



Family Ophthalmology Center
Pediatric Eye Associates, Inc.

GARIMA LAL, MD, FAAP

*Board Certified, American Board of Ophthalmology
General and Pediatric Ophthalmology and Strabismus*

WELCOME TO OUR OFFICE

Patient's Full Name (NOMBRE) : _____ **Today's date**(FECHA): _____

Mailing Address (DIRECCIÓN):

Street: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ **Work Phone:**(_____) _____
(TELÉFONO) (TELEFONO DEL EMPLEADOR)

Cell Phone: (_____) _____
(TELÉFONO DE CELULAR)

(Check one): Sex: Male (HOMBRE) Female (DAMAS)

Age(EDAD) : _____ **Date of Birth:** _____ **SS:** _____
(FECHA DE NACIMIENTO) (NO. SEGURO SOCIAL)

Occupation/School grade: _____ **Name of employer/school:** _____
(OCUPACIÓN) (NOMBRE DEL EMPLEADOR)

Pediatrician/Family Physician:
(DOCTOR GENERAL)

Name: _____

Office Address: _____

Office phone: (_____) _____

Office fax: (_____) _____

Preferred Pharmacy:

Name: _____

Address: _____

City, Zip: _____

Phone: (_____) _____

Fax: (_____) _____

Were you referred to us by your pediatrician or primary care doctor? (check one) Yes No

If "No", who referred you, or how did you hear of us? _____

WE HAVE TRANSITIONED TO ELECTRONIC MEDICAL RECORDKEEPING AND WILL BE COMMUNICATING APPOINTMENT REMINDERS, RECALLS, and BILLING CONCERNS ELECTRONICALLY.

EMAIL ADDRESS: _____ **CELLULAR:** _____

Family Status: Patient is living with parent(s) or living with relative, guardian, or foster parent
Parents/Patient are (check one): married separated divorced single

The primary policy holder for this patient is the: (Circle one) Mother Father Spouse

Full Name of Spouse/ Father(PADRE) **(or guardian):** _____ **Date of Birth:** ____/____/____

Occupation: _____ **Daytime Phone:**(_____) _____ **SS#:** _____

Full Name of Spouse/Mother(MADRE) **(or guardian):** _____ **Date of Birth:** ____/____/____

Occupation: _____ **Daytime Phone:**(_____) _____ **SS#:** _____

Emergency name/phone number where parents/guardians can be reached (EN CASO DE EMERGENCIA):

Name: _____ **Phone:** _____

Relationship to patient: _____

Names of other relatives who are patients of the doctor: _____

I authorize Pediatric Eye Associates, Inc. to medically exam and treat the above named patient.

Guardian signature: _____ **Relationship:** _____

Garima Lal, MD Pediatric Eye Associates, Inc/Family Ophthalmology Center
Consent for Disclosure of Medical Information (Permiso para divulgar su condición
médica)

I, _____, hereby allow and give consent for the following family members, friends, or health care surrogates to accompany me in the exam room during my visit, access the Patient Health Record, or to discuss my health information with the physician.

Yo _____, autorizo a los siguientes familiares, amistades o personas a cargo de mi bienestar, a presenciar o discutir mi condición de salud durante mi visita o la visita de mi hijo/a con el médico:

1. _____
2. _____
3. _____

May we leave a message on your answering machine, cell phone, or with the person that answers the phone?
(Nos permite dejar un mensaje en su grabadora, celular, o con la persona que conteste el teléfono?)

(check one): YES (SI) OR NO (NON)

May we communicate with you via email, and/or text messaging, regarding appointments, billing inquiries and other administrative questions? (Nos permite enviar un mensaje electrónico y / o celular sobre su appointment, sus billes u alguna otra pregunta sobre su informacion medica?)

(check one): YES (SI) OR NO (NON)

EMAIL: _____ CELLULAR: _____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Pediatric Eye Associates, Inc., and I may revoke any authorizations at any time by providing written notification of my request.

Hago constar haber recibido una copia de las prácticas de privacidad de Pediatric Eye Associates, Inc. y puedo revocar cualquier autorización en cualquier momento mediante notificación por escrito de mi solicitud.

I have provided my email address, and I authorize you to communicate with me via email regarding appointments, billing inquiries and other administrative questions. I have also opted out of paper delivery and would like billing statements sent electronically. I also allow you to use my cell phone for text messaging for appointment reminders. I am aware of the risks of sending and receiving PHI via unencrypted email and over cellular modalities, and I am giving authorization to use such a potentially insecure method of communication. If I receive communication that is not directed to me, I agree to not disseminate and immediately destroy such communications. I understand that I may revoke this authorization at any time, by written request.

