Please complete all patient information forms attached. To better assist you in a timely manner, to guarantee communication with your referring and primary care physicians and to properly care for you, it is very important that we receive all of the enclosed information upon your arrival at Galiani Ophthalmology Associates. In order to ensure efficiency in billing functions and precert procedures, it is pertinent that all insurance information be accurate and current. Thank you for completing all of the forms enclosed.

Information Regarding Your Office Visit:

• Your visit with us may last up to 90 minutes depending on the type of evaluation you require.

• Your eyes may be dilated for the examination, please bring sunglasses if you have them, if not please ask our receptionist for a pair. You may also need a driver if you feel you are unable to drive with dilated pupils due to light sensitivity, glare or blurred vision. On the

Day Of Your Appointment You Will Need To Bring The Following:

• The completed patient information forms attached.

• Your current list of eye drops and medications.

• Current Insurance Cards.

• If your insurance requires a referral to see a Specialist, please make sure to have your Primary Care Physician issue this for you.

• Co-pays for a "Specialist" as noted on your insurance cards.

• A valid picture Identification card such as a Driver's License.

• Contact lens information, brand, power of lenses and solution.

**** Please Note****

Without a proper referral, payment will be due at the time of the office visit. If your insurance is non-participating, payment will be collected at the time of the office visit. For Refractions and Contact lens fittings, payment will be collected at the time of the office visit. **Please feel free to contact us with any questions, 215-345-5144.**

Galiani Ophthalmology ASSOCIATES

Patient Registration Form

All paperwork must be filled out in completion. Please do not leave any fields blank.

Patient Name:_____ DOB:_____ Sex:_____

Address:_____

Social Security Number:_____ Email:_____

Primary Number:_____ Alternate Number:_____

Employer:_____ Occupation:_____ Marital Status:_____

Primary Care Physician:_____ Phone:_____

Present Optometrist:_____ Phone:_____

Present Cardiologist:_____ Phone:_____

Other Specialist:_____ Phone:_____

Review of Symptoms. Please circle all that apply

GI: Nausea | Vomiting | Diarrhea | Weight Loss

Heart/Lungs: Asthma | Chest pain | Shortness of breath | Cough | Irregular heartbeat

GU: Pain on urination | Incontinence | Increase in urinary frequency

HEENT: Headaches | Hearing loss | Sore throat

Skeletal: Joint pain | Muscle pain | Back pain

Skin: Rashes | Bruises | New skin lesions

Neuro: Headaches | Seizures | Dizziness | Numbness or Tingling

Endocrine: Excessive thirst | Excessive urination | Hot or cold intolerance

Physician Signature:_____

Patient Name:_____ **DOB**:_____

Medical History: Please check all that apply

- Diabetes, If So What Type? _____
- High Blood Pressure
- High Cholesterol
- Thyroid Abnormalities
- Heart Disease
- Stroke
- Asthma
- Cancer
- Arthritis
- Other:_____

  _____

Surgical History: Please list all previous surgeries

- _____
- _____
- _____
- _____
- _____

Ocular History: Please check all that apply

- Wears Glasses
- Wears Contacts
- Cataracts
- Dry Eyes
- Macular Degeneration
- Glaucoma
- Other:_____

Ocular Surgical History: List all previous ocular surgeries and/or laser history

- _____
- _____

Physician Signature:_____

Patient Name:_____ **DOB**:_____

Medication and Allergy List

Pharmacy Name: _____ Phone Number:_____

Pharmacy Address:_____

Medication name and dosage:

(If you are not on any medications please write no medications below)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

List all allergies and reactions: **(If no allergies, please write NKDA below)**

- _____
- _____

Patient Name:_____ **DOB**:_____

Social History:

- Do you smoke cigarettes?_____ How much?_____ Years smoked?_____
- Do you vape?_____ How often?_____ Years smoked?_____
- Do you drink alcohol?_____ How much?_____ How often?_____
- Do you take any legal or illegal drugs? _____ Yes _____ No
  -If so please list them in the enclosed Medication list.

Family History: Any family history of the following?

Macular Degeneration, Diabetes or Glaucoma**:**_____

Other:_____

Quality Measures: All following questions must be answered if you are 65 or older.

- Have you received your pneumonia vaccine? _____
- Do you have a health care proxy in the event you are unable to make your own decisions? _____
- Do you have a living will? _____

Which statement best reflects your wishes on advanced care recommendations?

_____Do Not Intubate: I do not wish to have a breathing tube, even if its necessary to save my life.

_____Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

_____Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Patient Name:_____ **DOB**:_____

Insurance Information

***Primary Insurance**:_____ Eff Date:_____

ID Number:_____ Group #:_____

Subscriber Information (If other than yourself):

Name:_____ DOB:_____ Relationship:_____

***Secondary Insurance**:_____ Eff Date:_____

ID Number:_____ Group #:_____

Subscriber Information (If other than yourself):

Name:_____ DOB:_____ Relationship:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Galiani Ophthalmology Associates or my insurance company to release any information required to process claims.

