



PATIENT PRIVACY NOTICE AND CONSENT

Our notice of privacy practices provides information about how we may use and disclose protected health information about you (HIPAA). This notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of our notice may change, at which time you will be provided with a revised copy, or may request an updated copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in relationship to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient or representative/guardian understands that:

- Protected health information may be disclosed or used for treatment, payment or health operations.
- The practice has a notice of privacy and that I have received this notice.
- The practice reserves the right to change the notice of privacy policies.
- I have the right to restrict the uses of their information but the practice does not have to agree with those restrictions.
- I may revoke this consent in writing at any time and all future disclosures will then cease
- The practice may provide or perform necessary and agreed upon condition treatment upon the execution of this consent

I have read and understand the above policies.

[x] _____
_____ ***Patients Signature***

Date

_____ ***Name (print)***

Date



Patient Demographics

Were you referred by a doctor? YES NO *If yes, name of doctor:

Last Name:		First Name:		MI:
DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> widowed <input type="checkbox"/> divorced	Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____	

SSN (min. of last 4 digits needed for insurance purposes only):

Local Address:

City:	State:	ZIP code:
--------------	---------------	------------------

Home Phone:	Mobile Phone:
--------------------	----------------------

Can PEI leave messages that might contain medical info at this number? YES NO
 Can PEI send text message regarding upcoming appointments? YES NO

Email:

Can PEI contact via email? YES NO

****Worker's Comp Patients ONLY****

Employer Name:
Employer address:

Responsible Party (for minors or authorized signer for non-signing adults)

Relationship to patient:	Name (Last, First):
Address (if different from patient's):	
Phone (if different from patient's):	



Person to Contact in Case of Emergency: If the patient has a designated healthcare/financial surrogate or person with Power of Attorney, please provide a copy of the documentation for the patient's chart.	
Last Name:	First Name:
Phone #:	Relationship to patient:

The above information is true and correct to the best of my knowledge.

[x] _____

Patients Signature

Date

Name (print)

Date

CONSENT FOR DILATING EYE DROPS

In order to thoroughly examine your eyes and diagnose certain eye diseases such as glaucoma and macular degeneration, it is usually necessary to administer dilating drops. Dilating drops enlarge the pupil of the eye to allow for the examination of the inside of your eye; without pupil dilation, the doctor gets only a limited view of the eye. These drops usually cause blurred vision and make reading/focusing on near objects difficult or impossible until pupils return to normal size. The length of time that vision will be blurred and the degree of eyesight impairment varies from person to person. It is not possible to predict how much or how long your vision will be affected. We strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving. If you do not feel comfortable driving after dilation, we advise that you have someone accompany you for driving.

Please initial below to indicate you understand and agree to the following statement.

I consent to being dilated at today's visit if necessary.

REFRACTION FEE (\$35)

Refraction is a diagnostic test performed by the technician and/or physician for evaluation purposes or to determine glasses/contact lens prescriptions. This test is usually NOT covered by health insurance and is therefore 100% patient responsibility. A copy of your current prescription will be made available to you if applicable.

The refraction fee of \$35 will be collected at the time of service.

Please initial below to indicate you understand and agree to the following statement.



I am responsible for the \$35 refraction fee as it is not covered by medical insurance.

I have read and understand the above statements.

[x] _____

Patients Signature

Date

Name (print)

Date

FINANCIAL POLICY

Monthly statements on all accounts with an outstanding balance will be sent to the address provided. Your account is to be kept current accordingly; all self-pay charges, insurance or co-payments, co-insurances and deductibles will be collected at the time of service when applicable. Payments may be made via check, cash, Care Credit, Visa, Mastercard, Amex or Discover. A returned check will result in a \$30 service fee and all future payments will be required in the form of cash, or credit/debit card.

*****It is your responsibility to inform our office of any insurance, address or phone number changes.**

Medical Insurance: Please submit card(s) to receptionist.	
Primary:	Secondary:
Vision Insurance Plan:	
If this insurance info is incorrect, I understand charges are subject to patient responsibility.	
Name of insured person:	DOB:



Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent/legal guardian	Phone #: (if other than patients):
---	---

We will submit your claims; however, we must emphasize that as medical providers, our relationship is with you, NOT your insurance company. It is YOUR responsibility to inform us of any changes to your insurance policy so that your coverage can be verified prior to your appointment, including any VISION plan you may have separate from your health insurance. Although we may be an IN-network specialty provider for you insurance, not all services are 100% covered, you may be responsible for charges applied to deductibles or co-insurances. It is your responsibility to be aware of what services, provided by this practice, are or are not a covered benefit under your individual insurance plan. We cannot verify this for your individual plan. YOU are responsible for any non-covered charges not payable by your insurance policy. We do not file third insurance claims, or reimbursement forms. We will only file to two insurance companies.

I authorize release of any medical information to the above insurance companies to determine benefits payable. I request that payment be made on my behalf to Orest M Krajnyk, MD PA/Precision Eye Institute for any services furnished to me. I understand any charges not payable by my participating insurance after verification will be my responsibility.

I have read and understand the above policies.

[x] _____

Patients Signature

Date

Name (print)

Date

Patient History

Please check ANY/ALL that apply to the patient.

Ocular History:	Ocular Surgeries:
------------------------	--------------------------

- | | | |
|---|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> Contacts/glasses | <input type="checkbox"/> Narrow Angles | <input type="checkbox"/> Corneal Transplant |
| <input type="checkbox"/> Corneal disorder | <input type="checkbox"/> Ocular Migraines | <input type="checkbox"/> LASIK or RK/PRK: |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Retinal tear | <input type="checkbox"/> Lid surgery |
| <input type="checkbox"/> Flashes/floaters | <input type="checkbox"/> Retinal detachment | <input type="checkbox"/> Punctal Plugs |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other Ocular Symptoms | <input type="checkbox"/> Retinal Laser |
| | _____ | <input type="checkbox"/> YAG Capsulotomy |
| | _____ | <input type="checkbox"/> Glaucoma laser/surgery |
| | _____ | <input type="checkbox"/> Other: _____ |
| | _____ | |
| | _____ | |

Please check ANY/ALL that apply to the patient.

Medical History:	Surgical History:
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Auto immune disease
<input type="checkbox"/> Chronic migraine	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes: Type: _____	<input type="checkbox"/> COPD
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hepatitis Type: _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Stroke	<input type="checkbox"/> Staph or MRSA
<input type="checkbox"/> Thyroid disease: Hyper OR Hypo	Please list any surgeries you've had in the past below. _____ _____ _____ _____ _____ _____ _____

Family History:

Glaucoma
 Macular Deg.
 Diabetes
 Autoimmune disease
 Other: _____

Pharmacy Name & Location:

Primary Care Doctor Name (if local):

Medications: Please list all CURRENT RX or OTC medications including eye drops or provide list that we can make copy of.

Name of Medication:	Dosage/ frequency	Name of Medication:	Dosage/ frequency
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Allergies: Please list all allergies to medications and/or latex, etc.

Social History: Please check any that apply to the patient



Smoker (cigarettes/cigars/chewing tobacco)?

CURRENT FORMER NEVER

If current/former, how many years?

Drink alcohol?

Occasionally

Daily

Never

Drive?

Day

Night

Never

The above information is true and correct to the best of my knowledge.

[x] _____

Patients Signature

Date

Name (print)

Date