(Usted puede comunicarse conmigo a través de correo electrónico dado sobre las citas, consultas de facturación y otras cuestiones administrativas). También le permiten utilizar mi teléfono celular para mensajes de texto para los recordatorios de citas. Soy consciente de los riesgos de enviar y recibir PHI a través de correo electrónico sin cifrar y estoy autorizando el uso de un método de comunicación potencialmente inseguro. Si recibo una comunicación que no está dirigida a mí, estoy de acuerdo en no difundir e inmediatamente destruir tales comunicaciones. Entiendo que puedo revocar esta autorización en cualquier momento, mediante petición escrita.

Patient's name (nombre del Paciente) _____

Signature (firma del paciente o guardian):

Relationship to Patient:

Date (fecha):

MINOR CHILD-CONSENT FOR EXAMINATION AND TREATMENT

Minor Full Legal Name: _____

Date of Birth: _____ Gender: ☐ Female ☐ Male

I consent to medical care and treatment for my minor child, by or under the direction of the physicians of Pediatric Eye Associates, Inc (d/ba Family Ophthalmology Center, (the Practice), including his/her associates, fellows and assistants.

I do hereby state that I have legal custody, and I have truthfully provided the names and contact information of the legal guardians with whom legal custody is shared. I understand that if I have sole parental responsibility for the child, I have provided a copy of standing court orders to the Practice. I agree to assume all financial responsibility for all expenses of care.

Assignment of Temporary Authority to a Designated Adult

I understand that I am authorizing an assignment of medical power of attorney. This assignment: - authorizes the patient to be accompanied to the medical office visits at **Pediatric Eye Associates, Inc.** by individuals listed below to which disclosure is being authorized, -authorizes **Pediatric Eye Associates, Inc.** to examine, and medically treat the patient in my absence, and, *transfers all powers of medical decision-making to the assignment during the medical examinations for which he/she is being authorized. **Pediatric Eye Associates, Inc.** is dedicated to helping the patient obtain the treatment needed for their condition.

I understand that it is my responsibility to obtain from the assigned individual any communications, correspondences, and/or medical prescriptions regarding this patient's medical encounter. Should the doctor feel that it is necessary for communication to be made directly to myself based on medical judgement, I agree to be available to accompany this patient for examination and/or discussions upon request of **Pediatric Eye Associates, Inc.** I further accept that although I am assigning a temporary power of attorney, the responsibility of complying with any recommended ongoing medical treatment plans, as well as making and keeping follow-up appointments at the recommended intervals is ultimately mine alone.

AUTHORIZED DESIGNATED ADULTS:

1. _____ Relationship: _____

2. _____ Relationship: _____

This assignment of Temporary Authority ends: (CHOOSE ONE)

on (date): _____

or when the following events occur: **when child reaches the age of 18.**

Parent / Legal Guardian Signature: _____

Printed Name: _____

Signed this _____ **day of** _____, **20**_____



GARIMA LAL, MD, FAAP
Board Certified, American Board of Ophthalmology
General and Pediatric Ophthalmology and Strabismus

INSURANCE INFORMATION

Your claim can not be paid without the following information

Primary Insurance Company: _____

Policy or ID #: _____

Name of Policy Holder: _____ **Sex:** ____

DOB: _____

Secondary Insurance Company: _____

Policy or ID #: _____

Sex: ____

Name of Policy Holder: _____

DOB: _____

VISION PLAN company: _____

ALL PATIENTS AND GUARANTORS: Please read the following paragraphs and sign below:

Medicare and Primary Insurance

I request that payment of authorized benefits be made on my behalf to Garima Lal, MD and/or Pediatric Eye Associates, Inc for services furnished to me by the healthcare providers of Pediatric Eye Associates, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and/or any other healthcare insurance plans and their agents responsible for the reimbursement of my healthcare claims any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay my healthcare claims. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or entity Pediatric Eye Associates, Inc. accepts the charge reimbursement determination of the Medicare Carrier and/or my insurance carrier(s) as full reimbursement as provided in their participating provider agreement. I am responsible for copayments, coinsurance, deductible, out-of-pocket expenses and non-covered services as determined by my healthcare plan(s). My signature further verifies that I will notify Pediatric Eye Associates, Inc of any changes to my health insurance coverage status, including benefit and plan changes and if I join an HMO or other plan in which my Medicare or other healthcare benefits have been relinquished. I understand it is my responsibility to update Pediatric Eye Associates, Inc of any changes in my healthcare coverage.

Medigap and Secondary Insurance

I understand that if a Medigap policy or secondary healthcare insurance is indicated, my signature authorizes release of the information to the insurer or entity. I request that payment of authorized secondary insurance benefits be made on my behalf to Garima Lal, MD, and/or Pediatric Eye Associates, Inc. The same shall apply to tertiary and quaternary healthcare benefit policies. This assignment of benefits shall remain in effect unless revoked by me in writing. A copy of this assignment and my signature shall remain on file and is considered as valid as the original.

