



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.**



## 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 paid 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 avert 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:\_\_\_\_\_