FOCUS Eye Group

(P) 610-384-9100 (F) 610-384-3937

3000 CG Zinn Road, Thorndale, PA 19372 1175 Lancaster Avenue, Berwyn, PA 19312

Welcome to our Practice! We look forward to serving you!

Last_____

First_____

Mi_____

Date of Birth_____

SS#_____

Address_____

City_____

State_____

Zip_____

Email_____

Preferred Phone_____

☐ Home ☐ Work ☐ Cell

Secondary Phone_____

☐ Home ☐ Work ☐ Cell

Ethnicity_____

Family Physician_____

Family Physician Phone_____

Emergency Contact_____

Phone_____

☐ Home ☐ Work ☐ Cell

Relationship_____

How did you hear about our practice?

Relative
Friend
Internet
Insurance
Other_____
Physician
Optometrist

To make sure you are getting our office communications, be sure to verify that all of your information is current, and please let us know if there are any changes to your phone number or email address.

For Office Use Only: Pt Number: _____ Doctor: ____

Medical History Form

Patient name:_____ **Occupation:**_____

Family Physician (Name/Practice and Phone):_____

Drug allergies:_____

Do you have now or have you ever had:		**Comment:**
Skin problems like eczema or psoriasis	YES_____NO_____	_____
Problems with your hearing	YES_____NO_____	_____
Breathing problems like asthma or emphysema	YES_____NO_____	_____
High blood pressure/heart problems/surgery	YES_____NO_____	_____
Stomach/acid reflux problems	YES_____NO_____	_____
Kidney/bladder/prostate problems	YES_____NO_____	_____
Muscle or joint pain/arthritis	YES_____NO_____	_____
Neurological headaches/migraines	YES_____NO_____	_____
Headaches (stress/sinus/etc.)	YES_____NO_____	_____
Diabetes – date of on set: _____	YES_____NO_____	_____
Treatment: Diet Controlled_____Oral medications_____Insulin_____		
Thyroid problems	YES_____NO_____	_____
Blood problems like anemia	YES_____NO_____	_____
High cholesterol	YES_____NO_____	_____
Depression/anxiety	YES_____NO_____	_____
Seasonal/environmental allergies	YES_____NO_____	_____
Infectious disease like HIV or Hepatitis	YES_____NO_____	_____
Cancer – location:_____ year:_____	YES_____NO_____	_____
Treatment: Chemotherapy_____ Surgery_____ Radiation_____		
Head/eye trauma	YES_____NO_____	_____
Major surgeries or hospitalizations:	YES_____NO_____	_____
Please explain:_____		

Do you smoke? Never Former Current **Drink alcohol?** Yes No Social

Current Medications (name and dosages): ***please use other side for additional medications***

1. _____ 6._____
2. _____ 7._____
3. _____ 8._____
4. _____ 9._____
5. _____ 10._____

Current Eye Medications:

1. _____ 3._____
2. _____ 4._____

Over the Counter Preparations (vitamins etc)

1. _____ 3._____
2. _____ 4._____

Preferred Pharmacy Name and Address_____

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The completion of this form allows anyone listed to obtain information regarding your office visits, test results, appointment dates/times, and financial information. Please do not list other physicians' offices.

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. This form must be signed and dated each year.

Patient Name_____ Date of Birth_____ SSN (last four digits)_____

Entity Requested to Release Information: Focus Eye Group Other_____

Purpose of request: (who will be authorized to receive information)

I authorize the entity identified above to disclose or provide protected health information about me to the individual(s) listed below.

Who will be authorized to receive information:

(list the individual or entity who is to receive your PHI)

Individual/Entity Name and Relationship_____

Individual/Entity Name and Relationship_____

Individual/Entity Name and Relationship_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity or person(s) identified above:

__**Entire patient record**; or, check only those items of the record to be disclosed:

__*Office notes from_____to_____ __Nursing home/home health/hospice/other physician records

__Test results __Record of HIV and communicable disease testing

__Financial history report (previous 3 years) __Record of mental health or substance abuse treatment

__Only the following _____

Purpose of disclosure

__Patient request __Other (please specify)_____

- The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.
- * This authorization will expire at the end of the current calendar year, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the current calendar year.
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected healthcare information; therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.

For Office Use Only: Pt Number: _____ Doctor: _____

Patient Financial Responsibility and Insurance Disclaimer
I understand and agree that I am financially responsible for all charges for services rendered and/or products ordered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services, and any other screening ordered by the doctor or staff.

Co-payments and self-pay services that are not covered by insurance will be collected at the time of service. The cost of any returned check fees are considered patient responsibility.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements, or any other type of benefit limitation for the services I receive, and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company. Our office does not make the rules. They are determined by your specific medical insurance or vision plan.

Office Communication Practices
We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by call, text, email, or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

I have received and/or been given the opportunity to review Focus Eye Group's Notice of Privacy Practices.

_____
Printed Patient Name (and Representative Name if applicable)

_____
Patient or Representative Signature

_____
Date

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your eye care to Focus Eye Group. When you schedule an appointment with Focus Eye Group, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Effective January 1, 2021 any patient who fails to show or cancels an appointment and has not contacted our office with at least **24 hours notice** will be considered a No Show and charged a **$50.00 fee**.

- The fee is charged to the patient, not the insurance company, and is due at the time of the next scheduled appointment.

- If a third No Show or cancellation occurs with no 24 hour notice, the patient will be dismissed from ourpractice.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show/cancellation fee. You may contact Focus Eye Group Monday through Friday. Should it be after regular business hours, you may leave a message.

Focus Eye Group: 610-384-9100

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Patient or Representative Signature Relationship to Patient (if not self)

_____ _____

Printed Patient Name Date

For Office Use Only: Pt Number: _____ Doctor: ____