WELCOME NEW PATIENT

Welcome new Patient!!!!

Thank you for choosing our practice for your eye care needs. If you already have an appointment, we look forward to meeting you. If you have not made an appointment please do so by calling 610-270-2770.

In order to provide you with the best possible care, we request that you bring the following completed forms and items listed below with you to your eye doctor appointment.

- New Patient Forms
- **A list of all your MEDICATIONS**
- Your current health insurance card(s)
- Photo Identification

If you are enrolled in an HMO that requires a referral for specialist, please be sure to request one from your primary care physician.

If you feel any previous Medical Records may be important to your treatment, please sign our Medical Records Release Form and present this to your doctor requesting those records to be sent to our office prior to your exam.

Thank you for your cooperation in helping us to help you.

If you have any questions please contact the office.

Cordially Yours,

Jill Schneider, M.D.
Kristin M. DiDomenico, M.D.
Montgomery Professional Building
1330 Powell Street, Suite 610
Norristown, PA 19401
(610) 270-2770
Fax (610) 270-2620

Jill Schneider, M.D.
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Ophthalmology and Ophthalmic Surgery
1330 Powell Street, Suite 610
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PATIENT INFORMATION

Name: ________________________________ Sex: M F (E-mail): _____________________________

Address:____

City:____ State:________________ Zip Code:_________________

Home Telephone: ( ) ________________ Work ( )_______________ Cell ( )_________________

Social Security #:_____________________________ Age:________ Date of Birth:_____________________

Marital Status: M S D W Spouse's Name:____

Guardian's Name (if patient under 21):____

Emergency Contact:____________________________ Emergency Phone Number:_____________________

PRIMARY CARE PHYSICIAN: ____

REASON FOR APPOINTMENT: ____

Insurance Company____

Policy#_____________________________________ Group#______________________________

COMPLETE THIS SECTION IF PRIMARY INSURANCE HOLDER IS SPOUSE, PARENT, ETC.

Insured Party's Name____

Relationship____ Date of Birth_________

Address____

Social Security #__________________________________ Phone Number_________________________

Your eyes may be dilated. Dilation will make the pupils of your eyes large for several hours and can cause; light sensitivity, glare and blurred vision. Dark glasses are required. If you do not have your own, please ask us for a pair.

Patient signature ______________________________ ***Date*** ___________

Financial Information-Please read carefully and sign:

The insurance information I have submitted to you represents my current primary (and secondary, if applicable) medical coverage. In signing below, I authorize any insurance benefits to be paid directly to Jill Schneider, MD, PC, and I understand I am financially responsible for all non-covered services, deductibles, co pays, coinsurance, and charges considered not medically necessary by my insurance company.

Please be advised:

The patient is responsible for providing us with a valid referral at the time of **EACH** office visit per your HMO plan. Even though we participate with your health care insurance, your policy may **NOT** include routine eye exams and/or refractions and payments are due at time of service. **Co pays are also due at the time of service.** We do not participate in or bill to private vision plans such as Davis Vision, VSP, or Cole Vision.

Notice of Privacy Practices Acknowledgement

In signing below, I acknowledge being given the opportunity to review the Notice of Privacy Practices for Jill Schneider, M.D., P.C.

In refusing to sign, I understand that my protected health information may still be used for my treatment, payment for services rendered to me, and operations of this practice.

Signature____ Date_________________

_____ Refused to sign witnessed by ____ Date_________________

In signing below I consent to allowing my protected health information be used and disclosed for the purposes of treatment, payment, and health operations according to HIPAA guidelines.

If you wish to give us permission to disclose your protected health information to any other individuals who may be involved in your care, please list them below:

Name:______________________________________ Phone:________________________________ Relation:_________________

Name:______________________________________ Phone:________________________________ Relation:_________________

Name:______________________________________ Phone:________________________________ Relation:_________________

Signature____ Date_________________

Refractions

Refraction is the measurement of your best corrected vision. Our physicians perform this service when you want or need new glasses or when they need to monitor your vision for diagnostic purposes. Our fee for refraction is $40. If your insurance does not pay for a refraction, payment will be expected at the time of service. Medicare does not pay for a refraction for any reason. Other insurances may or may not pay for a refraction depending on the terms of your individual policy. Since we cannot know everyone's individual coverage, we will bill your carrier for the service first. However, if they do not pay us, we will bill you. As we are always striving to keep both our costs and yours down, we appreciate your cooperation in this matter.

Preferred Pharmacy Information (locally):

Name____

Address____

Phone Number____

If you would like us to transmit your prescriptions to your pharmacy via the internet, please provide us with your pharmacy information as accurately as possible. Please note that if you change pharmacies, you must inform us of the change.

Signed ____ Date_________________________

I do not wish to participate in this program. I want paper prescriptions instead.

