HUNTERDON
FAMILY EYE CARE

Komal Abbas, O.D.
Susan Freed-Gilvey, O.D.
Rachel M. Halatin, O.D.

1465 Route 31 South
Annandale, NJ 08801
Tel: (908) 730-6774
Fax: (908) 730-9011

☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Rev

First Name and Last name | Preferred Name

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse | Date of Birth | Age | SSN#

Address | City | State | Zip

Home Phone | Cell Phone | Email Address | ☐ Ok to text? ☐ Ok to e-mail?

Occupation (if student, grade in school) | Employer (if student, name of school)

Name of Insurer for ***VISION*** care | Name of Insurer for ***MEDICAL*** care

Name of Primary Holder | Primary's Date of Birth | Primary's SSN#

Primary Care Physician | Office Location | Pharmacy Name | Pharmacy Location

PAYMENT POLICY & RELEASE OF PATIENT INFORMATION

Payment is expected when services are rendered, unless other arrangements are made in advance. ***It is your responsibility to know your insurance coverage for your routine/medical exams and/or materials.*** Insurance that covers your visit must be presented at time of visit, or the patient will be responsible for lab fees if glasses or contacts are not ordered from your insurance lab. Glasses must be dispensed to you within 60 days of purchase or they will be dismantled and deposit will be lost. The patient or responsible party will pay for services rendered which are not fully covered by an insurance or third party plan. If an account becomes delinquent, the patient will pay the balance plus reasonable collection agency and/or attorney fees and interest on the unpaid account.

For your protection, contact lenses may not be reordered without a yearly exam. Our Licensed Opticians will make the safest and best recommendation for eyeglass lens options, based on individual patient needs. I give my permission for this office to exchange exam or chart information with insurance or third-party carriers and consulting doctors or professionals involved in my care. My consent is good for all future services.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS

Signature of patient or responsible party | Date

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MEDICAL HISTORY FORM

Reason for today's examination

MEDICATIONS/VITAMINS/SUPPLEMENTS

DRUG ALLERGIES

MEDICAL CONDITIONS:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Cholesterol
- ☐ Thyroid
- ☐ Heart Condition
- ☐ Previous Concussions
- ☐ Double Vision
- ☐ Other

Please list additional medical conditions you have been diagnosed with

OCULAR HISTORY

Have you ever been diagnosed with eye problems?

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration

Have you ever taken any eye medications? If so, which ones?

Have you ever had any eye surgeries? Please explain.

FAMILY HISTORY

Has anyone in your family ever been diagnosed or treated for:

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart Condition

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SOCIAL HISTORY

Do you currently or have you ever smoked? If so, how many packs per day, how many years, and when did you quit?

Do you consume alcohol? If so, socially? 1-2 per day? More than 2 per day?

REVIEW OF SYSTEMS

Allergic/ Immunologic
- ☐ NONE
- ☐ Drug Allergy
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Environmental Allergy
- ☐ OTHER

Endocrine
- ☐ NONE
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Thyroid dysfunction
- ☐ Hormonal Dysfunction
- ☐ OTHER

Hematologic/ Lymphatic
- ☐ NONE
- ☐ Anemia
- ☐ Leukemia
- ☐ Large Blood loss
- ☐ OTHER

Psychiatric
- ☐ NONE
- ☐ Depression
- ☐ Panic Disorder
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ OTHER

Cardiovascular
- ☐ NONE
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ OTHER

Eyes
- ☐ NONE
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Surgery
- ☐ OTHER

Integumentary
- ☐ NONE
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ OTHER

Respiratory
- ☐ NONE
- ☐ Bronchitis
- ☐ Asthma
- ☐ Smoker
- ☐ Emphysema
- ☐ OTHER

Constitutional
- ☐ NONE
- ☐ Developmental Disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma

Gastrointestinal
- ☐ NONE
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ OTHER

Musculoskeletal
- ☐ NONE
- ☐ Ankylosing Spondylitis
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ OTHER

Ear, Nose, & Throat
- ☐ NONE
- ☐ Upper Respiratory Tract infection

Neurological
- ☐ NONE
- ☐ Multiple Sclerosis
- ☐ Epilepsy

Genitourinary
- ☐ NONE
- ☐ STD - viral herpetic or chlamydia

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RECREATIONAL PROFILE

Do you participate in any sports or recreational activities? ☐ YES ☐ NO

If yes, what kind?

