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
Because of our current worldwide pandemic and for the safety of our patients and staff, we have been forced to drastically change the way we conduct eye exams. We are stringently following the recommendations of the CDC and the American Academy of Ophthalmology. We apologize for any inconvenience this may cause.

Important information to know when coming to our office:

Please feel free to park in the parking garage, but note that you must enter the Professional building on the FIRST FLOOR and have your temperature checked prior to coming to our office suite. If your body temperature measures over 100 degrees F, you will be asked to leave and reschedule. If you feel you may have been exposed to the corona virus, have a cough, sore throat, fever or any other symptoms of illness, you need to reschedule your appointment.

Since you may be taking the elevator to the 6th floor, after checking in on the first floor of the Professional Building, you may want to consider wearing gloves. We will have hand sanitizer available when you enter our office.

You must wear a mask, preferably a mask without a valve. If the only mask you have has a valve, wear it to the office but we will give you another mask when you arrive. The mask needs to be on your face, covering your nose and mouth, the entire time you are in the office, including the time in the exam room. DO NOT REMOVE YOUR MASK FOR ANY REASON WHILE IN OUR OFFICE.

Patients are asked to enter the office alone unless there is a special circumstance, which needs to be cleared by our office prior to your visit. Visitors accompanying you must wait in their cars.

Please do not enter the office prior to your appointment time. The appointment times have been carefully staggered for your safety and the safety of our staff.

Copays and other charges will be collected prior to your office visit. You will not be checking in or out at the front desk at the time of your visit. We will call you to schedule followup visits.

You will be asked to avoid speaking while in the exam room unless the technician or doctor asks you a question. Talking in general will be kept to a minimum.

Please do not leave tissues on the counter or on the floor in our office.

When the exam is finished, you will be guided to exit by the back door, which is not the way you entered.
Jill Schneider, M.D.
Kristin M. DiDomenico, M.D.
Ophthalmology and Ophthalmic Surgery
1330 Powell Street, Suite 610
Norristown, PA 19401
Phone (610) 270-2770
Fax (610) 270-2620
www.schneidereyemd.com

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  P  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 __________

O 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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/HIV</td>
<td></td>
<td></td>
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<tr>
<td>ALCOHOLISM</td>
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<tr>
<td>ARTHRITIS</td>
<td></td>
<td></td>
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<tr>
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<td>ARTIFICIAL JOINTS</td>
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<td>ASTHMA</td>
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<tr>
<td>BELL’S Palsy</td>
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<tr>
<td>BLADDER CONDITION</td>
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<tr>
<td>BLEEDING CONDITION</td>
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<tr>
<td>CANCER-TYPE</td>
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<tr>
<td>CHEMICAL DEPENDENCY</td>
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<tr>
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<tr>
<td>DEPRESSION/ANXIETY</td>
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<tr>
<td>DIABETES, HOW LONG</td>
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<td></td>
</tr>
<tr>
<td>EAR, NOSE OR THROAT CONDITION</td>
<td></td>
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<tr>
<td>EMPHYSEMA</td>
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<tr>
<td>EPILEPSY</td>
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<tr>
<td>HAYFEVER OR ALLERGIES</td>
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<tr>
<td>HEARING LOSS</td>
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<td></td>
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<tr>
<td>HEART ATTACK/HEART CONDITION</td>
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<tr>
<td>HEPATITIS-TYPE</td>
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<tr>
<td>HERPES</td>
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<td>N</td>
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<tr>
<td>HIGH BLOOD PRESSURE</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>HIGH CHOLESTEROL</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>INFECTIOUS DISEASE</td>
<td>Y</td>
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<tr>
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<tr>
<td>LUPUS</td>
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<tr>
<td>LYMIE DISEASE</td>
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<td>N</td>
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<tr>
<td>HEADACHES/MIGRAINES</td>
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<td>N</td>
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<tr>
<td>MULTIPLE SCLEROSIS/OSTEO</td>
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<tr>
<td>PACEMAKER</td>
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<tr>
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<tr>
<td>SKIN CONDITION</td>
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<tr>
<td>SPINAL STENOSIS</td>
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<td>N</td>
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<tr>
<td>STOMACH CONDITION</td>
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<td>N</td>
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<tr>
<td>STROKE</td>
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<td>N</td>
</tr>
<tr>
<td>THYROID CONDITION</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>TUBERCULOSI</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>WEIGHT GAIN OR LOSS</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

5. Any **drug allergies** or sensitivities? 
   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

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
- Retinal Tear or Detachment
- Blindness
- Cataracts
- Macular Degeneration
- Diabetes

Other conditions not listed:
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: ______________________________

________________________, (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 AUTHORIZED FAMILY MEMBER
New Fee Schedule for Precertification Forms, and Missed Appointments.

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.

Missed appointments

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.

By signing below you acknowledge you have read the changes noted above.

Patient signature: ___________________________ Date: ___________________________