X Signature:_____ Date:_____

Emergency Contacts

1. Name of Contact:_____ Relationship:_____

Primary Number:_____ Alternate Number:_____

2. Name of Contact:_____ Relationship:_____

Primary Number:_____ Alternate Number:_____

Patient Name:_____ **DOB**:_____

Notice of Privacy Practices

This notice describes how Galiani Ophthalmology Associates, PC may use and disclose your personal Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are required or permitted by law. "Protected Health Information" is personal information including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health services.

PHI (Protected Health Information)

Uses & Disclosures of PHI:

- Treatment, payment and healthcare operations (unless pain in full by patient/person behalf of the patient other than healthcare plan)
- Patient or designated representative
- Legal purposes
- Marketing purposes with written permission
- Fundraisers with written permission

Unauthorized disclosure is permitted:

- As required by law
- For public health services and communicable diseases
- For investigation of claims and audits
- To protect victims of abuse, neglect or domestic violence
- When judicial and administrative proceedings are necessary
- For law enforcement purposes or specialized government functions
- To coroners and funeral directors
- For research
- To advert a serious threat or criminal activity
- For disability documentation
- For workers compensation
- For inmates

Permitted disclosures will only be released with your written consent or the written consent of a parent or guardian of a minor patient, unless notes above for unauthorized disclosure as permitted by law. You may revoke this authorization, at any time, in

writing, except to the extent that your physician or the physicians practice has taken in reliance on the use or disclosure indicated in the authorization.

Safeguards for the protection of PHI:

- Patient paper records and electronic health records (EHR) are stored in a secure location. EPHI is protected in accordance with the administrative, physical and technical safeguards of the HIPPA security rule.

Patients Rights:

- Our patients have the right to privacy and respect regarding their personal information
- You have the right to inspect and copy your protected health information with reasonable notice
- You have the right to receive care without discrimination due to age, sex, race, color, religion, sexual orientation, marital status, culture, language, disability, gender identity or ancestry.
- You have the right to restrict your protected health information if the service was paid in full by patient or patient representative.
- You have the right to request a restriction on how your personal protected health information is used
- You have the right to have your physician amend your protected health information
- You have the right to receive confidential communications from us by alternative means or at an alternative location
- You have the right to receive an accounting of certain disclosure we have made of your protected health information
- You have the right to file a complaint if you believe that our safeguards and procedures have not been followed. Any privacy issues complaints should be directed to the privacy officers of Galiani Ophthalmology Associates PC. to the practice administrator

Acknowledgement of Receipt of Notice of Privacy Rights

I have received the notice of privacy practices of Galiani Ophthalmology Associates, PC and have been provided the opportunity to review it at my leisure.

X Signature:_____ Date:_____

Patient Record of Disclosures

In general, the HIPPA privacy rules give the individual the right to request restriction on uses and disclosures of the protected health information (PHI) for the purpose of continuity of my care or to adjudicate my account. This authorization does no take place o our standard "Release of Records Authorization".

I authorize my PHI to be disclosed to the following individuals:

1. Name_____ Relationship_____

2. Name_____ Relationship_____

3. Name_____ Relationship_____

Uses and disclosures for treatment may be permitted without prior consent in an emergent situation.

We reserve the right to change terms of this notice. You have the right to object or withdraw. As provided in this notice.

Print Name:_____

X Signature:_____ Date:_____

Galiani Ophthalmology Associates, PC Financial Policy

Due to the changes in healthcare we may not be aware of your insurances regulations or protocol. Please review your benefits to ensure your visit is covered. We are here to assist you if needed.

Although we participate with may insurance companies such as Aetna, IBC, Keystone, Personal Choice, Medicare and most major medical insurances some of these plans **DO NO COVER ROUTINE EYECARE.** Some insurances only cover **MEDICAL VISITS.**

If your insurance requires a **referral** and you arrive at our office without one, you will be required to call your PCP and request a referral for that day, pay for the visit in full or reschedule. **WE CANNOT** provide services without the proper referral. These measures are in place to ensure you get the most from your insurance without paying unnecessary out-of-pocket expenses.

You MUST present your insurance cards and a valid legal identification card to our staff at the time of the visit. Please be aware that **you are responsible for all DEDUCTIBLES, CO-PAYMENTS or NON COVERED SERVICES** at the time of the visit, regardless of your insurance. Most insurance plans will not cover a refraction and the fee for this service is $45.00, therefore, it is your responsibility to pay for the refraction at the time of service. **All services that are not paid for at the time of the visit will be subject to a $10.00 service fee.**

Payment for services rendered is due AT THE TIME OF SERVICE. It is NOT our policy to bill for services rendered, co-payments or deductibles. We accept cash, personal checks, Visa, Master Card, Discover and American express.

I understand the above policy and agree to abide by the regulations of my insurance company, as well as, the policy of Galiani Ophthalmology Associates, PC.

I authorize my insurance benefits be paid on my behalf to Galiani Ophthalmology Associates, PC for all services furnished to be by that physician or supplier. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

My signature below will also serve as authorization to release information to my insurance company.

Print Name:_____

X Signature:_____ Date:_____