Signed ____ Date_________________________

Names, Addresses and Phone Numbers of any physicians who should be made aware of this consultation with a report:

1.____

2.____

3.____

4.____

5.____

HEALTH HISTORY

1. Please list all **prescription medications**:

MEDICATIONS	PRESCRIBED FOR WHAT CONDITION
____	____
____	____
____	____
____	____
____	____
____	____
____	____
____	____

2. Please list all **over the counter medications, vitamins, and health food supplements** (such as fish oil, omega 3, and aspirin):

____

____

3. Have you had surgery in the past? Y N

If yes, please list all operations:

____

4. Have you had recent Blood work/MRI/CT Scan Y N if yes when and where:

____

4. Circle “Yes” or “No” to indicate if you have or have ever had any of these conditions

AIDS/HIV	Y	N	HERPES	Y	N
ALCOHOLISM	Y	N	HIGH BLOOD PRESSURE	Y	N
ARTHRITIS	Y	N	HIGH CHOLESTEROL	Y	N
ARTIFICIAL HEART VALVE	Y	N	INFECTIOUS DISEASE	Y	N
ARTIFICIAL JOINTS	Y	N	KIDNEY DISEASE	Y	N
ASTHMA	Y	N	LUPUS	Y	N
BELL’S PALSY	Y	N	LYME DISEASE	Y	N
BLADDER CONDITION	Y	N	HEADACHES/MIGRAINES	Y	N
BLEEDING CONDITION	Y	N	MULTIPLE SCLEROSIS/ OSTEO	Y	N
CANCER-TYPE______________________	Y	N	PACEMAKER	Y	N
CHEMICAL DEPENDENCY	Y	N	PROSTATE CONDITION	Y	N
DEMENTIA/ ALZHEIMERS	Y	N	REFLUX	Y	N
DEPRESSION/ ANXIETY	Y	N	SCLERODERMA	Y	N
DIABETES, HOW LONG_______________	Y	N	SHINGLES	Y	N
EAR, NOSE OR THROAT CONDITION	Y	N	SKIN CONDITION	Y	N
EMPHYSEMA	Y	N	SPINAL STENOSIS	Y	N
EPILIPSY	Y	N	STOMACH CONDITION	Y	N
HAYFEVER OR ALLERGIES	Y	N	STROKE	Y	N
HEARING LOSS	Y	N	THYROID CONDITION	Y	N
HEART ATTACK/ HEART CONDITION	Y	N	TUBERCULOSIS	Y	N
HEPATITIS-TYPE ____________________	Y	N	WEIGHT GAIN OR LOSS	Y	N

5. Any **drug allergies** or sensitivities? Y N
If yes, please list with type of reaction: ____

Pneumonia Shot Y N Flu Shot Y N Pregnant Y N

6. Do you smoke? Y N Social

7. Do you drink alcohol? Y N Social

EYE HEALTH HISTORY

1. Please list all eye medications:

EYE DROP/OINTMENT	WHICH EYE AND FREQUENCY
____	____
____	____
____	____

2. Any past or current eye problems? Y N
If yes, please list any injuries, surgeries, lasers, diseases, etc:

____

FAMILY MEDICAL HISTORY

List any FAMILY MEMBERS diagnosed with:

Glaucoma_____________________________________ Cataracts_________________________________

Retinal Tear or Detachment______________________ Macular Degeneration______________________

Blindness_____________________________________ Diabetes__________________________________

Other conditions not listed: ____

MONTGOMERY PROFESSIONAL BUILDING
1330 POWELL STREET, SUITE 610
NORRISTOWN, PA 19401

TELEPHONE (610) 270-2770
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Jill Schneider, M.D.
Kristin M. DiDomenico, M.D.
OPHTHALMOLOGY AND OPHTHALMIC SURGERY

Consent to Release or Obtain Medical Records

[**from previous optometrist/ophthalmologist**]

I, ________________________________ , (___/___/___)
(DATE OF BIRTH)

authorize Jill Schneider, M.D. to release to or obtain from:
(CIRCLE ONE)
Facility/Company/Person: ____

Address ____________________________ Attn: ________________________

____
(CITY) (STATE) (ZIP)

copies of ___________________________ medical records from the medical record
(MY OR PATIENT'S NAME)

of the above named patient for the time period ___________ to ___________.

_______________________________ _____________________________
PATIENT NAME DATE WITNESS DATE

____
PARENT/GUARDIAN IF MINOR UNDER 18 YEARS OR AUTORIZED FAMILY MEMBER

JILL SCHNEIDER, MD

<u>New Fee Schedule for Precertification Forms, and Missed Appointments.</u>

As of January 2015 Insurance Companies are putting a great responsibility on doctors' offices. They are mandating precertification forms for medications some patients have been on for a long time and for procedures patients require. This process has put an unbelievable amount of stress on the office staff and doctors not to mention you the patient as well. Our office is being inundated with forms that are pages long to complete for each medication and procedure.

We know these are very hard times financially for all of our patients. With that being said, it brings us as doctors to make a very difficult decision. Our office has come to a point where we have to be reimbursed for all the time our doctors and staff members must spend filling out forms and calling insurance companies, but we are not being given any choice.

If you have a medication that requires prior authorization, this office will ask you to contact your insurance company and find out what medication you **CAN** receive through your prescription plan that is in the same family of drugs and that does not need precertification. If you are unable to secure this information and need our staff to interact with your insurance company, there will be a fee of $10.00 - $25.00 charged to you by our office. Understand that we cannot guarantee that we will be successful in having your medication approved.

Our office will continue to perform the preauthorization for medical procedures without any charge to you.

<u>Missed appointments</u>

A fee of $25.00 will be charged if you fail to keep your appointment or if our office does not receive notification of cancellation at least 24 hours prior. Payment of this fee will be necessary before a new appointment will be scheduled.

We never would have thought that the healthcare system would require us to charge for such services. Unfortunately, this paperwork and the insurance company interactions now cost physician offices a great deal of time which needs to be compensated.

<u>By signing below you acknowledge you have read the changes noted above.</u>

Patient signature: _______________________ Date: _____________________