packet

Please complete the following pages prior to your appointment. You may email completed forms to paperwork@childrenseye.com OR print and return completed forms to our front desk staff.

Your child's first visit will last **approximately 2 hours**.
Their eyes will be dilated, so their vision may be blurry for the remainder of the day. A school note can be provided by our front desk staff.

If you are being referred for possible surgery, please complete the authorization for release of confidential information form attached. In addition, please have the referring doctor fax recent office notes to (401) 444-4862.

If you have any further questions feel free to message us online or call us at (401) 444-7008.

Thank you!

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

Dear New Parents and Patients,

We would like to welcome you and your child to Pediatric Ophthalmology and Strabismus Associates. **If you requested an appointment online, we will call you in the next 24-48 hours to schedule your eye examination at one of our two office locations.**

Providence (Main Office): 2 Dudley Street, Suite 505 Providence, RI 02905 (401) 444-7008

East Greenwich Office 1351 South County Trail Building 2, Suite 220 East Greenwich, RI 02818

Please print and complete the forms below. Please bring with you your insurance card, a referral from your primary care doctor if your insurance requires it, and any pertinent medical records.

Copays are due at the time of the visit. We are a specialist, so if you have a specialty copay, we will collect that amount. If your insurance has a deductible, you will be required to pay $200.00 for your visit. We will bill your insurance for the deductible, and either bill you or issue a refund if the fee is more or less than the $200.00.

If you will require an interpreter for your visit, please be sure to bring someone to assist you with translation.

Should you have any questions or concerns regarding your appointment or our office policies, please call the office. If you need to cancel or reschedule your appointment, please call us and we will be happy to reschedule.

Thank you and we look forward to meeting you and your child! Sincerely,
Pediatric Ophthalmology and Strabismus Associates

REFERRALS/AUTHORIZATIONS

If your insurance company requires a referral or authorization for a specialist visit, you must bring it on the day of your appointment, or you will be responsible for the fee. It is your responsibility to obtain any referrals or authorizations.

We do not accept any vision plans, such as Eyemed, VSP, etc.

PLEASE SEE IMPORTANT INFORMATION ATTACHED REGARDING ROUTINE VISION CARE

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors
- Conduct normal healthcare operations, such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Parent/Guardian Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient/guardian's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason:

_____

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

STATEMENT OF FINANCIAL RESPONSIBILITY
ASSIGNMENT OF BENEFITS

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Pediatric Ophthalmology and Strabismus Associates. I authorize payment to Pediatric Ophthalmology and Strabismus Associates. I understand that my insurance carrier may not approve or reimburse my medical services in full, due to usual and customary rates, benefit exclusions, coverage limits or lack of authorization/referral. I understand that I am responsible for paying my provider directly for any policy deductibles, co-insurance or co-payments within thirty (30) days of service. Presenting an inactive or invalid insurance card will result in full responsibility of payment by me. I understand that if I do not have an authorization or referral for a visit and my insurance requires one, that I may be responsible for the full charges for that date of service. If for any reason I cannot make the full required payment, I understand that I may call Pediatric Ophthalmology and Strabismus Associate to may payment arrangements.

MISSED APPOINTMENTS/RETURNED CHECKS

We require a 24-hour notification if you are unable to keep your appointment. There is a fee for any returned checks.

_____ _____

Patient Signature Date

_____ _____

Patient Name Date of Birth

_____ _____

Parent/Guardian Signature Date

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

Vision VS. Medical Diagnosis

Many commercial insurance plans do not cover visits for what they consider routine eye care. Some of these plans offer "eye plans", which we do not accept (VSP, Eyemed, etc). Routine eye exams are visits that are for vision-related issues only.
Some insurance companies do not recognize a vision diagnosis as a medical condition.

If your child has a vision-only diagnosis at the end of the exam, we will submit it to your insurance, but they may deny it. If the insurance company denies a claim, it is your responsibility to pay it. We will bill you directly.

Unfortunately, we cannot tell you whether or not your child has a routine vision diagnosis, or a medical diagnosis, until they are seen by our doctors. Once the exam is complete, we will submit the bill according to how the doctor coded it. We will do everything we can within coding guidelines to try to get the claim paid by your insurance company.

Generally, the following insurance plans do cover routine diagnosis coded exams: Blue Cross

Blue Shield of RI
Neighborhood Health Plan of RI United
Health Care – Ritecare only Tricare
RI Medical Assistance

We recommend that you check with your insurance provider, to see what their guidelines for eye exams are prior to your appointment. If you have already used your routine visit elsewhere, your insurance will not pay for another.

Patient Name **Patient Date of Birth**

Patient or Parent/Guardian Signature **Date**

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

2 Dudley St, Suite 505 Providence RI 02905
Phone 401-444-7008 Fax 401-444-4862

I hereby authorize Pediatric Ophthalmology and Strabismus Associates, Inc. to:

_____OBTAIN FROM:
_____RELEASE TO:
_____EXCHANGE WITH:

Name: _____

Address _____

City _____State_____Zip Code _____

The following information:
Medical Records _____
Verbal Communication _____

Patient Name _____
Patient Date of Birth_____

I understand that my records are protected under Federal Confidentiality Regulations (42 CFR Part 2), Confidentiality of Alcohol and Drug Abuse Treatment, RI Mental Health Law (40.1-2-26), and Health Care Information Act (RI General Laws 5.37.3-4), and cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that I have a right to revoke (or cancel) this authorization at any time, and I must do so in writing. I understand that revocation will not apply to the extent that action has already been taken in response to this authorization. I also understand that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This consent will automatically expire one (1) year from the date of authorization for the sharing of information related to ongoing service provision.

I further release Pediatric Ophthalmology and Strabismus Associates, Inc. and its employees from any liability arising from the release of this information to such persons/agencies, provided the said release of information is done substantially in accordance with applicable law.

Signature of Patient or Parent/Guardian Date

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

New Patient Registration

Patient Name _____ Date of Birth_____/_____/_____ Gender _____

Nickname_____ Favorite Activity_____

Street _____ City_____ State_____ Zip_____

Primary Phone_____ O Home O Cell 2nd Phone_____

Primary Care Physician_____ Referring Physician_____

Office/Street*_____ City*_____

State*_____ Zip*_____ Phone*_____ Fax*_____

*Address/contact used by our office staff to provide an updated letter from our doctors regarding your visit

Parents/Legal Guardians
(Please provide at least one contact)

Name	_____	Name	_____
Address	_____	Address	_____
	_____		_____
Cell Phone	_____	Cell Phone	_____
Employer	_____	Employer	_____
Work Phone	_____	Work Phone	_____
Home Phone	_____	Home Phone	_____
Email	_____	Email	_____

Emergency Contact _____ Relationship _____ Phone # _____

If phone communication is necessary, please check one:

O Leave a message with detailed information. O Leave a message with call back number only

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

Insurance Information

PRIMARY INSURANCE

Insurance Name: _____

Member ID: _____

Group Number: _____

Member Name: _____

Subscriber DOB: _____

Subscriber SS#: _____

Relationship to Patient: _____

SECONDARY INSURANCE

Insurance Name: _____

Member ID: _____

Group Number: _____

Member Name: _____

Subscriber DOB: _____

Subscriber SS#: _____

Relationship to Patient: _____

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

CONSENT for COMMUNICATION via E-MAIL and TEXT MESSAGE

I, _____, hereby consent to have the staff of Pediatric Ophthalmology and Strabismus Associates (POSA), which may include reimbursement and billing staff and technicians involved in my care communicate with me and my physicians, where appropriate, via e-mailing or text messaging regarding the following aspects of my medical care and treatment: test results, prescriptions, appointment, billing, etc. I understand that e-mail and/or text message is not a confidential method of communication and may have the following risks:

- Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Your employers and/or on-line services may have a right to inspect emails and texts sent through their systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection or errors can occur in the transmission.
- Emails and texts can be used as evidence in court.
- Emails and texts may not be a reliable means of communication.
- Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

I further understand that there is a risk that e-mail or text message communication between my physician and me or members of my physician's office staff, or between my physician and other physicians regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my providers or go to the Emergency Room and not rely on e-mail or text message. I agree not to disclose sensitive medical information such as information related to HIV, Mental health or substance abuse. I understand and acknowledge that POSA cannot guarantee the privacy, security or confidentiality of information transmitted via email or text. I understand that I may revoke my consent at anytime by advising POSA in writing.

Email Address:_____ Cell Phone for Text Messages:_____

Signature Date

_____ _____

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

New Patient Questionnaire

Reason for visit or primary concern (Important, please complete):

History of Eye Problems:

Yes	No		
		Glasses	How old is current pair? _____
		Contact Lens	How old is current pair? _____
		Prisms	How long? _____

Yes	No	Past Ocular History	Yes	No	Past Ocular History
		Eye exam by specialist			Eye Injury
		Amblyopia aka "Lazy eye"			Recurring "pink eye"
		Patching or dilating drops			Cataract
		Misaligned eye			Glaucoma
		Eye muscle surgery			Diabetic eye disease
		Other eye surgery			Other eye disease

Additional history for "Yes" responses:

Medical History

Yes	No	Condition	Yes	No	Condition	Yes	No	Birth/Development History
		Frequent ear infections			Diabetes			Prematurity
		Sinus disease			Anemia			Problems in pregnancy
		Heart Disease			Kidney disease			Problems in delivery Baby
		High blood pressure			Neurologic disease			kept in hospital
		Asthma			Seizures or stroke			Delay walk, talk or development
		Allergies (Med allergies list below)			Depression			
		Arthritis			Cancer			
		Thyroid problems			ADHD/ADD			
		Previous surgery or hospitalization			Other illness not listed			

Additional history for "Yes" responses:

PEDIATRIC OPHTHALMOLOGY AND STRABISMUS ASSOCIATES

Medication

List current medications or eye drops being used

Eye drop or medication	Frequency and/or dosage	Why is this medication being used:

Family History

Sibling(s) names seen at this practice:_____

			Which relative (check which applies)				
Yes	**No**	**Family Eye Health**	**Father**	**Mother**	**Sister**	**Brother**	**Other**
		Glasses before age 6					
		Amblyopia ("lazy eye")					
		Patching treatment					
		Strabismus (crossed/wandering eye)					
		Eye muscle surgery					
		Cataracts					
		Glaucoma					
		Blindness					
		Other serious eye disease					

I hereby declare that all information stated on this form is correct to the best of my knowledge:

Completed By: _____Date: _____

Physician Signature: _____Date: _____