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. Please read the following information carefully. If you have any questions, ask us. We cannot proceed with any exams until all the necessary forms for your child are completed and signed by a parent or legal guardian.

General Information

• An initial office visit or full eye exam takes at least 60-75 minutes and normally requires the use of dilating eye drops.

• We make every effort to run on time, but occasionally your visit may be longer because of situations beyond our control. For example, the doctors may need to treat an emergency or counsel a parent about a complex problem. Some children may need a little extra time to complete their exam. Rest assured that we will treat your child in the same kind and caring manner and they will not be rushed.

• **An adult with legal authority must accompany all patients under 18 years of age**. You may not send your child with a neighbor, sibling, au-pair, nanny, grandparent, or other adult without a signed note giving your permission for that person to act on your behalf.

• We require at least 24 hours notice for cancelled or rescheduled appointments. **Without proper notice, you will be charged a $50 cancellation fee.**

Insurance and Financial Information

• We participate with many medical (health) insurance plans. ***We do not participate with Vision Plans***.

• It is your responsibility to understand the rules and benefits of your insurance policy. If you have medical insurance, we will try to help you work within the rules and framework of your policy. Questions regarding coverage should be directed to your insurance carrier or to the benefits coordinator at the workplace that provides your insurance.

• Please understand that we do not know what services may or may not be covered under your insurance plan. We work according to the rules of your insurance carrier and per our agreement with them, but we have no control over what your insurance company considers a covered benefit.

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

In-Network Visits

• We will need to see a copy of your insurance card at the time of *each* visit.

• **Co-insurance** and **co-payments** are the patient's responsibility. Co-payments are due at the time of the visit. We will not see any patient without the co-payment being made before the exam begins. Payments may be made by cash, check, credit card, or debit card.

• It is your responsibility to obtain a **referral** if required by your insurance plan. We must have a referral at the time of the visit. We cannot accept "back dated" paper referrals. Many insurance companies issue or use electronic referrals. In such circumstances, the referral for your child must be in the system prior to your visit. Please do not wait to call your primary care physician to obtain a referral when you arrive at the office. This will delay your appointment and we will likely need to reschedule your child's visit.

• Insurance may not pay for the cost of your (child's) visit because you have a **deductible**. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.

• 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 insurance carrier as such. In the event that your insurance plan does not cover any part of your child's visit (i.e., they deny it as a "non-covered" service), you will be responsible for payment.

• Though this practice may participate with your insurance, some policies may only cover a **"medical"** issue as opposed to a **"vision"** issue. Alternatively, some plans may allow for a "routine" eye exam and not a "medical" one. We understand this is a source of much confusion. The coding we submit to insurance for your child's visit reflects their symptoms and the physical findings on their examination. Please do not ask us to change or make up a diagnosis code after the fact in order to fit a particular policy allowance. If your insurance carrier denies the claim or does not cover any charges, you will be responsible for payment.

• We submit claims to your insurance carrier for you, but you are responsible for responding to any requests from the insurance carrier for further information. Failure to respond to your insurance company's requests for information will result in a claim denial and you will be responsible for full payment to us.

• You must notify us if there are any changes in your insurance coverage. Even a small discrepancy on the claim form may lead to a denial of coverage by your insurance company.

• If your coverage is not in effect at the time of the visit, as determined by your insurance company, the financial responsibility for full payment will be yours.

• **The parent signing this document is the person responsible for payment**. In situations where the patient's parents are divorced or separated, the parent bringing the child for the exam (and signing this document) is the responsible party. We do not bill the other parent.

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Out-of-Network Visits

• If we do not participate in your insurance plan, payment for services is due at the time of service. It is your responsibility to submit any claims for out-of-network reimbursement to your insurance carrier. We will gladly provide you with a receipt and forms detailing the codes and charges for your child's visit.

Overdue Balances and Returned Checks

• **Returned checks are subject to an additional fee of $35**.

• Accounts with outstanding balances beyond 30 days may be flagged for collections or sent to a collection agency. Accounts flagged for collections or sent to a collections agency will be charged a collection services fee by this practice. The amount of the collection services fee charged will be in addition to the original balance owed. **The collection services fee will be $50 or one third (33.33%) of the outstanding balance, whichever is greater**. In addition to the collection services fee, accounts may be subject to any actual attorney's fees incurred by us in seeking to secure account payment.

Should you have any questions regarding any of these 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. This document can also be found in the "New Patient Forms" package on our website.

Patient Name_____

Parent / Guardian Name _____

Parent / Guardian Signature _____ Date_____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, am aware that Pediatric Eye Associates' Privacy
Parent or Legal Guardian

Policy regarding Protected Health Information (PHI) is available in the office and on the practice's website at *www.kideyedoc.com/forms.* I am aware that I can also request a copy be sent to me by contacting the practice via telephone or email.

Name of Patient: _____

_____ _____
Signature of Parent or Legal Guardian Date

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