EYE CARE OF DELAWARE LLC

(302) 454-8800
eyecareofdelaware.com

PATIENT REGISTRATION

Last Name	First	MI	Female Male Other	Birth Date
Address	Apt #	City	State	Zip Code

Race: White Black/African American Asian American Indian Indian Other
Ethnicity: Hispanic Non-hispanic Prefer not to report
Language: English Spanish ASL Other _____

Please Check Preferred Contact	Home Phone:	Cell Phone:	Work Phone:

Email	Occupation	Marital Status	Live Alone or with someone?

Pharmacy Name & Phone Number	Primary Care Physician & Phone Number

Emergency Contact Name	Emergency Contact Phone	Relationship

Referring Doctor Name	Practice Name	Phone	Last Visit Date
Is this your regular eye doctor?	If NO, who is your regular eye doctor?		Last Visit Date

Reason for today's visit:	Date started:

Location: Right Eye Left Eye Both Eyes
Severity: Mild Moderate Severe
Quality: Blurry Foggy Double Other _____

Glasses Yes No If Yes: How often do you wear?
Contacts Yes No If Yes: Soft Hard Last Date Worn:

Do you have difficulty with any of these activities, even with glasses?

Driving Watching TV Crafts
Reading Computer Use Other _____
Writing Recreational Activities

Do you drive? Yes No Explain _____
Do you drink alcohol? Yes No If yes, Occasionally 1/day 2- 3/day 4+/day
Do you use recreational drugs? Yes No Have you ever had a blood transfusion Yes No
Are you pregnant? Yes No

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Medication Reconciliation

List all medications you take including prescribed, over the counter, herbal supplements and vitamins. Be sure to include any eye drops that you use. List <u>medication</u> allergies below.

Medication	Dosage	Frequency	To the right of this shaded area is for medical office use only				

Note: If medication is **<u>not</u>** taken orally, please inform the technician at the time of your office visit

Are you allergic to any medications?: Yes No

List medication allergies: _____

Do you use tobacco? YES NO if yes, _____ packs /cigarettes per day. Counseled: _____

Patient Name: _____ Date of Birth: _____

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Patient Name: _____ DOB: _____

PRIVACY AUTHORIZATION NOTICE

I have read the Notice of Privacy Practices and by signing this form consent to the use and disclosure of my protected health information. I have the right to review the Notice before signing this consent and I am aware that terms of the Notice may change.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

Additionally, I authorize the release of information to the following person(s):

Name	**Relationship**
_____	_____
_____	_____

PATIENT CONSENT FOR MEDICAL RECORDS MAINTENANCE

I have read the Eye Care of Delaware, LLC Medical Records Maintenance Policy (included in the Notice of Privacy Practices) and by signing this form consent to this arrangement.

Signature: _____

EYE CARE OF DELAWARE, LLC OFFICE AND FINANCIAL POLICY

I have read the Eye Care of Delaware, LLC/Cataract and Laser Center, LLC Office and Financial Policy and by signing this form consent to the terms.

Signature: _____

PATIENT AUTHORIZATION ASSIGNMENT OF MEDICARE/MEDICAID BENEFITS

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to any physician utilizing the Eye Care of Delaware and/or Cataract and Laser Center for any service furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Service (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare/Medicaid assigned cases, the provider agrees to accept the charge determination of the Medicare/Medicaid carrier and I am responsible for the deductible, co-insurance and/or the 20% Medicare does not pay, and for any non-covered services. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Signature: _____

COMMERCIAL/HMO/BLUE SHIELD/SECONDARY INSURANCE

I request that the payment of authorized benefits be made either by me or on my behalf to any physician utilizing the Eye Care of Delaware and/or Cataract and Laser Center, for services provided to me. I authorize any holder of medical information about me to release it to my insurer, or any information needed to determine these benefits payable for related services. I am responsible for any insurance deductible, co-insurance, non-covered services and exclusion of benefits. It is my responsibility to obtain any referrals required for services. If a referral was required and not obtained I will be responsible to pay for the services received. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as the original.

