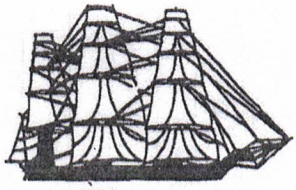

Niagara Eye Associates

Appointment Date _____

Patient's Name (please print) _____

If a Child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

E-mail Address _____

Birth Date _____ M or F _____ SSN _____

Employer _____ Occupation _____

Spouse's Employer _____ Work Phone _____

Health Insurance Carrier _____ Policy # _____

Medicare/Medicaid _____ Policy # _____

How did you find out about our office? _____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date _____

Date: _____

Patient Name: _____ Primary Care Physician: _____

MEDICAL INFORMATION SHEET QUESTIONNAIRE

1. **Past Medical History:** Do you have?

☐ Asthma	☐ Liver Disease	☐ High Cholesterol
☐ Heart Disease	☐ Kidney Disease	☐ Gerd
☐ Lung Disease	☐ Thyroid Disease	☐ Cancer
☐ Diabetes	☐ High Blood Pressure	☐ Depression
☐ Arthritis	☐ Stroke	☐ Other _____

2. **Past Systemic Surgeries?** Please list any and the dates:

_____

_____

_____

3. **Past Eye Surgeries or Laser Surgery History:**
   - ☐ Cataract Surgery Date: _____
   - ☐ Glaucoma Surgery Date: _____
   - ☐ Retina Surgery Date: _____
   - ☐ Other _____

4. **Diagnosed Eye Disease:** *List any you have?* _____

_____

Please check yes or no if you follow a retina specialist: ☐ *Yes* ☐ *No*
If yes please write the doctor's name and date of last exam

_____

5. **Family History of Eye Diseases and relationship to the patient:**
(for example father/ mother/ sister/ brother/ etc):

☐ Glaucoma _____	☐ Blindness _____
☐ Cataracts _____	☐ Other _____
☐ Retinal _____	☐ None

6. **Medications**: *Drug Name/ Dose/ Strength*
How do you take it (for example once a day, twice a day, etc)

_____

_____

_____

_____

7. **Drug Allergies:**

_____

Niagara Eye Associates
1801 West 8th Street
Erie, Pa. 16505
814-455-8004 Fax: 814-456-6054

Niagara Eye Associates
Personal Communicaton of Your Patient Information

NAME_____ **Date of Birth**_____

There may be times when we would like to informally contact you with information, or when you may want us to tell others, such as family or friends, about your condition or treatment. For instance, we may need to contact you to report test results or you may want us to inform your family of how your treatment is proceeding. We refer to this type of informal communicaton as "Personal Communication". Please fill out this form to help guide us in providing Personal Communication about you.

Niagara Eye Associates has my permisson to Bill my Insurance: YES_____ or NO_____

1. Please indicate who else (if anybody) we may communicate with concerning your condition and/or treatment?

____No one
____My Spouse, please print name:_____
____My Children, please print name:_____
____My Parent(s) please print name:_____
____Others: _____

Emergengy Contact Person, please print name: _____

Number of Emergency Contact:_____

2. May we provide Personal Communication to you by telephone?

___ Yes ___No

If yes, please list the telephone number we may use, if it is other than what we currently have on file: _____.

3. If you are not available when we call by telephone, may we provide the information to the person who answers, or leave the information on the answering machine?

___Yes ___No

4. If we use regular mail to provide Personal Communication to you we will use the address you have given us. If you want us to use an address different than what we have on file, please list it here:

_____

_____

5. May we provide appointment reminders by means of texting.

___Yes ____No If Yes cell number: _____

6. May we provide appointment reminders by means of e-mail.

___Yes ____No If Yes e-mail address:_____

7. If there are any other specific requests for restriction on Personal Communication that you would like to make, please note them here:

_____

_____

8. This form will remain in effect for the following terms:

____As Long as I am a patient____This treatment & follow up only___Other: _____

I understand the following with respect to this form:

- I may refuse to complete/sign this form. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- If the person(s)receiving information about me through Personal Communication is not a health care provider or a health plan covered by Federal Privacy Regulations, the information may be re-disclosed and no longer protected by Federal Privacy Regulations.
- I may change or revoke this form in writing at anytime, for future Personal Communications.

_____ _____

Signature of patient or patient's legal representative Date

_____

Print patient's name

_____ _____

Print name of legal representative (If applicable) Relationship to patient

Patients Name: _____

Advance Beneficiary Notice (ABN)

We expect that your insurance plan may not pay for the item(s) or service(s) that are described below, therefore we are collecting the payment of $50.00 in advance. If, by chance, your insurance plan covers the refraction (92015) we will reimburse you the fee of $50.00. If your insurance plan does not pay for that service you should still be entitled to receive a refraction, especially if it is recommended by the doctor.

A refraction is when you are examined for a new prescription for eyeglasses and are physically handed a prescription. Unfortunately, most insurance plans do not feel a refraction is medically necessary.

The purpose of this form is to help you make an informed decision as to whether or not you would like to receive this service, with the understanding that you may be expected to pay for this service.

Feel free to ask a technician for clarification if you do not understand the content of this form.

Please choose one of the following options by checking the relevant box, then sign and date below.

_____ Option 1: Yes, I would like a prescription for eyeglasses

_____ Option 2: No, I do NOT wish to receive a prescription for eyeglasses

_____ Option 3: I will let the doctor decide if necessary

In addition, contact lens fitting fees are not covered under medical insurance, therefore a fee will incur if you elect to proceed with a contact lens fitting/exam. Please ask technician for details.

_____ _____

Signature of patient or person acting on behalf of the patient DATE