Healthcare Plan Requirements

Some healthcare plans require the insured to seek medical services from certain healthcare providers or facilities or to obtain a referral, authorization, precertification and/or approval in order to reimburse medical fees and costs. I understand and agree that I have personally reviewed my healthcare plan and understand the coverage restrictions applied to the reimbursement of my medical expenses as determined by my healthcare plan. If I fail to comply with the requirements of my healthcare plan I understand and agree that I am responsible for full payment of all medical services rendered.

Preferred Participating Providers

Pediatric Eye Associates, Inc. participates as in-network providers with most insurance plans. I understand that it is my responsibility to verify participation. If Pediatric Eye Associates, Inc. does not participate with my healthplan, I understand and agree that I am responsible for all fees associated with my care. Payment for services are due when services are rendered and may be made by cash, check, debit card, MasterCard, Visa, Discover and American Express.

Release of Information

Pediatric Eye Associates, Inc. may disclose all or part of my medical record, including financial information, alcohol or drug abuse, psychiatric illness, communicable disease and/or HIV status to any person or entity which is liable or under contract for reimbursement of medical services rendered and any healthcare providers or entities participating in my medical care. Pediatric Eye Associates, Inc. may also disclose on an anonymous basis any information concerning my care which is necessary or appropriate for the advancement of medical science, medical education, medical research, collection of statistical data or pursuant to local, state or federal law, statute or regulation.

OTHER FEES:

\$35.00 returned check/nonsufficient funds/chargeback fee

\$50.00 NO show fee/non-cancellation fee

\$35.00 unused authorizations/expired authorizations due to cancelled appointments (must reschedule within authorization grace period)

\$25.00 form completion fee

\$5.00 monthly charge for balances over 60 days old

\$50.00 charge to send account to collections (in addition to applicable collections fees: 35% of total balance)

Non-covered Services and Advanced Beneficiary Notice

I understand that my healthcare insurance plan may not cover all services even though my physician determines the service(s) to be medically necessary. Examples of non-covered services include, but are not limited to, services not specified as being covered by my healthcare plan, treatment or tests not authorized by my healthcare plan or services that are specifically excluded or limited by my healthcare plan. I understand and agree that a Advanced Beneficiary Notice (ABN) will be obtain any time it is expected that my healthcare plan may not cover a service. I understand and agree that if a service, test, treatment or drug is not covered by my healthcare plan I am personally responsible for the fees associated with any and all non-covered services, unreimbursed, under reimbursed and/or denied services. FOR EXAMPLE, A “REFRACTION” IS REQUIRED TO PRESCRIBE GLASSES. IN CHILDREN, THIS SERVICE IS A MEDICALLY NECESSARY PART OF A COMPLETE EYE EXAM. IT IS MOST OFTEN NOT CONSIDERED PART OF MEDICAL CARE AND FALLS UNDER VISION OR ROUTINE EYE COVERAGE, AND MAY BE REFUSED BY YOUR MEDICAL INSURANCE POLICY. UNLESS VERIFIED BY THE INSURANCE COMPANY PRIOR TO YOUR OFFICE VISIT, THE REFRACTION FEE OF \$60.00 IS PAYABLE AT THE TIME SERVICES ARE RENDERED. IN CHILDREN, IT IS USUALLY THE REASON FOR THE OFFICE REFERRAL.

Financial Agreement

I understand that insurance is a means of reimbursement and not a substitution for payment. Pediatric Eye Associates, Inc. will file my healthcare claims on my behalf for medical services rendered. I agree to pay all copayments, coinsurance, deductibles, out-of-pocket expenses and non-covered services as determined by my healthcare insurance plan at the time of service. I understand and agree that I am ultimately responsible for payment of all fees for services rendered regardless of my insurance status. I understand and agree to promptly pay any account balances upon the receipt of a statement from Pediatric Eye Associates, Inc. or upon arrival at the office prior to services. Furthermore, I understand and agree that my account may be accessed additional fees, including interest charges and late fees for outstanding balances, returned payments, the duplication of medical records, special forms or reports and appointment cancellation and no show fees. If it becomes necessary to send my account for collection, I agree to pay collections expenses and fees of 35% of the outstanding balance (as calculated on the due date) which will be added to the outstanding balance. IF the account is referred to an outside attorney for collections, I agree to pay all attorney’s fees as established by the court in addition to my outstanding account balance and administrative account fees. **There will be a \$35.00 administrative fee for nonsufficient funds, returned checks, or merchant chargebacks.** I understand that it may become necessary to terminate the patient-physician relationship if I fail to meet my financial responsibilities or my financial arrangements become unsatisfactory.

