Campanella Eye Associates PC

Your Family Eye Care Specialists

Peter C. Campanella, M.D.
Ophthalmology
Cataract Surgery
Eyelid Surgery
Botox Injections

Bradley L. Loeb, O.D.
Optometry
Contact Lens Specialist
Corneal Refractive Specialist

General Information_____ Date:_____
Name: _____ Preferred Name: _____
Street Address: _____
City, State, Zip: _____
Cell phone: _____ Home phone:_____ Email:_____
Preferred Contact Method (circle one): Text Cell Home Email
Date of Birth: _____ Identify as: Male Female Other
Marital Status (circle one) Single Married Divorced Legally Separated Widowed
Emergency Contact Name: _____ Relationship:
Emergency Contact Phone number: _____
Occupation/Employer: _____ Full time or Part time
Primary Medical Insurance: _____
Primary Member Name: _____ Employer:
Primary Member Date of Birth: _____ Last four of SSN:_____
Insurance ID #:_____
Insurance Policy or Group Number: _____
Your relationship to Primary Member: Self Spouse Child Other
Vision Insurance Name:_____
Primary Member Name: _____ Employer:
Primary Member Date of Birth: _____ Last four of SSN: _____
Insurance ID #: _____
Insurance Policy or Group Number: _____
Your relationship to Primary Member: Self Spouse Child Other

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Name: Date of Birth: Date:

Are you currently experiencing any of these eye conditions? Check all that apply	Do you have any of the following conditions? Check all that apply	Do you have any of the following conditions? Check all that apply. Continued from previous column.
□. Dryness	□. Environmental Allergies	□. Anemia
□. Tearing	□. Skin conditions—-Type:	□. Joint Pain
□. Itching	□. Hearing Problems	□. Auto Immune Disease—Type:
□ Loss of Vision	□. Asthma	□. Diabetes Type I or Type II
□. Glare or Light Sensitivity	□. Emphysema/ COPD	□. Thyroid Abnormalities. Hyper / Hypo
□. Double Vision	□. Anxiety/ Depression/ ADHD	□. Cancer. Type:
□. Flashes or Floaters	□. Headaches	□. Kidney Problems
□. Redness	□. Seizures	□. Gastrointestinal Problems / GERD
□. Eye Pain	□. Multiple Sclerosis	□. AIDS / HIV
□. Distorted Vision or Halos	□. Hypertension	□. STD. Gonorrhea / Syphilis
□. Cataracts	□. High Cholesterol	□. Hepatitis. — Type:
	□. Heart Disease	□. Pregnant or Nursing
	□. Stroke	
Do you have a history of eye surgery? Yes or No. Use back of form if needed. If yes, date and type of procedures:	**Medications: Use back of form if needed:**	**Please list any other health conditions:**
		Flu Vaccine: Yes or No
		Pneumonia Vaccine: Yes or No
Have you or a family member ever been diagnosed with any of the following? (Circle)	**Allergies: Use back of form if needed.**	**Tobacco use**: Yes. No. History of.
Macular Degeneration: Yes. No. Family	□NKDA	**Illegal Drug Use** — Yes or No - Type
Glaucoma: Yes. No. Family		**Alcohol use**
		□Less than 1 drink per day □1 or more drinks per day

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Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date. You have the right to restrict how your protected information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing. However, such a revocation will not be retroactive.

May we phone, email or send a text to confirm appointments? Yes No

May we leave a message at home or on your cell phone? Yes No

May we discuss your medical condition, billing, or insurance with a member of your family? Yes No

If yes, please provide the name and relationship of authorized individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

By signing this form, I agree to the terms above. I acknowledge that a copy of Campanella Eye Associate's Notice of Privacy Practices was made available to me.

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____

Parent/ Guardian if patient is a minor

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Vision Exam vs. Medical Exam

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit. We have prepared this form to help you understand how your visit is submitted to your medical or vision insurance. Benefits may vary based upon the reason for your visit.

