Pediatric Ophthalmology of NJ – Medical Information Form Page 1 of 2
Chief Complaint and Review of Systems

M / F / / / /

Patient Last Name, First Name, Middle Name | Sex | Date of Birth | Date Form Completed

Y / N

Premature? | Birth Weight and Gestational Age | Name of person completing form

What is the reason for this examination? Please give as detailed information as possible relating to the symptoms or reasons for this particular visit and the duration of the problem.

Review Of Other Information Please circle either Yes or No for the following questions. Detailed information about any positive answers may be written on the next page.

Ocular History:

Wear glasses now	Y N	Other Retinal Diseases	Y N
Glasses in the past	Y N	Glaucoma	Y N
Using contact lenses	Y N	Uveitis / Iritis	Y N
History of eye surgery	Y N	Cataracts	Y N
Any eye medicines	Y N	Tear Duct Obstructions	Y N
Strabismus (crossing or wandering eyes)	Y N	Corneal Diseases or Problems	Y N
Amblyopia (poor vision even with glasses)	Y N	Chalazia / Hordeola (Sties)	Y N
Ptosis (droopy eyelid or eyelids)	Y N	Blepharitis (Infection of lid edges)	Y N
Anisocoria (unequal pupils)	Y N	Trauma to the eye, eyelid, or eye socket	Y N
Retinopathy of Prematurity (ROP)	Y N	Other eye problems not listed above	Y N

Medical History:

Medications (prescription or over the counter)	Y N	Endocrine Problems (diabetes, thyroid, etc.)	Y N
Medically related allergies (drugs, latex, etc.)	Y N	Ear, Nose, Throat Problems (sinusitis, deafness, etc.)	Y N
Other allergies (seasonal, food, etc.)	Y N	Craniofacial Malformations	Y N
Respiratory problems (asthma, apnea, etc.)	Y N	Infectious Diseases (Lyme, HIV, mononucleosis, etc.)	Y N
Heart problems (murmurs, defects, etc.)	Y N	Cancer, Tumors or Growths	Y N
Hematologic problems (anemia, bleeding, etc.)	Y N	Rheumatologic Diseases (JRA, Irritable Bowel, etc.)	Y N
Kidney or Urinary Problems	Y N	Other Medical Issues not listed above	Y N
Neurologic Problems (seizures, hydrocephalus etc.)	Y N	Surgical Procedures	Y N
Developmental Problems (delays, ADHD, etc.)	Y N		

Family History (This section is for other family members not for problems in the patient):

Glasses in immediate family members	Y N	Strabismus or Amblyopia	Y N
Glaucoma in infancy or childhood	Y N	Hereditary Eye Disorders	Y N
Glaucoma in adults	Y N	Hereditary Medical Disorders	Y N
Cataracts in infancy or childhood	Y N		

Signature of Doctor Reviewing Form | Date Form Reviewed | Is Page 2 needed / completed?

Pediatric Ophthalmology of NJ – Medical Information Form Page 2 of 2
Please provide details of any Yes answers from Page 1

Patient Name (Last, First, Middle) | Patient Birth Date | Date Completed | Name of Person Completing Form

Signature of Doctor Reviewing Form | Date Form Reviewed

PEDIATRIC OPHTHALMOLOGY OF NJ - BACKGROUND INFORMATION SHEET
PLEASE PRINT LEGIBLY

PATIENT NAME_____ PEDIATRICIAN / REFERRING DOCTOR_____

PATIENT HOME ADDRESS (PLEASE INCLUDE ZIP)

_____ PATIENT HOME NUMBER_____

_____ PRIMARY CELLULAR PHONE_____

_____ PATIENT DATE OF BIRTH_____AGE_____SEX____

EMAIL ADDRESS FOR RECALL PURPOSES_____

NAME OF INSURED GUARDIAN _____SEX_____

INSURED ADDRESS
(IF DIFFERENT FROM PATIENT'S)

_____

_____

_____

PARENT / GUARDIAN HOME PHONE
(IF DIFFERENT FROM PATIENT'S)_____

CELLULAR PHONE _____

INSURED SOCIAL SEC#_____

INSURED DATE OF BIRTH_____

INSURED EMPLOYER NAME AND ADDRESS

_____

_____

_____

INSURED WORK PHONE_____

ANY EMERGENCY INFORMATION OR PHONE NUMBERS:

_____

PRIMARY INSURANCE COMPANY ADDRESS,
AND PHONE NUMBER

_____

_____

_____

PERSON HOLDING POLICY_____DOB_____

SS#_____GROUP#_____

PARENT / GUARDIAN INDIVIDUAL #_____

PATIENT # (IF DIFFERENT
FROM INSURED _____

SECONDARY INSURANCE COMPANY NAME, ADDRESS,
AND PHONE NUMBER

_____

_____

_____

PERSON HOLDING POLICY_____DOB_____

SS#_____GROUP #_____

PARENT / GUARDIAN INDIVIDUAL #_____

PATIENT # (IF DIFFERENT
FROM INSURED) _____

I authorize the release of any information needed for the processing of any medical claims. I further authorize payment of any outstanding balance on this and future claims to be paid directly to Pediatric Ophthalmology of NJ, P.C.

Printed Name_____ Signature_____ Date_____

PEDIATRIC OPHTHALMOLOGY OF NJ, P.C. • OFFICE AND FINANCIAL POLICIES

GENERAL INFORMATION

Payments may be made by cash, check, credit card, or debit card. However, we do **not** accept American Express.

