# Welcome to University Children's Eye Center

We are pleased that you have chosen us as your pediatric eye specialists. We will do everything we can to make each visit as pleasant as possible.

## What to Expect at Your Child's First Visit to Our Office

During an ophthalmic exam, the doctor will evaluate your child's visual acuity, eye movement, eye alignment, and overall health of the eye. Your child will also be screened and evaluated for amblyopia ("lazy eye"), strabismus (misaligned or "crossed" eyes), cataracts, glaucoma, retinal abnormalities, as well as other ocular and general medical conditions which might affect eyesight.

We try to make the exam fun for your child. During much of the exam, younger children will be looking at age-appropriate toys. Games are played to obtain the cooperation of young children. **A comprehensive eye examination takes time, so plan to spend <u>at least</u> one and a half hours in our office.**

For most initial eye examinations, your child's eyes will be dilated with eye drops. This allows the ophthalmologist or optometrist to examine vital structures of your child's eyes including the optic nerve and retina. Dilation will make the pupils look larger than normal. Some children may have difficulty reading and be light sensitive for up to 24 hours, but the major effect of the drops is gone in approximately 6 to 8 hours. On a bright day, your child may be sensitive to sunlight, so you may wish to bring sunglasses if your child has them and/or limit the time spent outside. Your may need to help your school-age child with homework and other near work as the eyesight may still be blurry for several hours.

## What to Bring with You to Your Child's Appointment

- The completed 4 pages of registration forms. (Please do not mail these in.)
- Any glasses or contact lenses that your child wears.
- If your child has seen other eye doctors for an ongoing problem, it can be helpful to have a copy of the records. It is usually best for you to call and request that the records be sent to you directly. Bring them with you to the appointment.
- Your insurance card, co-payment, and referral or authorization number (if required), if you plan on using insurance with which we participate.

As a courtesy to our other patients, please call us to reschedule your appointment if your child has a cold, fever, chicken pox, or other contagious disease. If you must cancel your appointment for any other reason, please give us at least 48 hours notice so that we can accommodate patients who have been waiting for their appointments.

We look forward to seeing you in our office. If you have any questions, do not hesitate to call.

The Doctors and Staff of University Children's Eye Center


**Main Office**
4 Cornwall Court
East Brunswick, NJ 08816
phone 732/613-9191
fax 732/613-1139

**Bridgewater Office**
678 Route 202/206 North Bldg 5
Bridgewater, NJ 08807
phone 908/203-9009
fax 908/203-9010

**RWJ/UMDNJ Dept of Ophthalmology**
125 Paterson Street 4th Floor
New Brunswick, NJ 08901
phone 732/613-9191
fax 732/613-1139

University Children's Eye Center, P.C. REGISTRATION

**Main Office**
4 Cornwall Court
East Brunswick, NJ 08816
732/613-9191

**Bridgewater Office**
678 Route 202/206 North Bldg 5
Bridgewater, NJ 08807
908/203-9009

**RWJ/UMDNJ Dept of Ophthalmology**
125 Paterson Street 4th Floor
New Brunswick, NJ 08901
732/613-9191

**Please Print**

Name of Patient _____ Date of Birth _____
last name/first name/middle initial month/day/year

Address _____ Home Phone _(_____)_____

_____ Occupation _____
city/state/zip code

Sex ☐ male ☐ female

Primary Doctor Name _____ Address _____

Other Physician(s) from whom the patient receives care (Please give name, specialty, address, and phone for each):

Were you referred to us by your pediatrician or family physician? ☐ Yes ☐ No

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

We like to send a report of your eye exam(s) to all physicians who care for you or your child. Please indicate here if you prefer that we NOT send a report to any of the above physicians.

