BRIGHT eyes OPTOMETRY

177 B East Main Street
New Rochelle, NY 10801
914-355-4775
914-355-4777
info@brighteyesny.com

1. **Please enter your information. We are bound by HIPPA Law to not give/sell this information you provide. Please Fill out this form in print as completely as possible.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married
○ Domestic Partner
○ Separated ○ Divorced
○ Widowed

SSN #: _____

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

2. **Emergency Contact**

Name: _____

Relationship to patient: _____ Phone Number: _____

Primary Care Doctor's Name _____ Doctor's Phone # _____

3. **Primary Medical Insurance: Please enter your Primary Care Insurance to avoid unnecessary waiting time and inaccurate billing.**

Insurance: _____ Subscriber #: _____

Group/ CIN#: _____

Insured Relationship:
○ Self ○ Dependent

4. **Secondary Medical Insurance: If applicable, please enter your Secondary Medical Insurance to avoid unnecessary waiting time and inaccurate billing.**

Insurance: _____ Subscriber #: _____

Group/ CIN#:

Insured Relationship:
○ Self ○ Dependent

Primary Insured. Name:

Date of Birth:

5. **Vision Medical Insurance: Please enter your VSP, EYEMED insurance information to avoid unnecessary waiting time and inaccurate billing.**

Insurance:

Subscriber #:

Group/ CIN#:

Insured Relationship:
○ Self ○ Dependent

Primary Insured. Name:

Date of Birth:

Social History

6. **Do you drive?**
   - ○ Yes
   - ○ No

7. **Do you use tobacco products?**
   - ○ Yes
   - ○ No

8. **If yes:**

How many packs/day?

Years smoking?

9. **Do you use illegal drugs?**
   - ○ Yes
   - ○ No

10. **If yes, how frequently?**

Ocular History

11. **Last eye exam?**

12. Do you or have worn glasses?

- ○ Yes
- ○ No

13. If yes, how old your most recent pair:

_____

14. Do you or have worn contact lenses?

- ○ Yes
- ○ No

15. If yes, which brand and prescription are you currently wearing?

_____
_____
_____
_____

16. Do you have an eye disease/ocular condition?

- ○ Yes
- ○ No

17. If yes, explain:

_____
_____
_____
_____

18. Have you had an eye infection, eye injury or eye surgery?

- ○ Yes
- ○ No

19. If yes, explain:

_____
_____
_____
_____

20. Have you worn an eye patch or had vision therapy?

- ○ Yes
- ○ No

21. If yes, explain:

Medical History

22. Medical Doctor:

Last Medical Physical exam with primary care doctor?

23. Do you have any allergies to medications or other substances?

- Yes
- No

24. If yes, please indicate:

25. Are you taking any medications? (including birth control, aspirin, OTC meds, home remedies)

- Yes
- No

26. If yes, please indicate:

27. Have you had any major injuries or hospitalizations?

- Yes
- No

28. If yes, please indicate:

29. Woman: Are you pregnant or breastfeeding?

- Yes
- No

Family History

(Note: any family history, including parents, grandparents, siblings and/or children; living or deceased)

30.

	No	Yes	If Yes, Who?
NO TO ALL			
Glaucoma			
Blindness			
Retinal Disease/Detachment			
Heart Disease			
Thyroid Disease			
Cancer			
Macular Degeneration			
Crossed Eyes			
Cataracts			
Diabetes			
Arthritis			
High Blood Pressure			

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

31. Constitutional

	No	Yes	?
Fever, Weight Loss/Gain			
Integumentary (skin)			

32. Neurological

	No	Yes	?
Headaches			
Migraines			
Seizures			

33. Eyes

	No	Yes	?
NO TO ALL			
Loss of Vision			
Blurred Vision			
Distorted Vision/Halos			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing/Watering			
Glare/Light Sensitivity			
Eye Pain or Soreness			
Chronic Infection or Eye or Lid			
Sties or Chalazion			
Flashes/Floaters in Vision			
Tired Eyes			

34. Endocrine

	No	Yes	?
Diabetes			
Thyroid/Other Glands			

35. Vascular/Cardiovascular

	No	Yes	?
High Blood Pressure			
High Cholesterol			
Chest Pain			
Vascular Disease			

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Notice Of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you may get access to this information. Please read it carefully. The privacy of your health information is important to us.

To Provide Treatment: We will use and disclose your health information within our office to provide you with the best health care possible. This may include business office staff, assistants, opticians and physicians. In addition, we may share our health information with referring physicians, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.

To Obtain Payment: We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or send electronically.

