Pediatric Ophthalmology & Strabismus Associates

New Patient Forms

Please review and complete the following pages prior to your appointment. You may print and return completed forms to our front desk staff, or email completed forms to POSA_paperwork@proton.me.

Your child's first visit will last approximately 2 hours. Their eyes will be dilated with eyedrops, so vision may be blurry for the remainder of the day and sensitive to the sun. You may want to bring sunglasses with you. A school note can be provided by our front desk staff.

If you are being referred for possible surgery, please be sure to complete the Authorization for Release of Confidential Information form. 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 at www.childrenseye.com or call us at (401) 444-7008.

Thank you!

Pediatric Ophthalmology & Strabismus Associates

Dear New Parents and Patients,

We would like to welcome you to Pediatric Ophthalmology and Strabismus Associates.

___________________________________'s appointment has been scheduled for:

Date:_________________________ Time:____________________ with Dr.____________________

at: **Providence (Main Office)**
2 Dudley Street, Suite 505
Providence, RI 02905

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

Please bring the following to your first appointment:
☐ pertinent medical records, eyeglasses and/or contact lenses (or printed prescriptions / contact lens boxes)
☐ all New Patient Forms completed and signed
☐ your insurance card
☐ an insurance referral from your primary care doctor if your insurance requires it.

INSURANCE REFERRALS / AUTHORIZATIONS
Knowing your insurance benefits is your responsibility. If your insurance company requires an insurance referral or authorization from your primary care physician (PCP) 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 prior to your appointment. Should you have questions regarding your coverage, please contact your insurance company.
We do not accept any vision plans, such as Eyemed, VSP, etc.

PLEASE BE SURE TO REVIEW OUR ATTACHED NOTICE on "ROUTINE EYE CARE" and "VISION vs MEDICAL DIAGNOSIS"

Copays are due at the time of the visit. We are a medical specialist. If you have a specialist copay, we will collect that amount. If your insurance has a deductible, you will be required to pay $200 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 $200.

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

No Show/Cancellation Policy: If you must reschedule or cancel your appointment, please call us at least 24 hours in advance, or you may be charged a $50 no-show fee. Failing to show up for your appointment is considered a "no show." After 3 "no shows," you may be discharged from the practice.

Should you have any questions or concerns regarding your appointment or our office policies, please call the office at (401) 444-7008. Thank you, and we look forward to meeting you and your child!

Sincerely,

Pediatric Ophthalmology and Strabismus Associates

(Revised Feb. 2025)

Pediatric Ophthalmology & Strabismus Associates

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 the 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.

____ ____________________
Print Patient Name — Date of Birth

____ ____________________
Signature of Patient or Guardian — Date

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

Date: __________ Initials:_________ Reason:____

Pediatric Ophthalmology & Strabismus Associates

CONSENT for COMMUNICATION via E-MAIL, TEXT MESSAGE, VOICE-MAIL

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

- Emails, texts, voice-mails 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, texts and voice-mails 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, texts and voice-mails can be intercepted, altered, forwarded or used without authorization or detection or errors can occur in the transmission.
- Emails, texts and voice-mails can be used as evidence in court.
- Emails, texts and voice-mails may not be a reliable means of communication.
- Email, texts, voice-mails 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, text message, voice-mail 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, text message, or voice-mail.** 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, text, voice-mail. I understand that I may revoke my consent at any time by advising POSA in writing.

Please check one:

☐ OK to send / leave messages with detailed medical information
☐ Leave a message with appointment information and call back number only

Email Address: ____

Cell Phone for Text Messages, phone calls, voicemail: ________________________________

____ ____________________
Print Patient Name Date of Birth

____ ____________________
Signature of Patient or Guardian Date

Pediatric Ophthalmology & Strabismus Associates

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Pediatric Ophthalmology and Strabismus Associates (Main Office)
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

Doctor/Clinic/Facility: ____________________

Address:____________________ City/State/ZIP:____________________

Phone: ____________________ Fax: ____________________

The following protected health information:
☐ All Medical Records
☐ Specific medical information: ____________________

____________________ ____________________ ____________________
Print Patient Last Name Print Patient First Name 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 Guardian Date

Pediatric Ophthalmology & Strabismus Associates

“Routine Eye Care” and “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” (VSP, Eyemed, etc), which we do not accept. Routine eye exams are visits that are for vision-related issues only, such as checking visual acuities, updating eyeglasses or contact lens prescriptions, and screening for eye disease. “Vision diagnoses” may be nearsightedness (myopia), farsightedness (hyperopia), or astigmatism. A “medical diagnosis” identifies specific eye diseases or conditions that require medical treatment, such as strabismus (eye misalignment), amblyopia (visual development disorder), conjunctivitis, chalazia (styes).

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 examined by our doctors. Once the exam is complete, we will submit the bill according to the diagnosis. We will do everything we can within coding guidelines to have the claim paid by your insurance company.

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

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 Associates to make payment arrangements.

RETURNED CHECKS: I acknowledge there is a $35 returned check fee, and I will be responsible for payment.

______________________________ ______________
Print Patient Name — Date of Birth

______________________________ ______________
Signature of Patient or Guardian — Date

Pediatric Ophthalmology & Strabismus Associates

Patient Last Name:______________________________ First Name:______________________

Date of Birth: ____________ Sex:________ Preferred pronouns:________ Nickname:________

School grade / Occupation:__________________ Favorite Activity/Hobbies: ________________

Address Street:___________________________ City:______________ State:_____ Zip:______

Primary Phone _________________________ Secondary Phone _________________________
☐ Home ☐ Cell ☐ Other ☐ Home ☐ Cell ☐ Other

Primary Care Physician: _________________________ Practice Name:_____________________
Address:____________________________________ Phone: _______________________

Referring Doctor: ____________________________ Practice Name:______________________
Address:____________________________________ Phone: _______________________

Guardian(s) / Emergency Contact(s)

Name_______________________________________ Relationship to patient:________________
Address (if different than patient) Street:______________________________
City:______________________________ State:_____ Zip:________________
Phone:_________________________________ Email:______________________________
☐ OK to discuss appointments and medical information with this individual

Name_______________________________________ Relationship to patient:________________
Address (if different than patient) Street:______________________________
City:______________________________ State:_____ Zip:________________
Phone:_________________________________ Email:_____________________
☐ OK to discuss appointments and medical information with this individual

Insurance Information

PRIMARY INSURANCE

Insurance Company:____________________ Subscriber DOB:_______________________
Group #:___________________________ Subscriber SS#:_______________________
Member ID:_________________________ Subscriber Address:_______________________
Subscriber Name:_____________________ Subscriber Phone#:_______________________
Relationship to Patient: __________________ Employer Name:_______________________

Do you have SECONDARY INSURANCE? (We do not accept any vision plans)

Insurance Company:____________________ Subscriber DOB:_______________________
Group #:___________________________ Subscriber SS#:_______________________
Member ID:_________________________ Subscriber Address:_______________________
Subscriber Name:_____________________ Subscriber Phone#:_______________________
Relationship to Patient: __________________ Employer Name:_______________________

PATIENT HEALTH HISTORY

Birth History: Premature Birth? ☐ No ☐ Yes If yes, born at how many weeks gestation?________
Birth weight:________ Any birth complications? ☐ No ☐ Yes
If yes, please explain: ____
____

Pediatric Ophthalmology & Strabismus Associates

Patient Last Name: ____________________ **First Name:** ________________ **Date of Birth:** __________

PATIENT HEALTH HISTORY

Reason for visit:

____

____

Eye History: (check all that apply, and provide additional details in the space provided)

☐ Previous eye exam with eye specialist?
- If yes, last exam date? ________________
- Name & location of eye doctor?__________

____

☐ Eyeglasses
- If yes, what age did you start? ____________
- If yes, how old is current pair? ____________

☐ Contact lenses
☐ Prisms
- If yes, when was this prescribed? __________

☐ Patching or dilating eyedrops
☐ Strabismus (misaligned eyes)
☐ Nystagmus
☐ Styes / Chalazia
☐ Cataracts
☐ Glaucoma
☐ Retina disease
☐ Eye injury
☐ Eye muscle surgery (**please describe below**)
☐ Other eye surgery (**please describe below**

Additional eye history: ____

____

Medical /Surgical History: (check all that apply, and provide additional details in the space provided)

☐ Arthritis
☐ Asthma
☐ Lung disease
☐ Allergies (environmental)
☐ Headaches / migraines
☐ Seizure
☐ Stroke
☐ Neurologic condition

☐ Autism
☐ ADHD
☐ Learning disability
☐ Developmental delay
☐ Hearing loss
☐ Sinus disease
☐ Thyroid problems
☐ High blood pressure
☐ Heart disease

☐ High cholesterol
☐ Diabetes
☐ Crohn's / Ulcerative colitis
☐ Kidney disease
☐ Cancer
☐ Genetic condition
☐ **Other** (describe below)
☐ **Non-eye Surgeries** (describe below)

Additional medical/surgical history: ____

____

Current medications (name, dose, frequency): ___________________________________

____

☐ **Drug Allergies** ☐ **Food Allergies** ☐ **Latex Allergies** **(please list):** _________________________

Tobacco use: ☐ Never ☐ Current (_____packs/day) ☐ Former (Quit # ______ years ago)

Family Eye / Medical History: (check all that apply, and specify who: mother, father, brother, sister, etc):

☐ None
☐ Eyeglasses (before age 6 years) ______________
☐ Amblyopia ______________
☐ Eye patch treatment ______________
☐ Eye misalignment ______________

☐ Eye muscle surgery ______________
☐ Cataracts ______________
☐ Glaucoma ______________
☐ Retina problem ______________
☐ Color Blind ______________

Any additional family medical / eye problems: ____

Sibling(s) or other family members seen at this practice: _________________________________

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

Completed By: ____ Date: ______________________

Physician Signature: ____________________________________ Date: ______________________