**Person Responsible for Account**

Name: _____ Address (if different from patient's)

Relation: _____ _____

Work Phone Number: _____ _____

Social Security Number_____

*The Parent or Guardian who accompanies a pediatric patient is responsible for payment at the time of service and for the child's account unless prior arrangements have been approved.*

**PRIMARY INSURANCE -- Please give complete information on all plans the patient is enrolled in.**

Insurance Subscriber (last name/first/middle initial)_____

Relationship to Patient _____ Date of Birth_____ Social Security Number _____

Address (if different than patient's) _____ Phone _____

_____

Person Responsible Employed by _____ Business Phone _____

Insurance Co. _____ Subscriber Number _____ Group/Contract # _____

**ADDITIONAL INSURANCE -- If patient is enrolled in more than one health plan, please complete the following.**

Insurance Subscriber (last name/first/middle initial) _____

Relationship to Patient _____ Date of Birth_____ Social Security Number _____

Address (if different than patient's) _____ Phone _____

_____

Person Responsible Employed by _____ Business Phone _____

Insurance Co. _____ Subscriber Number _____ Group/Contract # _____

***This Section for Pediatric Patients Only:***

**Who is Accompanying the Child Today?**

Name: _____

Relation: _____

Do you have legal custody of the child? ☐ Yes ☐ No

Written consent for us to treat the child is required if not.

**Mother's Information**

Full Name:

Daytime Phone:

Does the mother have legal custody of the child? ☐ Yes ☐ No

**Father's Information**

Full Name:

Daytime Phone:

Does the father have legal custody of the child? ☐ Yes ☐ No

**I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for this patient's account. I understand and accept that payment is due at the time of service unless we accept insurance assignment for a covered service. I also acknowledge that a cancellation fee of $25 will be charged if this office is not notified 48 hours prior to cancellation of an appointment, except in the case of an emergency.**

Signature of Responsible Party: _____ Date: _____

University Children's Eye Center, P.C.

# New Patient Questionnaire: Medical and Family History

**Name of Patient** _____ **Date of Birth** _____

**Why is the patient here to see the doctor?** _____

_____

**History of Eye Problems:** Has the patient had any of the following?

| Yes | No | | Age | Yes | No | | Age |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Eye exam | _____ | ☐ | ☐ | Eye injury | _____ |
| ☐ | ☐ | Glasses | _____ | ☐ | ☐ | Eye surgery | _____ |
| ☐ | ☐ | Patching | _____ | ☐ | ☐ | Other eye problems: | _____ |

**Recent Ocular Symptoms**

| Yes | No | | How long? | Yes | No | | How long? |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Frequent tearing or discharge | _____ | ☐ | ☐ | Frequent headaches | _____ |
| ☐ | ☐ | Crossed or wandering eye | _____ | ☐ | ☐ | Light sensitivity | _____ |
| ☐ | ☐ | Double vision | _____ | ☐ | ☐ | Tired eyes when reading | _____ |
| ☐ | ☐ | Abnormal head or eye position | _____ | ☐ | ☐ | Clumsiness or bumping into things | _____ |
| ☐ | ☐ | Abnormal eye movements | _____ | ☐ | ☐ | Can't make normal eye contact | _____ |
| ☐ | ☐ | Excessive squinting | _____ | ☐ | ☐ | Change in school or work performance | ____ |
| ☐ | ☐ | Excessive eye rubbing | _____ | ☐ | ☐ | Other symptoms: | |
| ☐ | ☐ | Blurred vision | _____ | ☐ | ☐ | | |

**Review of Systems (Medical History):**

Does the patient currently have or have a history of any of the following? Give details on 'yes' responses.

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | Fever or weight loss | _____ |
| ☐ | ☐ | Birthmarks, rash, or skin lesions | _____ |
| ☐ | ☐ | Frequent ear infections | _____ |
| ☐ | ☐ | Other ear, nose and throat problems | _____ |
| ☐ | ☐ | Developmental delays | _____ |
| ☐ | ☐ | Behavioral or attention deficits | _____ |
| ☐ | ☐ | Heart murmurs or other problems | _____ |
| ☐ | ☐ | Asthma or respiratory problems | _____ |
| ☐ | ☐ | Arthritis or other joint problems | _____ |
| ☐ | ☐ | Kidney or urinary disease | _____ |
| ☐ | ☐ | Diabetes | _____ |
| ☐ | ☐ | Digestion or gastrointestinal disorders | _____ |
| ☐ | ☐ | Sickle cell trait or disease | _____ |
| ☐ | ☐ | Genetic syndrome | _____ |
| ☐ | ☐ | Seizures or neurological problems | _____ |

**Allergies -** Does the patient have any allergies

to medications? ☐ Yes ☐ No Please list: _____

to substances? ☐ Yes ☐ No Please list: _____

Please complete next page →

**Has the patient ever had surgery?** ☐ Yes ☐ No If yes, please give details and dates below

_____

_____

**List any medications the patient is taking, including eye drops:**

_____

_____

**Birth History (Pediatric Patients only):**

Birth weight: _____ lb. _____ oz.

