MEDICATION SHEET

Patient Name: **Date**

Date Of Birth:

Allergies:

Pharmacy Name:

Pharmacy Address: **Phone#**

If you are CURRENTLY taking any of the following medications, please advise.

Flomax	(Y)	(N)
Plaquenil	(Y)	(N)
Prednisone	(Y)	(N)
Blood thinners	(Y)	(N)
Tamoxifen	(Y)	(N)

Current Medications (please include prescriptions AND over the counter medications)

Name	**Strength**	**Frequency**

Please indicate if you have had a:

FLU SHOT: Y N DATE

COVID-19 SHOT: Y N DATE REASON DECLINED:

PNEUMOVAX SHOT: Y N DATE:

****

For office use only

Tech initials and date _____ Physician signature and date _____

Tech initials and date _____ Physician signature and date _____

Tech initials and date _____ Physician signature and date _____

Tech initials and date _____ Physician signature and date _____

SPINAK MEDICAL EYE CENTER
FUNCTIONAL VISUAL NEEDS

PATIENT NAME: _____

DATE	DATE	DATE	DATE

Do you have difficulty with (with and/or without glasses on)…	**YES**	**NO**
Reading small print such as a newspaper, book or labels?		
Recognizing people when they are close to you?		
Judging distances or seeing steps, stairs or curbs?		
Reading traffic signs, street signs or store signs?		
Fine handwork like sewing, knitting, carpentry, writing checks or filling out forms?		
Playing games like bingo, dominoes or cards?		
Taking part in sports like hunting, golf or tennis?		
Cooking or watching TV?		
Do you drive a car?		
If no, did you stop because of your vision?		
Driving during the day because of your vision?		
Driving at night because of your vision?		
Seeing on a sunny day or with a glare at night?		

Report the <u>FREQUENCY</u> of your symptoms using the rating system below:

0 = Never 1 = Sometimes 2 = Often 3 = Constant

Symptoms:	**0**	**1**	**2**	**3**
Dryness, grittiness or scratchiness				
Soreness, pain or irritation				
Burning, watering or light sensitivity				
Eye fatigue or blurred vision				
Any of the above while reading, watching TV or working on the computer				

Report the <u>SEVERITY</u> of your symptoms using the rating system below:

0 = No Problems

1 = Tolerable – not perfect but not uncomfortable

2 = Uncomfortable – irritating but does not interfere with my day

3 = Bothersome – irritating and interferes with my day

4 = Intolerable – unable to perform my daily tasks

Symptoms:	**0**	**1**	**2**	**3**	**4**
Dryness, grittiness or scratchiness					
Soreness, pain or irritation					
Burning, watering or light sensitivity					
Eye fatigue or blurred vision					
Any of the above while reading, watching TV or working on the computer					

Have you ever considered cosmetic surgery on your eyelids? Yes or No

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SPINAK MEDICAL EYE CENTER
OPHTHALMOLOGY
DISEASES AND SURGERY OF THE EYE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & 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:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payments from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians 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 at the address above 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 health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I hereby authorize the release of my medical information to the following persons:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient Name:_____

Relationship to patient: _____

_____ _____
Signature of patient Date

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date_____ Initials_____
Reason_____

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Patient's Name_____
(please print)

It is the responsibility of all our patients to confirm our participation with your particular insurance company. While we are privileged to be able to provide Ophthalmology services to you, it is very hard for us to know all the individual requirements of every insurance plan. It is the patient's responsibility to be aware of the current terms of your insurance policy.
Some insurance plans differ within a company depending on the type of contract you or your employer has negotiated. Providing quality Ophthalmological care for patients is our primary concern. If there are any changes of service between appointments, please let us know at your time of service.

Be prepared to pay for your copay, coinsurance, deductible, or any non covered service (such as a REFRACTION) at the time of your visit. If you are an uninsured patient, payment in full is due at the time of service. Our office accepts cash, checks, and all major credit cards. Service fee may apply if billing for copay is requested by patient.

If your insurance company requires you to have a referral from your primary care physician, you must present your referral at the time of your visit. Patients without a valid referral will be rescheduled.

If you do not inform us of any special requirements with your contract and we order medically indicated services that are not covered by your policy, the office will have no option but to bill you directly for those services. Those charges will be the responsibility of the patient.