Signature: _____

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REFRACTION POLICY

A refraction is a diagnostic test used to determine the refractive error (or focusing error) of your eyes. A refraction is often used to calculate your glasses or contact lens prescription. It is also necessary data for the evaluation of cataracts and/or secondary membranes. For healthy eyes, the best corrected vision is generally 20/20. Worse vision can indicate a medical problem (such as cataracts) or can be due to a simple refractive error (such as nearsightedness or astigmatism). Unfortunately, Medicare and most medical insurance plans do not cover the cost of the refraction. These plans consider the refraction a separate non-covered service and require that it be billed to the patient. The cost of the refraction is $45.00 and due at the time of service. If you wish to be billed for the refraction and pay at a later date, the cost will be $60.00.

Signature: _____

LIFESTYLE QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Cataract Secondary Membrane

Do you have difficulty, **EVEN WITH GLASSES**, with the following activities? Please answer these questions pertaining to the eye with the worst vision, not both eyes seeing together.

1. Reading small print such as medicine bottle labels, a telephone book or texts on your cell phone?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great
2. Reading a newspaper, book, or restaurant menu?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great
3. Driving (nighttime, glares, halos, etc.)?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great
4. Reading traffic signs, street signs or store signs?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great
5. Performing hobbies (computer, crafts, sports, etc.)?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great
6. Writing checks or filling out forms?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great
7. Playing games such as bingo, dominos or crossword puzzles?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great
8. Watching television (TV guide, weather, sports, news scrolls)?	Yes	No	Not applicable
If yes, how much difficulty do you currently have?	Little	Moderate	Great

What is your desire to get rid of glasses:	Totally	Partially	Don't care
What is most important to you:	Close up vision	Mid-range vision	Distance vision

Patient Signature: _____

EYE CARE OF DELAWARE LLC

Welcome to Eye Care of Delaware and thank you for choosing Dr. Jeffrey R. Boyd and his staff for your cataract evaluation. Below is some information to help better prepare you for your upcoming visit.

We ask that you do the following prior to your appointment

- ✔ Please discontinue wearing soft contact lenses for **1 – 2 weeks** prior to your evaluation.
- ✔ Please discontinue wearing Rigid Gas Permeable (RGP or hard lenses) for **2 – 3 weeks** prior to your evaluation.

We also recommend starting the following regimen two weeks prior to your evaluation:

- ✔ Use artificial tear eye drops at least 4 times a day.
- ✔ Apply warm compresses to your eyes twice a day.
- ✔ Immediately after the warm compresses, thoroughly clean your eyelids with either a clean washcloth or Q-tip. Make sure to remove any cosmetics, discharge, crusting, or mucous from your eyelids and lashes.

For your convenience, our office has Dry Eye Convenience Kits available for purchase for **$50.00**. If you are able, we encourage you to obtain a kit prior to your visit and begin using it, as it has all of the necessary information and supplies needed.

Additional information for your upcoming appointment:

- ✔ Please allow a **minimum of 2-3 hours** for your visit. Your cataract evaluation consists of extensive testing and a dilated medical eye exam.

- ✔ In order to shorten your appointment time, please watch the short, educational video on our website www.eyecareofdelaware.com. The video can be located under the **Resources** section of the Home Page.

- ✔ Please complete and submit the **Cataract Evaluation Forms** under the **Patient Forms** link on our website (located on the upper right hand corner of the website). Completing these forms prior to your appointment will help to expedite your check in process.

- ✔ We strongly recommend that you bring a driver or companion to your appointment as your eyes will be dilated, however it is not a requirement that you do so.

