total eye care

New Patient Packet

Welcome to our Practice

MISSION STATEMENT

We are Total Eye Care Centers, a group of caring individuals working together as a team to support our practice mission of providing our patients the highest quality of care in a friendly and efficient environment. We feel privileged to serve our community by utilizing the most advanced technology available.

We are "**Dedicated to a Lifetime of Health Vision.**" Our goal is to not only meet every aspect of our patients' needs, but to also exceed their expectations. It is an attitude that separates excellence from mediocrity.

OUR DOCTORS

Harmon Stein, MD
Judith Lavrich, MD
Imitiaz Chaudhry, MD
William Brown, MD
Raymond Cianni, OD
Christina Benn, OD

SERVICES WE OFFER

- Comprehensive Adult & Pediatric Eye Care
- Management of Ocular Disease
- Laser Vision Correction – Custom LASIK. Bladeless LASIK, PRK
- Glaucoma Treatment (Laser/Surgical)
- No Stitch Cataract Surgery
- Crystalens® "Center of Excellence"
- Vision Implantable Collamer Lens (ICL)
- Adult & Pediatric Eye Muscle Surgery
- Vision Therapy for Focusing and Convergence Problems
- Dry Eye Management
- Floater Treatment
- Macular Degeneration & Diabetic Retinopathy Therapy
- Thyroid Eye Disease Management
- Medical & Surgical Retina Treatment
- Full Service Optical – Latest Designer Eyewear
- Contact Lenses – Specialty Fit
- Eyelid Surgery
- Allergy Testing

OFFICE LOCATIONS

1568 Woodbourne Road, Levittown, PA 19057
3100 Princeton Pike, Lawrenceville, NJ 08648
451 South State Street, Newtown PA 18940
2495 Brunswick Pike, Lawrenceville, NJ 08648

(215) 943-7800 (Phone) ● (215) 943-7993

Totaleyecarecenters.com
appointments@totaleyecarecenters.com

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Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I _____ understand that as part of my health care, **TOTAL EYE CARE CENTERS, PC** and/or **WOODBOURNE OPTIK, INC** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC change their notice, they will send a copy of any revised notice to the address I've provided (whether US Mail or, if I agree, email) prior to implementation.

[ ] **I authorize** TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to call in prescription renewals, when I so request, and recognize that the office arrangement may allow for other patients to inadvertently overhear my name and the prescription name(s). I understand if I choose not to permit this activity, TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC may be unable to telephone prescription orders and refills and will provide me with written prescriptions, or will require the pharmacist to call the practice for refill orders.

[ ] **I authorize** TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to provide prescriptions and prescription refills to other members of my immediate family.

[ ] **In the event that I need to be admitted to any hospital**, I understand that TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC will be required to call ahead and make admission arrangements for me. In this event, I understand that the office arrangement may allow for other patients to inadvertently overhear my name and the admission information. I understand if I choose not to permit this activity, TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC may incur delays with my admission information.

[ ] **I understand** that the practice of TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC is to call me to advise me of the results of laboratory tests or for other purposes. I hereby authorize Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations and/or WOODBOURNE OPTIK, INC to leave telephone messages at my home phone number that may include negative test results and requests for me to call the office to obtain test results or to make office appointments. I wish to have the following restrictions to the use or disclosure of my health information:_____.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and **accept / decline** the terms of this consent (circle one).

Patient / Legal Guardian Signature:_____ **Date:** _____

In the Case of a Minor, Relationship to Patient: _____

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Your Visit to Our Office: Please bring your **current insurance card and a government issued ID** with you to your appointment. If possible, please complete all registration forms prior to your visit to our office. **It is extremely important that your registration forms are kept up-to-date for billing purposes.** In the event that any of it has changed, you will be responsible to advise us so we may update your records.

Health Insurance: If you will be using your health insurance to settle your account, you must present your **CURRENT** insurance card to each visit. This is a requirement of your insurance company. Your health insurance is a contract between you, your employer, and the insurance company. We are not a port of that contract. Not all services are covered in all insurance contracts. Any non-covered service will be the patient's responsibility. **Co-payments and deductibles are to be paid at time of your visit or your appointment will be rescheduled. If we do not participate with your insurance, payment is required in another form.** We will provide you with an itemized bill so that you may submit the charges to your carrier for reimbursement.

Refraction: Refraction fee is $50.00. A refraction is an eye exam that measures a prescription or change in a current prescription for glasses or contact lens. This is usually optional, unless your doctor feels it needs to be done. If you DO NOT wish to be refracted, please tell the technician when you go back for your exam. Be aware that refractions are often non-covered services.