Healthcare Operations: Your health information may be used during performance evaluation of our staff, training programs for students, interns, associates, and business and/or clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

Appointment Reminders/ Communication: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. We may also contact you for follow up appointments, inform you of treatment options, and services that may interest you or a family member. These may include postcards, folding cards, letters, telephone, voice mail, text message or email.

Required By Law: We may use or disclose your PHI health authorities and health oversight agencies that are authorized by law to collect information when required to so do so by law enforcement officials, lawsuits and similar proceedings in response to a court or administrative order. This often times occurs when it becomes necessary to reduce or prevent a serious threat to your health and safety, that of another individual, the public or for Worker's Compensation and similar programs. Our patient medical records are kept confidential, secure and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by Bright Eyes Optometry prior to being filed in the medical record. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information to comply with Privacy Regulations. We will let you know promptly if a breach occurs that may compromise the privacy or security of your information.

Patient Rights: When it comes to your health information, you have certain rights. This sections explains your rights and some of our responsibility to you. You can ask to see or get a paper copy of this notice or of your medical records and other health information we have about you, usually provided with in 10 days of your request. You may ask us to correct your medical records if you think information may be incorrect or incomplete. We may say "no" to your request, but you will receive why in writing with in 60 days. You can file a complaint if you feel we have violated your rights with Bright Eyes Optometry by sending a letter

to 177B East Main Street, New Rochelle, NY 10801 or sending an email to info@brighteyesny.com.

By signing below, you acknowledge that you have read and understand the above Patient Agreement.

Patient Printed Name: Kelly Bonte

Patient/Authorized Representative Signature

Date

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Financial Responsibility Form

At Bright Eyes Optometry, we value you as a patient and appreciate that you have trusted us with your healthcare needs. In an effort to better inform you of our financial policies please review the information below and sign acknowledging that you understand our policies. Please know we are committed to protecting your information and provide you with the best optometric care.

Acknowledgement of Our Billing Policies

In the event there is a patient responsibility balance, we will make the following attempts to contact you regarding any Outstanding Balances:

- If we have your permission and personal email address on file, we will email you a notification that a statement is on the way. The notification is our first request for payment and outlines convenient methods for you to settle your balance with us.
- We will mail your 1st Statement. this statement gives you the option to mail us a check, call with a valid credit card and or come to our office and pay either check, cash, or credit.
- We will mail you a 2nd statement. This statement is a reminder that you have not made payment previously, and this is our final notice.
- After 90 days of non- payment or response, we will automatically freeze your medical chart and services will not be rendered until paid.

By signing this form you acknowledge that you will receive two billing statements and an opportunity to correspond with us regarding your account or make payment with alternate payment methods. If a payment or response is not received within 90 days, your medical chart will be automatically frozen and services will not be rendered until paid.

No-Show/Cancellation Fees

As a courtesy to our Providers and other patients, please note that except in case of an understandable emergency, our practice requires 24 hour notice for cancellations. Failure to show up for your appointment is unacceptable. We reserve the right to charge a non-refundable cancellation fee or no-show fee of $50.00 to your account or credit card on file without 24 hours' notice to cancel or reschedule an appointment.

Assignment of Benefits

I authorize Bright Eyes Optometry to submit claims to my insurance on my behalf, and my insurance to make payments directly to Bright Eyes Optometry for all covered services rendered by the group during the course of my treatment.

By signing below, you acknowledge that you have read and understand the above Patient Agreement.

Patient Printed Name: Kelly Bonte

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Disclosure and Consent for Medical and/or Surgical Procedures

You have the right as a patient to be informed about your condition and the recommended medical, surgical or diagnostic procedure to be used to treat or diagnose such condition so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent for a procedure.

I (We) voluntarily request Dr. Deutscher, as my eye care provider, to perform procedures deemed necessary, to treat my condition which will be explained to me.

I(We) understand that my doctor may discover other or different conditions which require additional or different procedures than those planned. I(We) authorize my doctor and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment .

I(We) understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedure(s) planned for me.

I(We) realize that common to surgical, medical and diagnostic procedures is the potential for infection and allergic reactions. I(We) also realize that the following risks and hazards may occur in connection with any procedure:

Dilation

Gonioscopy
Punctal Dilation
Punctal Plugs
Meibomian Gland expression
Prokera
Tonometry

I(We) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I(We) understand that certain complications may result from the use of any anesthetics including respiratory problems and drug reaction.

I(We) have been given the opportunity to ask questions about my condition, alternative forms of treatments, risks of non treatment, the procedure to be used, and the risks and hazards involved, and I(We) believe that I(we) have sufficient information to give this informed consent.

I(We) certify that this form has been explained to me/us that, I (We) have read it or had it read to me/us, that the blank spaces have been filled in and that I (We) understand it's contents.

Patient/Authorized Representative Signature	Date

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Client Signature

Date