PATIENT BACKGROUND INFORMATION

PLEASE COMPLETE ALL QUESTIONS ON THIS FORM

Patient Name: _____ First Visit: Y N (circle one)

Date of Birth: _____/_____/_____ Birth Weight: _____ Full Term Premature (circle one)

Sex: M F (circle one) If premature, how may weeks early _____

Siblings: Y N (circle one) Are any siblings patients here? Y N (circle one)

Their names: _____

Family History (Please list any eye conditions present in relatives, such as "lazy eye," crossed eyes, thick glasses, cataracts at birth, etc…): _____

_____

_____

Medical / Surgical History (Include all hospitalizations, surgical procedures performed, etc...): _____

_____

List all medications currently being taken: _____

_____

Does patient have allergies to any medications? _____

_____

_____

Other information the doctor should know: _____

_____

REVIEW OF SYSTEMS

Does your child complain of, or presently have symptoms of any of the following?
Please provide specifics:

- ☐ Headache: _____
- ☐ Neck Pain / Stiffness: _____
- ☐ Ear Pain / Infection/ Decreased Hearing: _____
- ☐ Difficulty Breathing / Wheezing: _____
- ☐ Joint Pain / Stiffness: _____
- ☐ Birthmarks/Skin Rashes: _____
- ☐ Delay in Development (motor skills, speech, etc…): _____
- ☐ Nausea / Vomiting/ Diarrhea: _____
- ☐ Fever / Chills: _____
- ☐ Flu-like Symptoms / Cough / Sore Throat: _____
- ☐ Urinary Infections / Frequency: _____
- ☐ Early signs of Puberty / Abnormal Menstruation: _____
- ☐ Other: _____

_____

_____

Pediatric Eye Associates, LLC

Patient Information

Patient Name: _____
Last First M.I.

Address: _____
Street

_____
City State Zip

Home Phone: _____

Date of Birth: _____

Email:
(for appointment reminders) _____

Pediatrician: _____

Address: _____

_____

Telephone: _____

Referring Doctor: _____
(if different from above)

Address: _____

_____

Parent/Guardian Information

Name: _____

Date of Birth: _____

Soc. Security #: _____

Address (if different from above): _____

_____

Cell Phone: _____

Work Phone: _____

Name: _____

Date of Birth: _____

Soc. Security #: _____

Address (if different from above): _____

_____

Cell Phone: _____

Work Phone: _____

Please complete for person responsible for bill

Name: _____ Relationship to Patient: _____

Insurance Information

Please provide all pertinent insurance information. If you have coverage by more than one carrier, please supply information for both carriers. Please present your referral form and insurance cards to the receptionist.

Primary insurance subscriber name _____ Patient relationship to subscriber _____

Secondary insurance subscriber name _____ Patient relationship to subscriber _____

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, PLUS COSTS ASSOCIATED WITH COLLECTIONS (INCLUDING ATTORNEY'S COSTS), MAY BE CHARGED on all balances owed to the provider that are past due. I AGREE THAT I WILL BE RESPONSIBLE FOR CHARGES THAT ARE DEEMED NON-COVERED BY MY (OR PATIENT'S) INSURANCE COMPANY.

_____ _____
Signature of insured or authorized person, patient or parent of minor Date

PEDIATRIC EYE ASSOCIATES, LLC
Pediatric Ophthalmology and Adult Strabismus

AMY LAMBERT, MD
RACHEL BLOOM, MD

Dear Parents,

Welcome to our practice! We are committed to providing your child with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policies. Please be sure to tell us about any secondary insurance you may have. In addition, we will need to see a copy of your insurance card(s) at the time of your visit. If your insurance carrier requires you to have a referral, this must be presented at the time of service, as well. We can only process your claim with this referral.

Some insurance plans require a co payment amount. This is to be paid at the time of service. If we do not participate with your insurance plan, payment in full is due at the time of the visit. Upon request, we will gladly provide you with a copy of your bill so that you may submit your expenses to your insurance carrier. Please understand that your insurance is a contract between you and your carrier. We do not know what specific benefits your plan has. Some services may be covered, and others may not. In the event that your plan has a deductible, you may be responsible for the balance.