Routine Eye Examinations:

A routine eye examination takes place when you come for an examination without any underlying medical conditions which may affect the eyes. Vision exams do not cover for management or treatment of medical problems. The doctor screens the eyes for disease and checks your vision. Examples that necessitate your visit being submitted as a vision exam include:

- Basic Eye Exam
- Glasses or Contact Lenses

Medical Eye Examinations:

Medical eye examinations are for evaluation of a medical related complaint or follow up of an existing condition are examples of an eye examination that would be billed to your medical insurance. Examples that will necessitate your visit being submitted as a medical exam include but may not be limited to:

- Diabetes Mellitus
- Dryness/Redness of eyes
- Allergies
- Floaters and or Flashes of light
- Glaucoma
- Cataracts
- Referral from outside Physicians
- Eye Irritation or Eye Pain
- High Risk Medications
- Eye muscle imbalance or lazy eye
- Macular Degeneration

The purpose of your visit will determine which insurance benefit will be used. Medical eye exams will be subject to co-pays and deductibles according to your medical insurance plan. Medical insurance typically does not cover the refraction (this is the part of the exam used to generate a glasses or contact lens prescription). You have the option to pay out-of-pocket for the refraction and or contact lens evaluation or you may schedule a return appointment to use your vision examination benefit. We are not able to bill medical insurance and vision insurance on the same day. They need to be done on two different days. We understand the distinction between medical and vision exams is often confusing so we will work with your insurance to minimize your out-of-pocket expenses.

Patient Name:_____ Date:_____

Patient Signature: _____
(Parent/Guardian if patient is a minor)

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Financial Policy:

At Campanella Eye Associates, it is our mission to provide the best possible eye care. This involves a mutual understanding between patients, doctors and staff. We encourage you to discuss any questions you may have regarding our payment policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for services is your responsibility. Payment for services are due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. This includes services provided for a patient who is a minor. The presenting parent is then responsible. We collect full payment for glasses at time of order and contact lenses at pick up. We gladly accept most forms of payment including: cash, check, credit cards and CareCredit. We are happy to offer these choices so that you can select a payment option that best fits your needs. Please ask if you would like more information on CareCredit in order to make an informed decision about which payment option you prefer.

We are providers for many medical insurance companies. As a courtesy to you for in network insurance plans, we will bill and receive payment directly from your medical insurance company for covered services. You will be responsible for any remaining balance. We make no claim to know what services your insurance covers. Your insurance policy is a contract between you and your insurance company - we are not part of that contract. It is your responsibility alone to know what services may or may not be covered by your insurance. We encourage you to refer to your insurance member services department if you have questions about covered services. Please be aware that some or perhaps all of the services provided may be non-covered services by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

Appointments:

We value the time you/we have set aside to take care of your eyes. If you are not able to keep an appointment, we request at least 24-hour notice. Patients who do not show up for 3 appointments without notifying us in advance may be assessed a fee.

If year late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

We strive to minimize any wait time; however, emergencies do occur and some patients may take longer than others. This may affect scheduled visit times. We appreciate your understanding.

Please read and sign the following:

1. I hereby authorize Campanella Eye Associates to bill my medical or vision insurance company for services provided, with payment to be made directly to Campanella Eye Associates. I authorize this office to release all information necessary to secure the payment. In the event I receive payment from my insurance company for services rendered in this office; I agree to endorse payment received to Campanella Eye Associates.

2. In the event Campanella Eye Associates is not a participating provider in my medical or vision plan, I will be expected to pay for all services rendered and materials received.

3. I understand and agree that I am directly and fully responsible to Campanella Eye Associates for payment of all charges. I understand that such payment is not contingent on any settlement, judgement, insurance decision, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay the anticipated balance in full or payment is not made, it is my responsibility to pay the doctor's bill and collection fees if applicable.

4. I understand that Medicare specifically does not cover the refraction portion of the eye examination and I am responsible for that fee.

This agreement will remain in effect until revoked by me in writing. I understand and agree to the above:

Patient Name: _____

Patient Signature: _____ Date: _____
(parent or guardian if patient is a minor)

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Consent for Dilation Drops:

Patient Name:_____ DOB:_____ Date:_____

Dilating drops are an essential part of a complete eye exam. They enlarge the pupils to allow the doctor to examine the inside of your eyes.

The drops blur your vision for a length of time which varies from person to person. Our doctors are not able to predict how long our vision will be affected. Your eyes will be sensitive to light; therefore, sunglasses should be worn after dilation.

If you do not know how you are going to react to the dilating drops, we recommend that you do not drive or operate heavy equipment after your examination.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilation drops. This is extremely rare and treatable with immediate medical attention. Please call our office if you experience eye pain, headaches or nausea after your examination.

I have read and completely understand the above information regarding dilation drops. If I choose to drive, I assume full responsibility (financial and otherwise) for the consequences resulting from this choice.

I authorize the doctor or designated assistants to administer dilating eye drops.

Patient's signature:_____ Print Name:_____
(Or authorized person to sign for patient)

Witness:_____ Witness Printed Name: _____