Berks Eye
Physicians & Surgeons, Ltd.

PATIENT INFORMATION

Patient's Name: _____ _____
First Middle Last Email Address

Address : _____
P.O. Box Street Address

_____
City State Zip

Telephone: _____ _____ _____
Home Work Cell

Date of Birth: _____ SS#_____ Marital Status: ☐ S ☐ M ☐ W Sex ☐ M ☐ F

Race: _____ Language: _____

Family Doctor: _____ Referring Doctor: _____

Insured/Responsible Party's Name: _____
First Last

_____
P.O. Box Street Address City State Zip

Date of Birth: _____ Relationship: _____ SS# _____

Primary Insurance Information

Name of Primary Insurance: _____

Secondary Insurance Information

Name of Secondary Insurance: _____

Tertiary/Vision Insurance Information

Name of Tertiary Insurance: _____

If you are being seen for a work related injury please list your Employer below:

Employer _____ Occupation _____

_____
Address City State Zip

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Other insurance company benefits be made either to me or on my behalf to Berks Eye Physician & Surgeons for any services furnished me by Berks Eye Physicians and Surgeons. Regulations pertaining to Medicare assignment of benefits apply. I authorize Berks Eye Physician & Surgeons to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claims / other insurance company claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to Berks Eye Physicians and Surgeons. I understand it is mandatory to notify Berks Eye Physicians and Surgeons of any other party who may be responsible for paying for my treatment.

Signature: _____ Date: _____

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Physicians & Surgeons, Ltd.

PAYMENT POLICY

Thank you for choosing Berks Eye for your eye care needs. We are committed to providing you with quality and affordable eye care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it prior to any treatment, ask us any question you may have and sign in the space provided. A copy will be provided to you upon request.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.

INSURANCE/CLAIMS SUBMISSION:

Your insurance policy is a contract between you and your insurance company. Any balance billing you receive for the services provided is your responsibility. When you give us the correct information, we submit claims to the insurance companies we participate with and will assist you in any way we reasonably can to help get your claims paid. Please be aware that some and perhaps all, of the services provided may be non-covered services according to your policy. You are responsible for paying for non-covered services. All co-payments and/or refraction fees must be paid at the time of service. If you are covered by an HMO (Health Management Organization) you are required to have a referral from your Primary Care Physician at the time medical service is provided. It is your responsibility to contact your Primary Care Physician. If you do not have a referral, you will be billed for the services. If you were involved in a motor vehicle accident, please have your claim number and address where the claim should be mailed. If this is a worker's compensation claim, please make certain we are on the panel of physicians at your workplace. We must have the claim number and address where the claim should be mailed.

UCR (USUAL CUSTOMARY REIMBURSEMENT):

You are responsible for payment regardless of the amount your insurance company approves. We accept UCR amounts from insurance carriers with whom we contract. The patient is responsible for deductibles, co-insurance or non-covered services as indicated by your carrier contract.

MINOR PATIENTS (UNDER 18 YEARS OF AGE):

The parent or guardian accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday in the year is usually the primary insurer. **Before your appointment,** please check your insurance policy to determine which company is primary. In divorce cases, we will bill the participation insurances. The parent who seeks medical treatment for their child will be the responsible party unless a copy of the court order showing legal liability is presented.

OPTICAL SERVICES:

Full payment of eyewear is required at the time most glasses are ordered. For all vision insurance eyewear orders, the total cost is due at the time of order placement. Our Contact Lens Coordinator will detail contact lens charges and payment schedules. Entire balance due must be paid for eyewear or contact lenses to be dispensed. All paid or partially paid optical or contact lens orders must be picked up within 60 days of patient notification they are ready for pick up. If not picked up by patient within 60 days, the order will be cancelled and patient deposit not refunded.

BILLING:

A billing statement will be mailed monthly. Payment for all medical services is due 14 days from the date of the invoice. All statements which go unpaid 45 days from the due date will automatically be assessed a $30.00 service fee and assigned for legal recovery to a professional collection agency/attorney. Please speak to our Practice Manager if you have a financial hardship. A payment plan is available.

COLLECTION BALANCES:

If you had a previous collection balance, are presently in collections or have a past due patient balance over 90 days, most often full payment is required before any new office visits will be scheduled. If you are unable to pay your outstanding balance, you will be referred to the nearest hospital emergency room or ophthalmology free clinic for your eye care.

MISSED APPOINTMENTS

Appointments that are not cancelled 24 hours prior are subject to a $25.00 charge. This charge is not covered by insurance and is the responsibility of the patient. This policy may be waived when circumstances warrant.

To indicate that you have read and understand this payment policy, please sign and date below.

Signature of Responsible Party Date

Berks Eye
Physicians & Surgeons, Ltd.

NOTICE OF PRIVACY PRACTICES

This notice serves to inform you of our practice policy regarding the use and disclosure of your private health information. It is also designed to give you an understanding of your rights to access of your private health information and restricted unauthorized access. If you have any questions about this notice, please contact our Privacy Officer.