- ✔ Please bring the following items to your appointment:
  ___ Current Eyeglasses
  ___ Current insurance cards (medical) and a valid photo ID
  ___ Payment for copays and deductibles (cash, check, American Express, Discover, MasterCard, Visa, Care Credit)

- ✔ Insurance and Payment

- Eye Care of Delaware specializes in medical conditions of the eye and we bill medical insurance for your visit. **We do not accept vision insurance**. If your insurance plan requires a referral for a specialist visit, you are responsible for obtaining the referral from your primary care physician (this is different from your optometrist referral). **Patients arriving without their referral will be required to reschedule their visit.**
- Copays, coinsurance and deductibles are collected at the time of service.
- Payment for any non-covered services will be due at the time of the visit.

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Optomap® Retinal Exam

In our effort to provide the most advanced technology available for our patients, Eye Care of Delaware is proud to offer the Optomap® Retinal Exam as an integral part of your eye exam today. This exam shows an in-depth view of the retinal layers where disease can start. The Optomap® can assist in the detection of eye diseases like glaucoma, macular degeneration, diabetic retinopathy, tumors, retinal tears and detachments…and so much more.

A Picture is Worth 1,000 Words

This non-invasive procedure takes less than one second and allows your doctor to see a much broader and more detailed view of the retina than possible with conventional methods. The Optomap® images will be reviewed with you and provide an excellent opportunity for you to learn about your own eye health. We can often catch retinal disease before it causes permanent vision loss.
The scan becomes a permanent part of your medical file, enabling our physicians to make important comparisons year to year. These images can also be shared with your other doctors to enhance continuity of care.

Because of the importance of the exam, our doctors prescribe the Optomap® Retinal Exam for all patients once per year as an essential part of your comprehensive eye exam. It is also strongly recommended for all patients considering cataract surgery since we can examine the retina to make sure surgery is a safe option for you.

Insurance typically does not cover any advanced screening technology beyond the medical eye exam. Because the Optomap® provides useful information about the condition of your retinas and optic nerves, we will be performing this test as an enhancement to the medical eye exam for a fee of **$60.00**.

Each patient will receive this procedure unless our staff is notified otherwise or unless you decline to have this test performed.

Should the Optomap® exam reveal medical pathology/disease conditions involving your optic nerve or retina, then your Optomap® retinal exams may be billed to your medical insurance for all Optomap® exams performed AFTER your initial screening Optomap® exam.

Please mark your choice below:

_____ I agree to have the Optomap® and will pay for the $60.00 charge on date of service.

_____ I do NOT want to have the Optomap®.

_____
Patient Name

_____
Patient Signature

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Refraction Fee Policy

What is a Refraction?

A refraction is a diagnostic test used to determine the refractive error (or focusing error) of your eyes. A refraction is often used to calculate your glasses or contact lens prescription. It is also necessary data for the evaluation of cataracts and/or secondary membranes.

Why is it necessary?

For healthy eyes, the best corrected vision is generally 20/20. Worse vision can indicate a medical problem (such as cataracts) or can be due to a simple refractive error (such as nearsightedness or astigmatism). As part of your medical exam today, we will check your vision with your current glasses. We also need to perform a refraction to determine your best corrected vision in order to diagnose your eye problem.

Why is there a fee for refraction?

Unfortunately, Medicare and most medical insurance plans do not cover the cost of the refraction. These plans consider the refraction a separate non-covered service and require that it be billed to the patient.

What is the refraction fee?

Our standard fee for refraction is **$45.00** when paid at the time of service. This fee is collected in addition to any medical co-payments your insurance requires. If you choose to be billed for the service and pay at a later date, the fee is **$60.00.**

What if I don't want the refraction?

You may decline this part of the exam by signing this form in the appropriate space below. However, please understand that the doctor may not be able to fully assess the health and function of your eyes.

Please mark your choice below:

Option 1: Accept Refraction

_____ I will pay $45.00 today for the refraction

_____ Please bill me $60.00 for the refraction

Option 2: Decline Refraction

_____ I decline the refraction service today. I understand that without the refraction, the doctor may not be able to fully assess the health and function of my eyes.

_____

Patient Name

_____

Patient Signature