Self-Pay: If you are self-pay, you will be expected to pay the day's charges on the day of the service. If you are having surgery, you will be expected to make mutually agreeable payment arrangements prior to receiving the service. If the service is considered elective (LASIK, refractive, and cosmetic procedures), payment must be made in full prior to the services being performed.

Auto Insurance / Legal Claims / Workman's Compensation: If you are seeing a physician as a result of an auto accident or other injury related to a legal claim against a third party, you will be considered self-pay. We will not file a claim with your auto insurance company or await a court settlement to be resolved. Also, several of our physicians provide services under workers compensation plans. If you need to see a physician for an injury related to your employment, please have your employer or workers compensation case manager make the appointment. Should you make the appointment yourself, be advised we must confirm your injury with your employer before being seen. You will need to provide us with the case number as well as the address to which the bill is to be sent.

Miscellaneous Forms: There will be a minimum processing fee of $15.00 for all forms requiring a doctor's signature. Please remember to bring all forms at the time of your visit. More complex forms may have an additional charge.

Past Due Accounts: Should your balance extend beyond thirty days of your initial statement date you may receive a courtesy collection call from our accounts receivable staff to resolve the amount. Should your balance extend sixty days or more past your initial statement date, collection procedures will commence, and you will be charged a **25% late/collection fee**. Past-due accounts cost both time and money; therefore, patients with delinquent accounts will be required to make payment at the time of service. Should your account be sent to a collection agency you must pay all past due amounts or make agreeable payment terms before subsequent appointments can be scheduled. Additionally, patients may be dismissed from our practice for financial matters.

Cancelled, Missed or No-Show Appointments: Your appointment time is reserved for your care. In the event that you must cancel or re-schedule, please give the office at least 24 to 48 hours' notice if you will not be able to keep your appointment. This will allow us the opportunity to offer your time to another patient. **In the event that you do not provide appropriate notice, you will be charged $45.00 for the missed or no-show appointment.** Payment of this fee is your responsibility and not a service reimbursed by your insurance company.

Records Release: Should the need arise to have your confidential medical records released our processing fee varies based on the size of the records. Allow five (5) business days for preparation and duplication. Appropriate HIPPA complaint corms must be signed and personal photo identification is required for pick up.

CONFIRMATION OF NOTICE: I understand the Financial Policies at Total Eye Care Centers, PC

Patient or Authorized Responsible Party's Signature: _____

Patient's Name: _____ **Date:** _____

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PLEASE COMPLETE BACK OF FORM→

PATIENT INFORMATION: please complete all applicable fields.

Name: _____ _____ **Gender:** _____
(Last) (First) (Middle) (Suffix or title)

Date of Birth: ____/____/____ **S.S.N.** ____-____-____ **Marital Status:** S M D W Separated

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

Emergency Contact Person:
Name: _____
Relation: _____
Phone: _____

Phone Numbers: **Preferred Number?** *(check one)*

Home: ( ) _____ ☐

Work: ( ) _____ ☐

Cell: ( ) _____ ☐

How would you like your appointments confirmed?
☐ **Phone Call** ☐ **Email** ☐ **Text**

Email: _____ @ _____

Employer Name: _____ **Employer Phone:** ( ) _____

How did you hear about us? *(circle one):* Social Media Internet Already Established Patient PCP Other:_____

PHARMACY INFORMATION: please complete all fields.

Pharmacy Name: _____ **Pharmacy Phone:** _____

PHYSICIAN INFORMATION: please complete all fields.

Primary Care Name: _____ **Physician Phone:** _____

INSURANCE INFORMATION: please complete all applicable fields.

Vision Insurance Carrier	**Policy Number**	**Group Number**	**Policy Holder Name**	**Relation to patient**
Medical Insurance Carrier	**Policy Number**	**Group Number**	**Policy Holder Name**	**Relation to patient**
Secondary Insurance Carrier	**Policy Number**	**Group Number**	**Policy Holder Name**	**Relation to patient**

RESPONSIBLE PARTY: includes guardians, policy holders, or any persons responsible for unpaid balances.

