Children's Eyes Albany
Patient Demographics

Date: _____

Patient Legal Name: _____ **DOB:** _____

Preferred/ Nickname: _____ **Height:** _____ **Weight:** _____

Sex at birth: ___ Male ___ Female **Gender Identity:** _____

Cell #:_____ **Home#:**_____ **Email:** _____

Address:_____ **City/State/Zip:**_____

Primary Doctor (Name & Location): _____

Referring Doctor (If different than primary): _____

Pharmacy (Name & Location)

_____

_____

_____

Other Specialist Providers (Name & Location)

_____

_____

_____

Primary Insurance:

Subscriber Name: _____

Company:_____

ID:_____

Group: _____

Secondary Insurance:

Subscriber Name: _____

Company:_____

ID:_____

Group: _____

Parent/ Guardian Information:

Parent 1 First & Last Name: _____

Relation:_____ DOB: _____

Email: _____

Phone #: _____

Address: ☐ Same as above

_____

Parent 2 First & Last Name:_____

Relation: _____ DOB: _____

Email:_____

Phone #: _____

Address: ☐ Same as above

_____

Parents Marital Status: Married Unmarried Separated Divorced Widowed Other

Additional/ Emergency Contact Information:

#1 Contact Name: _____ Phone #: _____ Relation:_____

#2 Contact Name: _____ Phone #: _____ Relation:_____

Children's Eyes Albany

Medical History

Birth History:

Premature? Y / N Number of weeks pregnant at delivery? _____ Birth Weight_____

Is this your child by: ____ Birth ___ Adoption ____ Foster ____Other: _____

Developmental History:

Growth Delay Motor delays/weakness Reading/Academic PT ST OT Special Education

Current Medication & Dosage:

_____ _____
_____ _____
_____ _____

Allergies:

Any Known Drug Allergies? If yes, drug & reaction:

_____

_____

Patient Medical History: List any major illnesses, hospitalizations, injuries or surgery

_____
_____
_____

Family History:

Eye related conditions: _____

Additional health conditions: _____

Who lives at home with child [Including parent(s)]

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you CURRENTLY have any of the following? If yes, please circle:

Decreased Vision Headache Weight Loss Fever Muscle Weakness Numbness Nervousness Memory Loss Chest Pain Shortness of Breath Nosebleed Sinus Problems Skin Reactions Trouble Swallowing Diarrhea Trouble urinating Nasal/Postnasal Discharge Other (Describe): _____

Reviewed by: _____

Children's Eyes Albany
920 Albany Shaker Rd. Suite 101
Latham, NY 12110

Patient Authorization Form

Patient Name:_____ Date of Birth:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand I may request in writing that you restrict how my PHI is used and disclosed to carry out treatment, payment or healthcare operations.

List of persons we are authorized to discuss your protected health information with:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship:_____

Other organizations to whom we can release medical information or health forms to?

School: _____

Daycare/Babysitter: _____

Other: _____

This authorization will remain in effect from the date signed below indefinitely unless I notify this office in writing. My revocation will be submitted to Children's Eyes Albany at the above address.

Print Name:_____

Relationship to patient: _____

Signature: X_____ Date: _____

Children's Eyes Albany

Financial Policy

I request that payment of authorized Medicare benefits be made on my behalf to Children's Eyes Albany for services furnished by Children's Eyes Albany. I authorize the holder of medical information about me to release to the health care financing Administration and its agents any information needed to determine the benefits payable to related services.

I understand my signature request that payment be made and authorize the release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of HCFA-1500 form or elsewhere on other approved claim forms, my signature authorized releasing to the insurer or agency shown.

Children's Eyes Albany accepts the charge determination of the Medicare carrier, Blue Shield of Western NY, or applicable DMERC, as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medicare/ Senior Advantage Signature_____

If Medigap policy or other health insurance is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary benefits be made on my behalf to Children's Eyes Albany.

Medigap/ Secondary Insurance Signature-_____

I hereby authorize payment of my medical and surgical insurance benefits to Children's Eyes Albany. I understand that I am financially responsible for any charges, whether or not paid by said insurance. If co-payment and/or deductible are designated by my insurance company of health plan, I agree to pay them to Children's Eyes Albany. I authorize Children's Eyes Albany to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Other Insurance Signature_____

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Latham, NY 12110

Dilation

Dilating the pupils with eye drops allows the doctor the best view of the internal structures of the eye and is considered the standard of care in new patients. The drops also permit the use of a technique which enables the doctor to prescribe glasses for pre-verbal children and can be useful in other situations where an accurate refraction might otherwise be difficult. This too is considered the "Gold Standard" when prescribing glasses for children and young adults. The drops, which are not painful, take 30 minutes to work properly, during which your child may play in the waiting room. Children who have had dilating drops may notice difficulty focusing on near objects and may be more sensitive to bright sunlight. These effects start to wear off after several hours, but may persist for longer, especially in individuals with light colored eyes. We understand that most children and many adults do not like eye drops. However, we are unable to provide the highest quality of care without their use and appreciate your understanding.

Refraction

Refraction is the measurement of the lens prescription required to give the best possible vision in each eye. It is an essential part of many eye exams, even in patients who appear to see well, and especially during childhood. However, Medicare and most commercial insurance plans have elected not to cover the cost of refraction and insist the $35.00 charge be billed separately.

Sensory Motor Examination

The sensory motor exam is comprised of a battery of tests which evaluate a patient's binocular cooperation and ocular alignment. It may be required in addition to those tests performed during a normal eye exam, especially in complex cases, such as those involving double vision (diplopia) and/or a horizontal or vertical misalignment of the eyes. Information from the sensory motor exam is then used to plan the best optical, medical and surgical treatment. This procedure is billed separately from the overall examination and is subject to additional fees (co-payments/deductibles).

No Shows

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments, we have instituted a $50 no show fee. You must give 24-hour advanced notice to cancel appointments. Failure to do so will result in a $50 fee charged to your account. Three consecutive missed appointments (no-shows) will result in dismissal from the practice.

Participation, Pre-Authorization, Referrals

I understand that I am responsible for contacting my insurance carrier(s) to confirm if the doctor you are seeing at CEA is participating with my insurance carrier(s) and that I am eligible for benefits on or before the date my visit(s) take place. Furthermore, I agree to contact my insurance carrier(s) and/or Primary Care Physician to determine if it is necessary to obtain any pre-authorization/ referral before my visit(s) take place. Moreover, I agree to pay for any dollar amount denied or applied to my deductible by my insurance carrier(s), due to the fact that I failed to present a pre-authorization/ referral at the time of my visit.

By signing below, I acknowledge that I have read and understand the information and policies above

Patient Name: _____ Parent/Guardian Name & Relationship_____

Patient/Parent/Guardian Signature: _____Date: _____