Additional Information

As a courtesy I agree to silence my cellular telephone and other electronic devices upon arrival for my appointments. If I must make or receive a telephone call I will step outside the office. I understand Pediatric Eye Associates, Inc. maintains a smoke free environment and will refrain from the use of all tobacco products while at my appointments. Weapons of any kind are strictly prohibited. My appointment time has been reserved for me and I will notify the office 24 hours in advance if I am unable to keep my appointment. I understand and agree my failure to kept scheduled appointments without properly notifying the office will result in a \$50.00 fee to my account and restrictions to future appointment bookings. Late arrivals will be seen as permitted or rescheduled as needed. I understand that due to the nature of the specialty, emergencies may delay scheduled appointments and occasionally make it necessary to reschedule appointments in order to accommodate emergency surgical care. The physicians and staff understand my time is valuable and will work diligently to minimize the length of my visit and ask for my patience and understanding in advance if delays occur. A copy of this consent, assignment, authorization and agreement may be used in place of the original. I have the right to obtain a paper copy of this notice, upon request, even if I have agreed to accept this notice alternatively i.e. electronically.

Dilation drops: I understand it is necessary for my/my child's pupils to be dilated (enlarged) in order for my retina to be examined. Mydriatic (dilating) drops frequently blur vision and make bright light bothersome. It is not possible to predict how my vision will be affected and for how long. I should not drive a vehicle or operate machinery. I consent to pupil dilation at each visit and understand the visual side effects and risks. **Consent for examination and treatment** of self: I consent to medical care and treatment for myself, or for my minor child, by or under the direction of the physicians of Pediatric Eye Associates, Inc (d/ba Family Ophthalmology Center, (the Practice), including his/her associates, fellows and assistants.

By signing below, I certify that have read this form, and I agree to abide by the policies set forth by Pediatric Eye Associates, Inc. All my questions have been answered.

PATIENT OR GUARDIAN SIGNATURE: _____ **RELATIONSHIP:** _____

DATE: _____



Patient's Medical History with Review of Systems

PATIENT NAME: _____ TODAY'S DATE: ____/____/____

If pediatric patient, name of person completing form: _____ Relationship to patient: _____

HISTORY OF EYE PROBLEMS:

1. What problem(s) are you (your child) having with your eyes? _____

2. Have you (your child) ever had any eye problems, patching treatment or surgery? Please be specific with approximate dates and the doctor who treated you. _____

3. When was your (your child's) last eye exam? _____ Who was the doctor or where? _____

4. Do you (your child) wear glasses? Yes ☐ No ☐ If yes, how long? _____

5. Do you (your child) wear contact lenses? Yes ☐ No ☐ If yes, what brand? _____

RECENT EYE SYMPTOMS:

YES	NO	IF YES, WHICH EYE?	YES	NO	IF YES, WHICH EYE?
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Pain or soreness
<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Excess tearing
<input type="checkbox"/>	<input type="checkbox"/>	Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Mucous discharge
<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Redness
<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Crossed or wandering eye

FAMILY HISTORY: Do the patient's **relatives** have any of the following?

YES	NO	IF YES, WHO?	YES	NO	IF YES, WHO?
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (bad vision in one eye)
<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	History of patching treatment
<input type="checkbox"/>	<input type="checkbox"/>	Genetic eye disease (runs in the family)	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus ("crossed or wandering eye")

At what age did your child's birth parents begin wearing glasses? Mother _____ Father _____

SOCIAL HISTORY: Do you (your child) smoke? Yes ☐ No ☐ Do you (your child) drink alcohol? Yes ☐ No ☐

MEDICAL HISTORY AND REVIEW OF SYSTEMS:

YES	NO	IF YES, EXPLAIN BELOW	YES	NO	IF YES, EXPLAIN BELOW
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or intestinal disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or urinary disease
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Skin disease
<input type="checkbox"/>	<input type="checkbox"/>	Other ear, nose or throat problems	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic(brain) problems
<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	<input type="checkbox"/>	Reading problems/learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Genetic diseases in family
<input type="checkbox"/>	<input type="checkbox"/>	Fever or weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder (anemia, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease			

Has the child received the recommended vaccines: Yes ___ No ___ date: _____ Adult influenza vaccine: Yes ___ No ___ Date: _____

1. LIST any previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems) **within the last five years:**

2. LIST all medications including eye drops: _____

3. LIST allergies to medicines or circle none: NONE _____

4. Birth history for patients 10 years old or younger: Birth weight: _____ lbs _____ oz
Length of pregnancy: ☐ Full term ☐ Premature- length of pregnancy if premature _____ weeks

LIST any problems with pregnancy: _____