Name: _____ _____ _____
(Last) (First) (Middle) (Suffix or title) Relation to patient

Date of Birth: ____/____/____ **S.S.N.** ____-____-____ **Phone:** ( ) _____

_____
Address Apt/Suite City State Zip

Employer Name: _____ **Employer Phone:** ( ) _____

PATIENT AUTHORIZATION

_____ _____ ____/____/____
Signature of Patient/Patient's Representative Relation to patient Date

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FINANCIAL POLICY: please review and sign below.

Payment Request and Assignment of Benefits

I request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, vision plan or other third-party payer, under the terms of the insurance policy or benefit plan be paid directly to Total Eye Care Centers (TECC). I understand that:

- I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan.
- If my account is referred to an attorney or agency for collection of any unpaid balances for which I am responsible, that I will also be responsible for reasonable attorney's fees and collection expenses.
- My obligation to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

RELEASE OF INFORMATION

I authorize TECC and/or their agents:

* To give the insurance provider, vision plan, or other third-party payer, or their agents, any medical or other information necessary to receive payment or obtain authorization for services, supplies and equipment.

* To request and receive directly, on my behalf, any information related to my insurance policy or vision plan (including, but not limited to, proof of my healthcare benefits).

* To file, on behalf of themselves or on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against any insurance company, vision plan or other third-party payer, to receive any benefits that may be due or payable under the insurance policy or vision plan.

* To give medical or other information to any healthcare practitioner providing healthcare services to me or receive information from them.

STATEMENT OF ASSISTANCE

I agree:

* To assist TECC in collecting benefits that may be due or payable under my insurance policy or vision plan for the services, supplies and equipment provided.

* To provide any additional information needed to process the claim for payment.

* That a photocopy or other reproduction of this document shall be considered as valid as the original.

REQUEST FOR CONFIDENTIAL COMMUNICATON OF PROTECTED HEALTH INFORMATION (HIPPA)

Name: _____ **Relation to Patient:** _____ **Phone:** (___) _____

Name: _____ **Relation to Patient:** _____ **Phone:** (___) _____

***only authorized person/s listed here will be able to discuss/receive your protected health information**

PATIENT AUTHORIZATION: please review all information, report changes, and sign annually.

I certify that the information on this form is correct and current:

Signature: _____ **Relation to Patient:** _____ **Date:** _____

Signature: _____ **Relation to Patient:** _____ **Date:** _____

Signature: _____ **Relation to Patient:** _____ **Date:** _____

Signature: _____ **Relation to Patient:** _____ **Date:** _____

Signature: _____ **Relation to Patient:** _____ **Date:** _____

This form should be completed whenever a change occurs and on an annual basis for each patient.

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MEDICAL HEALTH QUESTIONNAIRE

Name: _____ **Date:** ___/___/___ **DOB:** ___/___/___ **Age:** ____

Reason for visit: _____

Do you have any allergies to any medications, including Latex and Iodine? **YES NO**

If YES, please list the medications:

_____

List all major illnesses (diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

List any surgeries you have had (cataract, appendectomy): _____

Children under 5: Birth Weight ____lbs____oz Gestation _____weeks Pregnancy Normal / _____

Do you currently have any problems in the following areas? If **YES**, provide additional information:

	Y	N	Details
Eyes (poor vision, eye pain, tearing, redness, etc.)			
General/Constitutional (fever, heat stroke, weight loss/gain, tiredness)			
Ears/Nose/Throat (hard of hearing, ear ache, cough, dry mouth, etc.)			
Cardiovascular (high BP, racing pulse, etc.)			
Respiratory (congestion, wheezing, short of breath)			
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
Genital/Kidney/Bladder(painful urination, frequency, impotence, jaundice, etc.)			
Females – Are you pregnant or nursing?			
Muscles/Bones/Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, Rosacea, etc.)			
Neurological (numbness, headache, seizures, paralysis)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, insomnia)			
Blood/Lymph (bleeding, anemia, blood transfusion, etc.)			
Allergic/Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History: Has any member of your family (Mother, Father, Grandparent, Sibling) had any of these diseases?
(Circle all that apply & indicate family member)

Stroke _____ Heart Attack _____ Retinal Detachment _____ Glaucoma _____ Eye that turns _____
Diabetes _____ Hypertension _____ Macular Degeneration _____ Blindness _____ Lazy Eye _____
Arthritis _____ Thyroid Disease _____ Cancer (Type?) _____ Wore a patch when younger _____

Social History: Does your vision limit any activities of daily living (driving, reading, sports, work, etc.?) **YES NO**
Have you ever been exposed to HIV or Hepatitis?**YES NO**
Do you drink alcohol? **YES NO** If YES, how much? _____
Do you smoke? **YES NO** If YES, how much? _____