If your child is interested in contact lenses, please let us know in advance so that we may allot extra time for a fitting. **We do not give contacts to children under 12 years of age** except in for special medical conditions such as aphakia. Typically, contacts are not covered by insurance.

An initial office visit, or full yearly check will require at least 60-90 minutes and requires the use of dilating eye drops. These will make the patient's vision blurred and light sensitive for many hours. We make every effort to run on time and we do not double book patients. However, your time in the office may be longer because of situations beyond our control. For example, there may be an emergency, or a child may have an extremely complex problem which we were not aware of when the appointment was made, or there may simply be a large number of uncooperative young patients who take longer than expected to be examined

INSURANCE AND FINANCIAL INFORMATION

If you have medical insurance, we are committed to helping you work within the framework of your policy. However, it is important that you realize it is your responsibility to understand the rules of your plan. Any questions regarding coverage must be directed to your insurance carrier or to the benefits coordinator at your place of employment. Your insurance coverage is a contract between you and your insurance carrier, not with the physician. We do not control what benefits you have. We will work according to the rules of your insurance carrier as we are instructed to do, but we have no control over what the carrier considers a covered benefit.

Participating Plans: If you are seeing us as a participating provider in your plan, there are several important points to be aware of:

- If you have a diagnosis which your insurance carrier does not consider "medical," and you do not have vision coverage, your claim may be denied. In such a circumstance, you will be responsible for payment at our regular fee schedule **even if you had a referral**. We cannot fabricate a non-visual diagnosis to insure payment by the insurance carrier.
- Deductibles are the patient's responsibility. 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.
- 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 at the time of the visit**.
- 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. Not doing so will result in a claim denial and you will be responsible for payment.
- It is your responsibility to obtain referrals if required to do so by your insurance plan. We must have a referral at the time of the visit. We cannot accept "back dated" paper referrals. Many insurance carriers use electronic referrals. In such a circumstance the referral must be in the system prior to your visit. **We cannot have you call your primary care physician to obtain a referral when you arrive at the office**. This is disruptive and delays other patients. Additionally most primary care offices will not honor such a request.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours.
- If you have had any changes in your insurance coverage – even if there is only a small change in the co-payment amount or a change in the expiration date of the policy – you must notify us. Even a small discrepancy on the claim form such as the wrong end-date of coverage may lead to a claim denial.
- If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

Non-participating Plans: If you have insurance coverage, but we do not participate in your insurance plan, payment for services is due at the time of service. It will be your responsibility to forward any claims for reimbursement on to your insurance carrier. We will provide you with a receipt detailing the diagnosis and codes charged for the visit.

Responsible Parent: In a situation where the patient's parents are divorced or separated, our policy is that the parent bringing the child for an exam is the responsible party. We cannot bill the other parent. This has caused too many problems in the past and we cannot become entangled in legal battles between two parties.

MINORS

Someone with legal authority must accompany all patients under 18 years of age. You cannot send a child with a neighbor, sibling, au-pair, nanny, grandparent, or other adult without a signed note giving your permission for said person to act on your behalf. Whoever is accompanying the patient will be given information about the examination, and it is up to them to communicate this information to the parent or legal guardian. **We cannot call the parent or legal guardian at the time of the visit to explain the entire exam and findings over the phone.** This is disruptive and delays other patients.

MISSED APPOINTMENTS

We understand that people may have emergencies or may simply make a mistake and forget appointments. However, if more than one appointment is missed without a 24 hour notice (except in the event of an emergency) this will incur a $50 "missed appointment" fee. An appointment will not be rescheduled until the missed appointment fee is paid. Any patient who misses more than three appointments without notice will not be given another appointment.

Billing statements will be mailed to the responsible party. ***IF PAYMENT IS NOT RECEIVED WITHIN 60 DAYS, YOU WILL BE PLACED IN COLLECTIONS AND ANY INCURRED COLLECTION FEES WILL BE YOUR RESPONSIBILITY.***

I understand and agree to the above policies outlined for Pediatric Ophthalmology of NJ.

Patient or Guardian Signature	Printed Name	Date

Updated 9/9/14

Privacy Statement Acknowledgement Form

Signing this form acknowledges that I have received the form:
Notice of Privacy Practices - Pediatric Ophthalmology of NJ

Patient Name: _____

Guardian name: _____
(If patient is a minor or not competent)

Signature of Patient: _____
(Or Guardian if a minor)

Date: _____

☐ We often need to contact patients by phone – for example to return a phone call from you, or to confirm an appointment the day before your next visit. If you are not available, we will leave a message on your answering machine or voicemail. **If you DO NOT wish us to leave a message on your answering machine or voicemail, check this box.** If you leave this box unchecked, you are giving us permission to leave such messages.

Please list the names of persons (including physicians) with whom we are allowed to discuss the medical condition of the patient, and their relationship to the patient:

_____

_____

_____

_____

_____

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. If you have any questions about this Notice please contact our Privacy Contact: Office Manager

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website **(www.pedopnj.com)**, or by calling the office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

Section 1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may also give information to someone who helps pay for your care. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you. We may use medical information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.
Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.
Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Section 2. Your Rights
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Section 3. Changes
We reserve the right to changes this notice. We reserve the right to make the revised changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. In addition, each time you register for health services, we will offer you a copy of current notice in effect. This notice was published and becomes effective on February 6, 2003.

Section 4. Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact, the Office Manager, at 973-256-4111 or by mail (at 57 Willowbrook Boulevard, Suite 411, Wayne, NJ 07470) for further information about the complaint process.