The terms of this Notice of Privacy Practices are effective April 13, 2003. Berks Eye Physicians & Surgeons, Ltd. will share patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. Our office is required by law to maintain the privacy of our patients' health information and to provide patients with this Notice of Privacy Practices. Our office will abide by the terms of this notice so long as it remains in effect and we reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available in our office, or upon request to our Privacy Officer, 1802 Paper Mill Road, Wyomissing, PA 19610, and a copy may be mailed to your address maintained on file.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Our office is committed to maintain the confidentiality of your health information. However, your health information may be used and disclosed as customary and reasonable for purposes of treatment, payment and health care operations and pursuant to a signed authorization form. You have the right to revoke that authorization in writing unless any action had been taken in reliance on the authorization.

Treatment, Payment and Health Care Operation: Except as otherwise provided, or with your signed consent, our office will use and disclose your health information for purposes of treatment, payment and as otherwise necessary and permitted by law for our health care operations. This may include disclosure to another health care provider who, at the request of your physician, becomes involved in your treatment or for purposes of approval if reimbursement from your health plans.

Business Associates: At times, it may be necessary for us to provide your health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to sign an agreement stating their fiduciary responsibilities in using this private health information.

Family and Friends: If authorized by you, we will share your private health information with friends and family members to the extent that you authorize. In the case where you are incapacitated and we feel that disclosing limited health information is in your best interest, we will disclose such information to family and/or close friends for purposes of communication and decision making.

Appointments and Services: Our office may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits issues. You have the right to request an alternate method of communications in writing, and may send your request to the Privacy Officer.
The office staff will call your name aloud in the waiting area to escort you to your scheduled appointment.

Other uses and disclosures of your individual health information permitted or required by law, may be made without your consent or authorization as follows:

1. Any purpose required by law.
2. Public health activities such as required reporting of disease, injury, birth and death, and for required public health investigations.
3. As required by law if we suspect child abuse or neglect, we may also Release your individual health information as required by law if we believe you are a victim of abuse, neglect or domestic violence.
4. If necessary, to the Food and Drug Administration.
5. To your employer when we have provided health care to you at the request of your employer.
6. If required by law to a government oversight agency conducting audits, investigations or civil and/or criminal proceedings.
7. If required by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such release.
8. To law enforcement officials.
9. To coroners and/or Funeral Directors consistent with law.
10. If necessary to arrange an organ or tissue donation or transplant.
11. If you are a member of the military, as required by the Armed Forces Services; we may also release your individual health information if necessary for National Security or intelligence activities.
12. To worker's compensation agencies.

YOUR RIGHTS

1. **Restrictions on Use and Disclosure of Individual Health Information —** You have the right to request restrictions on some of our uses and disclosures of your health information. We retain the right to refuse such restrictions if we believe such termination is appropriate. In the event of a refusal by us, we will notify you. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer.
2. **Right to Restrict –** You have the right to restrict certain disclosures of your personal health information to a health plan provider when you are paying out of pocket in full for a service or item.
3. **Access to Individual Health Information —** You have the right to the inspection and copying of your health information maintained by our office. Such a request must be made in writing. Please see our written practice policy regarding copying patient records and fees associated. You may obtain a request for access form from our office. In certain circumstances, you may not be permitted access (e.g. psychotherapy notes, information compiled for legal action or information subject to prohibition by law). Depending on the circumstances, you may request a review of the decision to deny access.
4. **Amendments to Individual Health Information —** You have the right to request in writing that your health information maintained by our office be amended or corrected. Please contact the Privacy Officer for questions about amendments to your health information.
5. **Accounting for Disclosures of Individual Health Information —** You have the right to request in writing to receive an accounting of certain disclosures made by us of your health information after April 14, 2003.

COMPLAINTS: If you believe your privacy rights have been violated you may file a complaint with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing. There will be no retaliation for filing a complaint.

ADDITIONAL INFORMATION If you have questions or need additional assistance regarding this notice you may contact the Privacy Officer.

I hereby acknowledge that I have received a copy of the Berks Eye Notice of Privacy Practices. I understand that I am to review the policy, and I have been given a copy of the policy for my own records.

SIGNED:_____ **DATE:**_____

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Medical Information Release Form

Patient Name: _____ Date of Birth: _____

I authorize the release of information including diagnosis, records, examination rendered and claims information to:

Spouse: _____

Child / Children: _____

Other: _____

☐ Information may NOT be released to others.

My Instructions for Message Notification

Please call: ☐ my home ☐ my work ☐ my cell phone

If unable to reach me:

☐ You may leave a detailed message on my answering machine.

☐ Please only leave a message asking me to return your call.