Visual History:
Date of Last Exam: _____ Previous Eye Doctor: _____ Do you wear eyeglasses? **YES NO**
Have you ever had an injury to your eye? **YES NO** - What/When? _____
Do you wear contact lenses? **YES NO**

Do you have (Check all that apply):
□ Glaucoma □ Cataracts □ Retinal Disease □ Trouble Reading □ Headaches □ Dry Eyes □ Itchy Eyes □ Red/Watery Eyes □ Trouble Seeing Distance □ Eye Fatigue When Using Computer □ Eye That Turns or Wore a Patch When You Were Younger

ARE YOU INTERESTED IN? (Check all that apply):

□ Wearing Contact Lenses/Bi-Focal Contacts
□ Options for Dry Eye
□ Skin Rejuvenation for the Eyes or Face
□ Botox® for facial lines
□ Dermal Fillers to Add Volume to the Face
□ LASIK – Laser Vision Correction
□ Cosmetic Eyelid Surgery
□ Latisse® for Growing Longer Eyelashes
□ Removing Facial Vessels/Skin Tags
□ Removing/Reducing Brown, Liver or Age Spots

Would you like a complimentary consultation with our medical aesthetician to discuss skin care advice or products?
□YES □NO

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MEDICATION LIST

Patient Name: _____ **Date:** _____

Medication Allergies: _____

Medication	**Dosage** (mg, mcg, ml, etc)	**Frequency** (1x/day, etc.)

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TELEPHONE CONSUMER PROTECTION

PLEASE READ AND SIGN BELOW

In order for us to service your account or to collect monies you may owe, Total Eye Care Centers, PC, and/or our agents may contact you by telephone at any number associated with your electronic health record. This includes wireless telephone numbers, which according to your service plan, may result charges. Total Eye Care is not responsible for any charges, including data, that you may incur.
Total Eye Care Centers may also contact you by text message or email using the contact information you have provided. Methods of contact may also include pre-recorded/artificial voice messages, and or use of an automatic dialing device.

Please indicate whether you agree or disagree with the terms above:

I agree _____
(initial here)

I disagree _____
(initial here)

I authorize Total Eye Care Centers, PC and/or Woodbourne Optik Inc. to call in prescription renewals when requested, and recognize that the office arrangement may allow for other patients to inadvertently overhear my personal information such as my name and/or prescription name/s. I understand if I choose not to permit this activity, Total Eye Care Centers, PC and/or Woodbourne Optik Inc., may be unable to complete telephone prescription orders or refills, and will provide me with written prescriptions, or will require the pharmacist to call the practice for refill orders.

I authorize Total Eye care Centers to call in prescription renewals _____
(initial here)

I do not authorize Total Eye care Centers to call in prescription renewals_____
(initial here)

_____ _____/_____/_____

Patient Signature or Patient Guardian or Representative **Date**

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New Patient Questionnaire

Patient Name: _____ **Date:** _____

Email: _____ **Phone:** _____

Are you interested in (*check all that apply*)?

☐ Wearing Contact Lenses/Bifocal Contacts

☐ Treatment for Dry Eye

☐ Lasik – Laser Vision Correction

☐ Cosmetic Eyelid Surgery

☐ Cataract Surgery

☐ Allergy Testing

☐ Dietary Supplements for Ocular Health

Total Eye Care would also like to introduce you to our very own Medical Spa – Rejuvenation Medical Aesthetics (RMA)! Rejuvenation Medical Aesthetics' highly trained cosmetic team operates under our experienced and specialized physician and oculoplastic surgeon, Dr. Judith Lavrich. Take a look a look at possible concerns listed below and select all that apply:

rma
REJUVENATION
medical aesthetics

☐ Receding hairline or thinning hair

☐ Thin or light eyebrows

☐ Dark circles or bags under eyes

☐ Deep smile lines

☐ Thin lips or loss of volume

☐ Double chin or jowling (sagging skin below chin)

☐ Large or misshaped nose

☐ Forehead lines or crow's feet

☐ Droopy eyelids

☐ Facial volume loss or saggy skin

☐ Brown spots, rosacea, or uneven skin tone

☐ Fat reduction (Coolsculpting)

☐ Permanent Make-up

☐ Varicose Veins

Would you like to be contacted for complimentary consultation? ☐ Yes ☐ No ☐ Maybe later

If yes, how would you like to be contacted? Phone: (_____) _____ Email: _____