☐ Baseball	☐ Lacrosse	☐ Skiing/Snow sports	☐ Basketball
☐ Martial Arts	☐ Soccer	☐ Fishing	☐ Racquet sports
☐ Swimming	☐ Football	☐ Rollerblading	☐ Volleyball
☐ Golf	☐ Shooting sports	☐ Water sports (sailing, jetski)	☐ OTHER

It is critical to know that…

- ★ According to "Prevent Blindness America," 90% of all sports-related eye injuries are preventable with the proper use of protective sports eyewear.
- ★ The appropriate protective sports eyewear and polycarbonate lenses will help protect your eyes.
- ★ Effective January 2006, New Jersey law requires protective eyewear for school and organized sports.

I HAVE BEEN MADE AWARE THAT custom fit protective sports eyewear will help protect my children's eyes. They meet performance standards that exceed those met by everyday wear. Hunterdon Family Eye Care strongly recommends that I/my child wear protective sports eyewear, complete with polycarbonate lenses, when participating in any sport or recreational activity.

Patient Signature Date

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CANCELLATION/NO SHOW POLICY

Hunterdon Family Eye Care has a 24-hour cancellation policy. If you miss your appointment, cancel, or change an appointment with less than 24-hours notice, you will be charged a fee of $50.00.

- **This fee will not be billed to or covered by your insurance company.**

This policy is in place out of respect for our doctors and staff, but most importantly, for other patients waiting for appointments. Cancellations within 24 hours of your scheduled appointment are difficult to fill. By giving the office last minute notification, or failing to notify us at all, you prevent another patient from being able to be scheduled into that time slot.

Thank you for your understanding and cooperation.

By signing below, you acknowledge that you have read and understand the Cancellation Policy

Print name of patient

Signature of patient or responsible party Date

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ABOUT YOUR INSURANCE

Please provide your insurance cards to one of our staff members so we can make a copy. We need to have your medical insurance card on file should we need it for billing your insurance.

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types, and Hunterdon Family Eye Care accepts most insurance plans in both categories:

1. Vision plans (VSP, EyeMed)
2. Medical insurance (Blue Cross/Blue Shield, Medicare, and others)

Vision plans *only* cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management, or treatment of eye health problems).

Medical Insurance must be used for medical eye care.

Fees that are not paid by your insurance, such as deductibles, co-pays, or non covered services as allowed by your insurance contract, will be billed to you

I HAVE READ AND ACCEPT THESE POLICIES:

Print name of patient

Signature of patient or responsible party Date

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WELL VISIT AND MEDICAL EYE EXAM

A **routine eye examination** (well visit) focuses on maintaining excellent vision and good eye health, with or without eyeglasses or contact lenses. This exam is coded and billed differently than a medical eye visit.

Medical eye exams for problems such as diabetes, glaucoma, dry eyes, eye pain, bleeding in the eye, flashes and floaters, lid issues, rashes, etc., are addressed at sick or disease management visits. These problems require a different history, review of past treatments, additional testing and visits, and are coded and billed differently than a routine eye exam visit.

If we must combine a medical visit with a well visit and your insurance has coordination of benefits, we will submit the appropriate codes and charges to your insurance companies for both the well visit and the problem visit. This is the accepted way to bill for this type of appointment. Depending on your insurance plan(s), **you may be responsible for a portion of the bill.**

Print name of patient | Patient's DOB

Signature of patient or responsible party | Date

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HIPAA ACKNOWLEDGEMENT OF RECEIPT

This confirms that I read and was offered a copy of the Notice of Privacy Practices of Hunterdon Family Eye Care

_____

Print name of patient

_____

Signature of patient or responsible party Date

List any individuals that have permission to be told about my eye care needs: (relative, spouse, child, etc.)

_____

_____

_____

_____

I give permission for the staff to leave a message on my answering machine or with whoever may answer my home phone.

Initial: _____

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RETINAL IMAGING OPT OUT

I hereby elect to **OPT OUT** of retinal imaging, fully acknowledging that this procedure has the potential to detect *sight-threatening* conditions, including retinal detachment, macular degeneration, glaucoma, and ocular melanoma.

I understand that, in my decision to forgo retinal imaging, the doctor may recommend dilation of my eyes to facilitate a thorough examination. Should any retinal abnormalities be identified, I am aware that this will be billed as a medical office visit on the day the dilation is performed, which will occur on a separate date unless an emergency is identified, in which case today's exam will no longer be considered routine and will be billed to my medical insurance.

Print name of patient

Signature of patient or responsible party Date