Refraction Services and Fees

A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses (additional fees apply). It is an essential part of the eye exam.

A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service. (However, some insurances do)

Our office fee for a refraction is $75.00 and this fee is collected at the time of service.

- ☐ I accept full financial responsibility for the cost of this service and that any copayment, coinsurance or deductible I may have are separate from and not included in the refraction fee.
- ☐ I decline the cost of this service and understand that it will not be performed until payment is rendered.

For Contact Wears Only

Contact lens refractions are not covered by any insurance, even vision plans.

In addition to the $75 refraction fee, the contact lens refraction is an additional $50 and this fee is collected at the time of service

- ☐ I accept full financial responsibility for the cost of this service and that any copayment, coinsurance or deductible I may have are separate from and not included in the refraction fee.
- ☐ I decline the cost of this service and understand that it will not be performed until payment is rendered.

I have read the above information and understand that the refraction is a non-covered service

_____	_____	_____
Patient Name (Please Print)	**Signature of Patient, Parent, or Legal Guardian**	**Date**

ABN

In order to prevent any misunderstanding concerning the responsibility for payment for medical and surgical care, the following information is necessary for you to read and understand prior to you being seen by your physician

Some items or services may not be paid for by your insurance, however that doesn't mean that you should not receive it. There may be a good reason that your doctor recommended it. These services may include and are not limited to OCT, Pentacam, Photographs, Fundus Photos, and Allergy testing, Refractions, and Punctal Plugs, premium implants for cataract surgery, and iStent Inject Surgery. If you have any questions please ask our office.

Copays and Balances

- Due at the time of service
- If a check is returned for insufficient funds, a $25 surcharge will be incurred

Coinsurance/Deductibles

- Payment is expected once your insurance plan informs our office that these expenses are patient responsibility

Medicare Patients

- You are responsible for your yearly deductible
- Once the yearly deductible is met you will be responsible for the 20% coinsurance

I have read the above and agree that I am ultimately responsible for the balance on my account for any service provided.

_____ _____

Patient's Name Signature of Patient (or person acting on patient's behalf)

_____ _____

Insurance Date

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Insurance, your health information on this form may be shared with Insurance. Your health information which Insurance sees will be kept confidential.

Wyckoff Ophthalmology
Disease and Surgery of the Eye

Melanie Sinatra, M.D., F.A.C.S.
Diplomate of the
American Board of Ophthalmology

Andrea B. Antonelli, O.D.

Patient Information

Name: _____ Marital Status: _____Gender:_____

Address: _____ City: _____ State: _____ ZIP: _____

DOB:_____ SS#: _____-_____-_____ Race: _____ Ethnicity: _____ Language:_____

Home #: _____ Cell #: _____ Email:_____

Employer: _____ Occupation: _____ Emergency Contact: _____

Emergency Contact #_____

Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center? If so, please list name and phone number. Facility: _____ Phone: _____

Primary Care Physician

Dr._____ Phone: _____

Referring doctor (if not primary care): Dr. _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Location:_____ Phone #: _____

Responsible Party (Please complete this section if patient is a minor or has a legal guardian)

Name: _____ DOB: _____ Relation: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Email: _____

Past Medical History - *Please check all that apply and provide a brief explanation*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes 1 or 2
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hyper/hypothyroidism
- ☐ Lymphoma
- ☐ Myasthenia Gravis
- ☐ Seizures
- ☐ Strokes
- ☐ Radiation Treatment
- ☐ Other_____

Explanation:_____

_____

Past Surgeries

Name of Procedure	Date of Surgery	Surgeon
1.		
2.		
3.		
4.		
5.		

Review of Symptoms - *Please check all that apply*

Do you have any problems currently? Please check all that apply and provide a brief explanation

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding
- ☐ Burning on Urination
- ☐ Changing Moles
- ☐ Chills
- ☐ Congestion
- ☐ Cough
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dry Mouth
- ☐ Earache
- ☐ Fever
- ☐ Hay Fever
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Incontinence
- ☐ Insomnia
- ☐ Jaw Pain
- ☐ Joint Pain
- ☐ Paralysis
- ☐ Rapid Heart Beat
- ☐ Rash
- ☐ Redness
- ☐ Scalp Tenderness
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Stiffness
- ☐ Stroke
- ☐ Stuffy Nose
- ☐ Thyroid Abnormalities
- ☐ Upset Stomach
- ☐ Urinary Frequency
- ☐ Weight Loss
- ☐ Wheezing
- ☐ Other_____

Explanation:_____

_____

Alerts - *Please check all that apply*

- ☐ Artificial Heart Valve
- ☐ Artificial Joints (Within the last two years)
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ Flomax
- ☐ MRSA
- ☐ Narrow Angles
- ☐ Pacemaker
- ☐ Pregnant / Planning
- ☐ Premedication Prior to Surgery
- ☐ Pseudoexfoliation Syndrome
- ☐ Rapid Heart Beat with Epinephrine
- ☐ Steroid Responder

Explanation:_____

_____

Glasses and Contact Prescription

Date of Last Eye Examination: _____

Glasses Prescription Right Eye: _____ Glasses Prescription Left Eye: _____

Contact Prescription Right Eye: _____ Contact Prescription Left Eye: _____

Type of Contact ☐ Soft ☐ Toric ☐ RGP

Last Time Contacts Were Worn: _____

Current Ocular Review - *Please check all that apply*

Do you have any problems in the following areas currently? Please check all that apply and provide a brief explanation

- ☐ Amblyopia
- ☐ Blurred Vision
- ☐ Burning
- ☐ Difficulty Driving
- ☐ Distorted Vision
- ☐ Drooping Eyelid
- ☐ Dryness
- ☐ Excessive Tearing
- ☐ Eye Injury
- ☐ Eye Pain or Soreness
- ☐ Fluctuating Vision
- ☐ Foreign Body Sensation
- ☐ Glare or Light Sensitivity
- ☐ Infection of Eyelid
- ☐ Itching
- ☐ Keratoconus or any Corneal Disease
- ☐ Loss of Side Vision
- ☐ Loss of Vision
- ☐ Mucous Discharge
- ☐ Poor Night Vision
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Tired Eyes
- ☐ Other _____

Explanation:_____

_____

Past Ocular History - ***Please check all that apply, circle R for right eye and L for left eye and provide a brief explanation***

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Corneal Dystrophy R L
- ☐ Diabetic Retinopathy Background R L
- ☐ Diabetic Retinopathy Proliferative R L
- ☐ Dry Eyes
- ☐ Glaucoma R L
- ☐ Macular Degeneration R L
- ☐ Macular ERM R L
- ☐ Narrow Angles R L
- ☐ Ocular Hypertension R L
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Detachment R L
- ☐ Strabismus (lazy eye) R L
- ☐ PVD R L
- ☐ Floaters
- ☐ Optic Neuritis R L
- ☐ Orbital Fracture R L
- ☐ Herpes Simplex
- ☐ Herpes Zoster (Shingles)
- ☐ Trauma
- ☐ Corneal Ulcers
- ☐ Other_____

Explanation:_____

_____

Ocular Surgery - ***Please check all that apply, circle R for right eye and L for left eye, and provide a brief explanation***

- ☐ Blepharoplasty R L
- ☐ Cataract R L
- ☐ Corneal Transplant R L
- ☐ Eye Muscle Surgery R L
- ☐ Intravitreal Injections R L
- ☐ LASIK R L
- ☐ Laser Iridotomy R L
- ☐ PRK R L
- ☐ Ptosis Repair R L
- ☐ Punctal Plugs R L
- ☐ Retinal Laser Surgery R L
- ☐ Strabismus Surgery R L
- ☐ Trabeculoplasty R L
- ☐ Tube Shunt R L
- ☐ YAG Capsulotomy R L
- ☐ Botox / Fillers
- ☐ Other_____

Explanation:_____

_____

Allergies - ***Please check all that apply***

- ☐ Latex Allergy
- ☐ Adhesive
- ☐ Lidocaine
- ☐ Other _____
- ☐ No Known Drug Allergies

Social History

How many hours a day do you work on a computer? _____

Do you drive? ☐ No ☐ During the Day ☐ At Night ☐ Both

Do you drink alcohol? ☐ No ☐ Occasionally ☐ 1/day ☐ 2-3/day ☐ 4+ /day

Do you smoke? ☐ Never ☐ Everyday Smoker ☐ Occasional ☐ Former

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Present Medications

Medication Name (*including strength)*	**Directions (*dose, route, and frequency)***
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Family History - *Please check all that apply and provide a brief explanation*

- ☐ ARMD
- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Retina Detachment
- ☐ Strabismus
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other _____

Explanation:_____

_____

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Consent to Treat and Financial Responsibility

I hereby authorize employees and agents of Wyckoff Ophthalmology to render medical evaluations and care for the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

_____	_____	_____
Patient Name (Please Print)	**Signature of Patient, Parent, or Legal Guardian**	**Date**

Complete this section only if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____	_____
Signature of Patient, Parent, or Legal Guardian	**Date**

I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as a reasonable collection cost not to exceed 50% court costs, attorney fees and interest fees accrued with the collection of this account.

_____	_____
Signature of Patient, Parent, or Legal Guardian	**Date**

Patient Preferences Regarding Communion of PHI (Protected Health Information)

My preferred method of communication regarding my medical conditions and/or appointment information is selected below

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Other: _____

If I am unreachable at my preferred contact number please do one of the following

- ☐ Leave a message with detailed information
- ☐ Leave a message with a call-back number only

Please let our office know if you have any special requests regarding communications. For example, please inform us if you would like to be contacted at a separate number for test results.

Keeping our patient's information private is extremely important to us, as as a result we will only disclose information related to the Billing Account and medical conditions only to the patient, parent, or legal guardian.
If you would like to add additional contacts, other than a parent or legal guardian that Wyckoff Ophthalmology is allowed to disclose information to please designate them down below. I understand that I am not required to list anyone and I may change this list at any time in writing.

Print Name: _____ Relationship: _____ Contact Phone Number:_____

Print Name: _____ Relationship: _____ Contact Phone Number:_____

Print Name: _____ Relationship: _____ Contact Phone Number:_____

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Notice of Privacy Practices and Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. II understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up appointments among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may contact Wyckoff Ophthalmology at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of this Notice of Privacy Practices, but was unable to do so as document below

Initials: _____ Date: _____ Reason: _____