☐ _____

This release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

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MEDICAL HISTORY FORM

Patient_____Date_____Date of Birth: _____

Please circle (Yes *or* No) for each of the following medical conditions. If yes, please provide year of on-set. (If completed by someone other than the patient, give name & relationship) _____

Y N	High Blood Pressure	_____	Y N	Hard of Hearing	_____
Y N	Type 1 Diabetes	_____	Y N	Stroke	_____
Y N	Type 2 Diabetes	_____	Y N	High Cholesterol	_____
Y N	Heart Disease	_____	Y N	Migraine	_____
Y N	Heart Attack	_____	Y N	Blood Disorder	_____
Y N	Irregular Heart Beat	_____	Y N	Lung Disorder	_____
Y N	Carotid Artery Disease	_____	Y N	Thyroid Disorder	_____
Y N	Osteo/Rheumatoid Arthritis	_____	Y N	Intestinal Disorder	_____
Y N	Rheumatic Fever as a Child	_____	Y N	Psychiatric Disorder	_____
Y N	Hepatitis	_____	Y N	Seizures/Seizure Disorder	_____
Y N	Cancer	_____	Other:		_____

MEDICATIONS: Please list all medications taken regularly on the back of this form.

SURGICAL HISTORY: Please list surgeries you have had to **ANY** body part, along with the approximate year of surgery: _____
Use reverse side if necessary _____

Do you have any **METALLIC** devices/pieces in your body? □ **Yes** □ **No.** If yes, please provide location: _____

ALLERGIES (Medications, Latex, Environmental): _____

FAMILY HISTORY: (Parent, Grandparent, Sibling or Child)

Y N	Blindness (cause?)	_____	Y N	"Lazy Eye"	_____
Y N	Macular Degeneration	_____	Y N	Diabetes	_____
Y N	Glaucoma	_____	Y N	High Blood Pressure	_____

SOCIAL HISTORY: Lifestyle can also affect our health in many ways.
Do you drive? Y N Do you use tobacco? Y N Do you use alcohol? Daily Occasionally Never
Do you work with metals, fumes, chemicals or in a dusty environment? Y N Do you wear safety glasses? Y N
Do you work or have a hobby that you might need visual correction for at specific distances? Y N
Is there another adult living in your household? Y N

OCULAR HISTORY: (*New patients only)*

Y N	Eye Injury (Describe)	_____
Y N	Dry Eyes If yes, how treated?	_____
Y N	Contact Lenses If yes: Soft *or* Hard? Daily *or* Extended wear? Still wearing? Yes Not since	_____
Y N	Retinal Disorder or Surgery	_____
Y N	Cornea Disorder or Surgery	_____
Y N	Eyelid Disorder or Surgery	_____
Y N	Eye Muscle Disorder ("Lazy Eye") or Surgery	_____
Y N	Cataract (current) or Cataract Surgery	_____
Y N	Glaucoma or Glaucoma Surgery/Laser	_____

Other: _____

Patient/Guardian Signature:_____ **Date:**_____

************************REVIEWED AS DATED BELOW************************

Date _____by_____/_____ Date _____by _____/_____
Date _____by_____/_____ Date _____by _____/_____

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Medical History Form-
Supplemental

Patient Name:_____ Date:_____

Please circle if you are currently experiencing any of the following symptoms (Yes or No) to assist with the entry of your current medical status:

Yes	No	Fever	Yes	No	Shortness of Breath
Yes	No	Hearing Loss	Yes	No	Heartburn
Yes	No	Vertigo	Yes	No	Changes in Weight
Yes	No	Cough	Yes	No	Sinus Trouble
Yes	No	Abdominal Pain	Yes	No	Wheezing
Yes	No	Vomiting	Yes	No	Irregular Heartbeat
Yes	No	Chest Pressure	Yes	No	Nausea
Yes	No	Increased Thirst	Yes	No	Changes to Urine
Yes	No	Dizziness	Yes	No	Blood In Urine
Yes	No	Memory Difficulty	Yes	No	Fast Heartbeat
Yes	No	Changes in Mood	Yes	No	Intolerance to heat or cold
Yes	No	Dry Skin	Yes	No	Numbness in Extremities
Yes	No	Fatigue	Yes	No	Headaches
Yes	No	Nasal Congestion	Yes	No	Stress
Yes	No	Asthma	Yes	No	Rashes

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How Did You Hear About Us?

Patient Name:_____ Date of Birth:_____ Today's Date:_____

- ☐ AllAboutVision.com
- ☐ Berks County Living Magazine
- ☐ Berks Encore (Reading Eagle supplement)
- ☐ Berks Eye donated to my organization
- ☐ Billboard
- ☐ BodyZone
- ☐ Diabetes Postcard
- ☐ Event (Name:_____)
- ☐ Email from Berks Eye
- ☐ Friend/Family (Name:_____)
- ☐ Google Search
- ☐ Insurance Provider (Name:_____)
- ☐ Ophthalmologist Referral (Name:_____)
- ☐ Optometrist Referral (Name:_____)
- ☐ Patient First
- ☐ Physician Referral (Name:_____)
- ☐ Reading Eagle Newspaper
- ☐ Readingeagle.com
- ☐ Seminar (Location:_____)
- ☐ Social Media: ☐Facebook ☐Twitter ☐Pinterest ☐Instagram
- ☐ Verizon Superpages
- ☐ Welcome Wagon
- ☐ WFMZ.com
- ☐ WEEU Radio
- ☐ Y102 Radio
- ☐ Yellow Pages
- ☐ Other (Please state here:_____)