This practice "participates" with many different insurance companies. This means that we agree to submit your claim directly to that company and "accept" their reimbursement schedule for services that are covered under your particular contract. Some services may not be covered under your plan. For example, routine eye exams and refractions may not be covered benefits. You should check with your insurance carrier if you have a question about whether or not a particular service is a covered benefit of your plan.

Your insurance carrier requires us to fully itemize all procedures and services performed. **A refraction, for example, is a distinct and separate service from the eye exam itself, and is submitted to your carrier as such. In the event that your insurance plan does not cover any part of your child's visit (ie they deny it as a "non covered" service), you will be financially responsible for payment.**

Returned checks are subject to an additional fee of $35. Balances outstanding beyond 30 days may be sent to a collection agency, and will be subject to fee of $50 or actual collection costs of 30% (plus attorney's fees), whichever is greater.

We require at least 24 hour notice for rescheduled or cancelled appointments. Patients who miss appointments or do not cancel with at least 24 hour notice will be subject to a $50 fee.

Should you have any questions regarding our payment policies, please don't hesitate to ask. We advise you to keep a copy of this form for your records, and will gladly provide you with one upon request.

Patient Name_____

Parent / Guardian Name _____

Parent / Guardian Signature _____ Date_____

22 Old Short Hills Road, Lower Level – 1
Livingston, New Jersey 07039
(973) 422-1230 FAX (973) 422-1236
www.kideyedoc.com

PEDIATRIC EYE ASSOCIATES, LLC
Pediatric Ophthalmology and Adult Strabismus

AMY LAMBERT, MD
RACHEL BLOOM, MD

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered or have received a copy of Pediatric Eye
Patient/Guardian/Legal Representative

Associates, LLC Notice of Privacy Practices.

Name of Patient _____

_____ _____
Signature of Patient/Guardian/Legal Representative Date

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PEDIATRIC EYE ASSOCIATES, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPAA) REQUIRES ALL HEALTH CARE RECORDS AND OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PROTECTED HEALTH INFORMATION) USED OR DISCLOSED TO US IN ANY FORM, WHETHER ELECTRONICALLY, ON PAPER, OR ORALLY, BE KEPT CONFIDENTIAL. THIS FEDERAL LAW GIVES YOU, THE PATIENT, SIGNIFICANT NEW RIGHTS TO UNDERSTAND AND CONTROL HOW YOUR HEALTH INFORMATION IS USED. HIPPA PROVIDES PENALTIES FOR COVERED ENTITIES THAT MISUSE PERSONAL HEALTH INFORMATION. AS REQUIRED BY HIPPA, WE HAVE PREPARED THIS EXPLANATION OF HOW WE ARE REQUIRED TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.

WITHOUT SPECIFIC WRITTEN AUTHORIZATION, WE ARE PERMITTED TO USE AND DISCLOSE YOUR HEALTH CARE RECORDS FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

TREATMENT MEANS PROVIDING, COORDINATING, OR MANAGING HEALTH CARE PROVIDERS.
PAYMENT MEANS SUCH ACTIVITIES AS OBTAINING REIMBURSEMENT FOR SERVICES, CONFIRMING COVERGE, BILLING, OR COLLECTION ACTIVITIES, AND UTILIZATION REVIEW. AN EXAMPLE OF THIS WOULD BE BILLING YOUR HEALTH PLAN FOR YOUR HEALTH SERVICES.
HEALTH CARE OPERATIONS INCLUDE THE BUSINESS ASPECTS OF RUNNING OUR PRACTICE, SUCH AS CONDUCTING QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, AUDITING FUNCTIONS, COST MANAGEMENT ANALYSIS, AND CUSTOMER SERVICE. AN EXAMPLE WOULD INCLUDE A PERIODIC ASSESSMENT OF OUR DOCUMENTATION PROTOCOLS, ETC.

IN ADDITION, YOUR CONFIDENTIAL INFORMATION MAY BE USED TO REMIND YOU OF AN APPOINTMENT (BY PHONE OR MAIL) OR PROVIDE YOU WITH INFORMATION ABOUT TREATMENT OPTIONS OR OTHER HEALTH RELATED SERVICES INCLUDING RELEASE OF INFORMATION TO FRIENDS AND FAMILY MEMBERS THAT ARE DIDRECTLY INVOLVED IN YOUR CARE OR WHO ASSIST IN TAKING CARE OF YOU. WE WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN WE ARE REQUIRED TO DO SO BY FEDERAL, STATE OR LOCAL LAW. WE MAY DISCLOSE YOUR **PROTECTED HEALTH INFORMATION** TO PUBLIC HEALTH AUTHORITIES THAT ARE AUTHORIZED BY LAW TO COLLECT INFORMATION, TO A HEALTH OVERSIGHT AGENCY FOR ACTIVITIES AUTHORIZED BY LAW INCLUDED BUT NOT LIMITED TO: RESPONSE TO A COURT OR ADMINISTRATIVE ORDER, IF YOU ARE INVOLVED IN A LAWSUIT OR SIMILAR PROCEEDING, RESPONSE TO A DISCOVERY REQUEST, SUBPOENA, OR OTHER LAWFUL PROCESS BY ANOTHER PARTY INVOLVED IN THE DISPUTE, BUT ONLY IF WE HAVE MADE AN EFFORT TO INFORM YOU OF THE REQUEST OR TO OBTAIN AN ORDER PROTECTING THE INFORMATION THE PARTY HAS REQUESTED. WE WILL RELEASE YOUR **PROTECTED HEALTH INFORMATION** IF REQUESTED BY A LAW ENFORCEMENT OFFICIAL FOR ANY CIRCUMSTANCE REQUIRED BY LAW. WE MAY RELEASE YOUR **PROTECTED HEALTH INFORMATION** TO A MEDICAL EXAMINER OR CORONER TO IDENTIFY A DECEASED INDIVIDUAL OR TO IDENTIFY THE CAUSE OF DEATH. IF NECESSARY, WE ALSO MAY RELEASE INFORMATION IN ORDER FOR FUNERAL DIRECTORS TO PERFORM THEIR JOBS. WE MAY RELEASE **PROTECTED HEALTH INFORMATION** TO ORGANIZATIONS THAT HANDLE ORGAN, EYE OR TISSUE PROCUREMENT OR TRANSPLANTATION IF YOU ARE AN ORGAN DONOR. WE MAY USE AND DISCLOSE YOUR **PROTECTED HEALTH INFORMATION** WHEN NECESSARY TO REDUCE OR PREVENT A SERIOUS THREAT TO YOUR HEALTH AND SAFETY OR THE HEALTH AND SAFETY OF ANOTHER INDIVIDUAL OR THE PUBLIC. UNDER THESE CIRCUMSTANCES, WE WILL ONLY MAKE DISCLOSURES TO A PERSON OR ORGANIZATION ABLE TO HELP PREVENT THE THREAT. WE MAY DISCLOSE YOUR **PROTECTED HEALTH INFORMATION** IF YOU ARE A MEMBER OF THE U.S. OR FOREIGN MILITARY FORCES (INCLUDING VETERANS) AND IF REQUIRED BY THE APPROPRIATE AUTHORITIES. WE MAY DISCLOSE YOUR **PROTECTED HEALTH INFORMATION** TO FEDERAL OFFICIALS FOR INTELLIGENCE AND NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW. WE MAY DISCLOSE **PROTECTED HEALTH INFORMATION** TO FEDERAL OFFICIALS IN ORDER TO PROTECT THE PRESIDENT, OTHER OFFICIALS OR FOREIGN HEADS OF STATE, OR TO CONDUCT INVESTIGATIONS. WE MAY DISCLOSE YOUR **PROTECTED HEALTH INFORMATION** TO CORRECTIONAL INSTITUTIONS OR LAW ENFORCEMENT OFFICIALS IF YOU ARE AN INMATE OR UNDER THE CUSTODY OF A LAW ENFORCEMENT OFFICIAL. DISCLOSURE FOR THESE PURPOSES WOULD BE NECESSARY: (A) FOR THE INSTITUTION TO PROVIDE HEALTH CARE SERVICES TO YOU, (B) FOR THE SAFETY AND SECURITY OF THE INSTITUTION, AND/OR (C) TO PROTECT YOUR HEALTH AND SAFETY OR THE HEALTH AND SAFETY OR OTHER INDIVIDUALS OR THE PUBLIC. WE MAY RELEASE YOUR **PROTECTED HEALTH INFORMATION** FOR WORKERS' COMPENSATION AND SIMILAR PROGRAMS.

ANY OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOU MAY REVOKE SUCH AUTHORIZATION IN WRITING AND WE ARE REQUIRED TO HONOR AND ABIDE BY THAT WRITTEN REQUEST, EXCEPT TO THE EXTENT THAT WE HAVE ALREADY TAKEN ACTIONS RELYING ON YOUR AUTHORIZATION.

YOU HAVE CERTAIN RIGHTS IN REGARD TO YOUR **PROTECTED HEALTH INFORMATION** WHICH YOU CAN EXERCISE BY PRESENTING A WRITTEN REQUEST TO OUR PRIVACY OFFICER AT THE PRACTICE ADDRESS LISTED BELOW:

THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF **PROTECTED HEALTH INFORMATION**, INCLUDING THOSE RELATED TO DISCLOSURES TO FAMILY MEMBERS, OTHER RELATIVES, CLOSE PERSONAL FRIENDS, OR ANY OTHER PERSON IDENTIFIED BY YOU.
WE ARE, HOWEVER, NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION. IF WE DO AGREE TO DO A RESTRICTION, WE MUST ABIDE BY IT UNLESS YOU AGREE IN WRITING TO REMOVE IT.
THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF **PROTECTED HEALTH INFORMATION** FROM US BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS.
THE RIGHT TO ACCESS, INSPECT AND COPY YOUR **PROTECTED HEALTH INFORMATION**.
THE RIGHT TO REQUEST AN AMENDMENT TO YOUR **PROTECTED HEALTH INFORMATION.**
THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF **PROTECTED HEALTH INFORMATION** OUTSIDE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.
THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US UPON REQUEST.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR **PROTECTED HEALTH INFORMATION** AND TO PROVIDE YOU WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO **PROTECTED HEALTH INFORMATION.**

WE ARE REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE OF PRIVACY PRACTICES CURRENTLY IN EFFECT. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL **PROTECTED HEALTH INFORMATION** THAT WE MAINTAIN. REVISIONS TO OUR NOTICE OF PRIVACY PRACTICES WILL BE POSTED ON THE EFFECTIVE DATE AND YOU MAY REQUEST A WRITTEN COPY OF THE REVISED NOTICE FROM THIS OFFICE.

YOU HAVE THE RIGHT TO FILE A FORMAL WRITTEN COMPLAINT WITH US AT THE ADDRESS BELOW, OR WITH THE DEPARTMENT OF HEALTH & HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, IN THE EVENT YOU FEEL YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

FOR MORE INFORMATION ABOUT OUR PRIVACY PRACTICES, PLEASE CONTACT:

P R I V A C Y O F F I C E R
LARRY LEVY
PEDIATRIC EYE ASSOCIATES, LLC
22 OLD SHORT HILLS ROAD, SUITE LL1
LIVINGSTON, NJ 07039
(973) 422-1230

FOR MORE INFORMATION ABOUT HIPPA OR TO FILE A COMPLAINT:

THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF CIVIL RIGHTS
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, DC 20201
(877) 696-6775 (TOLL FREE)