We respectfully request that you call our office for any cancellations. If you fail to keep your appointment and do not call, a $25 no show fee will be applied to your account. We make every effort to make a courtesy confirmatory call regarding your appointment, however it is the responsibility of the patient to note time and date of appointment. No confirmation call does not excuse a no show fee. We thank you for understanding that no-shows keep other patients from being seen.

With your cooperation, you should receive all the benefits offered to you, and we can concentrate on caring for your Ophthalmological needs.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND I AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature_____ Date_____

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REFRACTION POLICY

1. **What is a REFRACTION ?**

Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

2. **Why is it necessary?**

Refraction is necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses, or due to a medical problem. A refraction is an essential part of an eye exam, however, **Medicare and most insurance companies DO NOT cover it.**

3. **How much is it?**

Our office fee for refraction is $65 in addition to the office visit copay and/or deductible. This is due at the time services are rendered.

4. **Contact lenses Rx fees**.

If you desire contact lenses - in addition to the refraction fee:

* one time contact lens fitting fee ranging between $150 - $250 depending on type of lenses will apply for all new contact lens patients.

** there is a yearly contact lens prescription renewal fee that ranges between $50 - $65 depending on type of lenses for all existing patients.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND I AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED. THIS AGREEMENT IS VALID FOR THE ENTIRE LENGTH OF MY TREATMENT WITH THE SPINAK MEDICAL EYE CENTER.

Name (please print)

_____

Signature_____Date _____

HEALTH HISTORY

Name_____ **Date** _____ **N/C:**_____,_____,_____,_____

YES	NO		YES	NO	
( )	( )	Asthma	( )	( )	Head or Spinal Injuries
( )	( )	Kidney Disease	( )	( )	Seizures, Convulsions, or Fainting
( )	( )	Tuberculosis	( )	( )	Extensive Confinement by Illness or Injury
( )	( )	Diabetes Type I ____ years	( )	( )	Sickle Cell Anemia
( )	( )	Diabetes Type II ____ years	( )	( )	Carotid Artery Disease
( )	( )	Migraines	( )	( )	Permanent defect from illness or injury
( )	( )	Psychiatric Disorder	( )	( )	Are you pregnant?
( )	( )	Any nervous disorder	( )	( )	High blood pressure
( )	( )	Heart Disease	( )	( )	Stroke
( )	( )	Ulcer	( )	( )	Suffering from any other disease?
( )	( )	HIV			

_____

_____

SOCIAL HISTORY

Marital Status: S M D W

Tobacco Use? Y N Pack/Years_____
Alcohol Use? Y N Drinks/Week_____
Occupation?_____

OCULAR HISTORY (HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?)

YES	NO		YES	NO	
( )	( )	Cataracts_____	( )	( )	Cornea Disease_____
( )	( )	Retina Disease_____	( )	( )	Glaucoma_____
( )	( )	Crossed Eyes_____	( )	( )	Injury_____
( )	( )	Iritis_____	( )	( )	Other Eye Disorders_____

Date of Cataract Surgery: Right_____ Left _____
Do you have a lens implant? ( ) YES ( ) NO

Date of Retina Surgery: Right_____ Left_____

Date of Any Other Eye Surgery_____
Explanation: _____

FAMILY HISTORY (HAS ANYONE IN YOUR FAMILY (BLOOD RELATIVE) HAD THE FOLLOWING?)

YES	NO		YES	NO	
( )	( )	Glaucoma_____	( )	( )	Cornea Disease_____
( )	( )	Cataracts_____	( )	( )	Diabetes Type I or II _____
( )	( )	Heart Disease_____	( )	( )	Diabetic Retinopathy_____
( )	( )	Macular Degeneration_____	( )	( )	Retinal Detachment_____
( )	( )	Retinitis Pigmentosa _____	( )	( )	Stroke_____
( )	( )	Other Eye Problems_____	( )	( )	Other Health Problems_____

Doctors Initials_____

PATIENT REGISTRATION

REFERRED BY:

PHONE BOOK___ TV___ INS CO___ FRIEND___ INTERNET___ ANOTHER PHYSICIAN_____ OTHER___

Patient Name_____ Gender: Male_____ Female_____ UNS_____

Guardian Name_____ Relationship to Patient_____

Date of Birth_____ / _____ / _____ SS#_____-_____-_____

Street Address_____

City_____ State_____ Zip_____

Home Phone (_____)_____-_____ Cell Phone(_____)_____-_____ Email: _____

Is it alright to leave a message? Y / N Is it alright to leave a message? Y / N

Pharmacy Name_____ Pharmacy Phone (_____) _____-_____

Primary Care Physician (PCP) _____ PCP Phone (_____) _____-_____

Emergency Contact _____ Phone (_____) _____-_____

Employer Name_____ Phone (_____) _____-_____

Is visit related to Workers Comp or No Fault incident? YES_____ NO_____

Primary Insurance Carrier _____ Lab(s) contracted with ins:_____

Policy# _____ Group# _____

Policy Holders Name_____ Date of Birth_____

DOES YOUR INSURANCE REQUIRE YOU TO OBTAIN A REFERRAL TO SEE A SPECIALIST?

YES_____ NO_____

Secondary Insurance Carrier_____

Policy# _____ Group# _____

Policy Holders Name_____ Date of Birth _____

VISION PLAN:

NAME: _____ ID#: _____

NO____ YES _____ I want to receive occasional emails about my appointment, office updates, and promotional announcements or coupons from Spinak Medical Eye Center.

PLEASE BE AWARE: MANY MANAGED CARE CONTRACTS (HMO'S & PPO'S) CONSIDER "WELL-CARE" VISITS (EXAMS NEEDED TO DETERMINE THE NEED FOR EYEGLASSES OR CONTACT LENSES) AS "UNCOVERED SERVICES." THIS MEANS THAT THE PATIENT MUST PAY FOR THESE SERVICES OUT OF POCKET. IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THEIR INSURANCE COMPANY REGARDING THEIR INDIVIDUAL POLICY.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME AND / OR FOR ANY BALANCE(S) TO INCLUDING BUT NOT LIMITED TO COPAYS, DEDUCTIBLES, COINSURANCES, AND ANY UNCOVERED SERVICE.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANY NECESSARY TO PROCESS MY MEDICAL CLAIMS.

PATIENT / GUARDIAN SIGNATURE _____ DATE _____

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OPHTHALMOLOGY
DISEASES AND SURGERY OF THE EYE

Dear Patient:

We would like to take this opportunity to welcome you to the Spinak Medical Eye Center. We are dedicated to providing quality Ophthalmological care to you. This letter contains answers to some of the most commonly asked questions by patients entering our practice. We hope you will find this information useful.

• Please be prepared as your initial visit will require you to be here for at least 1-2 hours.

• Please bring a list of current medications you are taking, as well as any pertinent medical information we may need.

• Please bring any current eyeglasses you wear and / or contact lens information. If you are a contact lens wearer, please remove your lenses prior to your appointment. Soft contacts should not be worn for one week prior to your appointment, and rigid contacts should not be worn for three weeks prior to appointments.

If for any reason – you feel that you cannot remove your contact lenses – please advise our office prior to your appointment. Additionally, if you wear gas permeable contact lenses, and cannot remove them prior to your visit, please bring in solution with you to the visit.

• Please bring a pair of sunglasses. If your eyes are dilated during your exam, you may be temporarily sensitive to the sun.

• Please bring your insurance ID card(s), and a photo ID and any applicable referral forms with you.

• In the event of an emergency outside of our normal business hours, patients may call the office and our answering service will contact the doctor on call for you.

• For your convenience, we offer an on-site optical shop. Middletown Opticians offers a wide range of eyeglasses and contact lenses. They can be reached at 845-735-0223

• Under normal circumstances, we provide a courtesy call to you to remind you of upcoming appointments. We do understand that occasionally situations come up that are beyond your control. In those instances, we request that you extend us the courtesy of a call to cancel your appointment within 24 hours notice. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that if you do not show up for an appointment, and fail to notify us of your inability to arrive, you will be charged a $25 no-show fee.

If you have any questions, or would like to gain additional information about the services we offer here at the Spinak Medical Eye Center, please visit our website at: www.spinakeyes.com

Please complete the attached paperwork and bring it with you to your appointment.

We look forward to seeing you on _____ at _____:_____ in Pearl River/Stony Point.

Thank you for choosing the Spinak Medical Eye Center for all of your eye care needs.