| Yes | No | (If 'yes', what was the problem?) | Yes | No | (If 'yes', why?) |
|---|---|---|---|---|---|
| ☐ | ☐ | Problems during pregnancy | ☐ | ☐ | Delivered more than 2 weeks early or late |
| ☐ | ☐ | Problems during delivery or forceps delivery | ☐ | ☐ | Baby kept in hospital due to illness |
| ☐ | ☐ | Delivery by cesarian section | ☐ | ☐ | Delayed development |

**Family History:** Have any of the patient's ***relatives*** had any of the following? Please indicate the relation to patient.

| Yes | No | | Relation to Patient | Yes | No | | Relation to Patient |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Glasses before age 6 | _____ | ☐ | ☐ | Cataracts in childhood | _____ |
| ☐ | ☐ | Amblyopia ("lazy eye") | _____ | ☐ | ☐ | Glaucoma in childhood | _____ |
| ☐ | ☐ | Patching treatment | _____ | ☐ | ☐ | Other serious eye disease | _____ |
| ☐ | ☐ | Strabismus ("crossed eye") | _____ | ☐ | ☐ | Complications from anesthesia | _____ |
| ☐ | ☐ | Eye muscle surgery | _____ | ☐ | ☐ | Genetic disease (that run in the family) | ____ |
| ☐ | ☐ | Blindness | _____ | ☐ | ☐ | Other serious illnesses: | _____ |
| | | | | | | | _____ |

Are both parents alive and in good health? ☐ Yes ☐ No

**Other medical concerns or problems not listed earlier:**

**Thank you.**

**I understand that the information that I have given is correct and complete to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my or my child's medical status. I authorize the staff of University Children's Eye Center, P.C. to perform the necessary in-office examinations that my child (or myself if an adult patient) may need.**

_____ _____

**Signature of patient or guardian** **Date**

I verbally reviewed the medical information above with the parent/guardian and/or patient named herein.

_____ Date _____

**Doctor's Comments:**

University Children's Eye Center
**Main Office**
4 Cornwall Court
East Brunswick, NJ 08816

# Assignment of Medical Insurance Benefits

Thank you for choosing us as your pediatric eye doctors. We will work with you to help you with your insurance claims, but would like you to understand our office policy regarding insurance assignment.

Payment is due at the time of service unless we accept assignment with your insurance company for a covered service. For our office to accept insurance assignment for services, we ask that you read and sign the following.

**You acknowledge that it is your responsibility to:**

1. Provide complete up-to-date information on medical insurance coverage for the patient. This includes information on all plans, if enrolled in more than one health plan.
2. Present a valid insurance card at each visit.
3. Pay any applicable co-payment at the time of service.
4. Present a valid referral or authorization number for services if required by your plan).
5. Inform us if the patient's need for medical services is due to a motor vehicle, worker's compensation, or other accident.
6. Pay within 30 days any balance on your account for any amount due this office, such as deductibles, coinsurance, co-payments, or non-covered services.

**You are ultimately responsible to pay the medical bill if the assignment of benefits is not honored in whole or in part.**

**Routine Vision Care Services and Other Non-Covered Services**

1. Some insurance plans have coverage for "routine" vision care and other services.
2. Please call your insurance company or benefits resource person to determine whether you have a "vision care rider". Our office can assist you in that determination. However, only your insurer can conclusively determine if a service is covered under your contract.
3. If coverage cannot be verified, payment is due at the time of service.
4. A referral from a primary care physician does not guarantee that the service will be covered (i.e. paid for) by your insurer. (A referral only gives the PCP's authorization; it is not a guarantee of benefits.)
5. Please be advised that our office does not code vision care services so that they will be covered as a medical service.

**Your signature below indicates**

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the medical insurance coverage information.
3. You authorize this office to release the medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to University Children's Eye Center, P.C.

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship to Patient

# University Children's Eye Center, PC

**Main Office**
4 Cornwall Court
East Brunswick, NJ 08816
732-613-9191

**Bridgewater Office**
678 Route 202/206 North
Bridgewater, NJ 08807
908-203-9009

## PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship to Patient

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |