PRECISION EYE INSTITUTE

PATIENT PRVACY 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***

PRECISION EYE INSTITUTE

Patient Demographics

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

Last Name:		**First Name:**	**MI:**
DOB:	**Sex:** **[ ] M [ ] F**	**Marital Status:** [ ] single [ ] married [ ] widowed [ ] divorced	**Race:** [ ] Caucasian [ ] African American [ ] Hispanic/Latino [ ] Asian [ ] 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***

PRECISION EYE INSTITUTE

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 (CPT code 92015) has been a "non-covered" service since Medicare was created in 1965. Since about 2007, Medicare and other commercial medical insurances have been enforcing the policy of requiring eye doctors to charge separately for refractions. 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, should a refraction need to be performed.

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***

PRECISION EYE INSTITUTE

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: [ ] self [ ] spouse [ ] 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***

PRECISION EYE INSTITUTE

Patient History

Please check ANY/ALL that apply to the patient.

Ocular History:		Ocular Surgeries:
[ ] Cataracts	[ ] Macular Degeneration	[ ] Cataract Surgery
[ ] Contacts/glasses	[ ] Narrow Angles	[ ] Corneal Transplant
[ ] Corneal disorder	[ ] Ocular Migraines	[ ] LASIK or RK/PRK:
[ ] Dry eyes	[ ] Retinal tear	[ ] Lid surgery
[ ] Flashes/floaters	[ ] Retinal detachment	[ ] Punctal Plugs
[ ] Glaucoma	[ ] Other Ocular Symptoms _____	[ ] Retinal Laser
	_____	[ ] YAG Capsulotomy
	_____	[ ] Glaucoma laser/surgery
		[ ] Other: _____

Please check ANY/ALL that apply to the patient.

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

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***

PRECISION EYE INSTITUTE

_____ _____

Name (print) *Date*

How did you hear about us?

(Please check or write name of referral)

[ ]	**Google**	**[ ]**	**Google Search**
[ ]	**Bing Search**	**[ ]**	**Yelp**
[ ]	**Yahoo**	**[ ]**	**Facebook**
[ ]	**Walk-In /Drove By**	**[ ]**	**Hometown News**
[ ]	**Yellow Pages**	**[ ]**	**Insurance Company**
[ ]	**Church Bulletin**	**[ ]**	**Other: _____**

Doctor Referral: _____

Personal/Patient Referral: _____