

Office Policies

- Please be prepared to provide us with the name and address of your primary care physician and pharmacy name and phone number
- If you are coming in for an emergency exam please be sure to contact primary care physician for referral if needed
- Please bring your medical health card so that we may keep on file for emergency medical visits
- Please bring your photo ID in order to comply with the RED FLAG LAW (prevention from identity theft)
- Our office will bill your insurance as a courtesy. If your insurance carrier denies payment, we will provide you with one statement and payment in full is expected upon receipt
- Exam copay is payable at the time of service
- 50% deposit is required at the time of eyeglass orders and payment in full at pickup
- Kindly give 24hr notice if appointment changes need to be made

Primary Care Physician (PCP)

Name: _____

Address: _____

Phone Number: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Please advise us of any doctors that you have seen within the past 6 months:

Please list all medication that you take:

Patient Information

Today's Date _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Home Number _____ Cell Number _____

Work Number _____ E-mail Address _____

Do you prefer to receive calls at: _____ Home _____ Work _____ Either

You or responsible party's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's Name _____ Workplace _____ Work # _____

If you are a student, name of school/college _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency? _____ Phone # _____

Health History

Do you or anyone in your immediate family have a history of the following?

____ Diabetes ____ Blindness ____ High blood pressure ____ Thyroid Disease

____ Cataracts ____ Glaucoma ____ Macular Degeneration ____ Turned/Lazy Eye

Please check any of the following conditions that apply to you:

____ Frequent headaches ____ Pregnant ____ Drug Allergies (list) _____

____ Allergies ____ Eye strain ____ Given birth last 6 months

Insurance Information

- **Please give BOTH your *vision* and *medical* cards to the receptionist**

• AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the eye doctor to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance co. to pay directly to the eye doctor or ophthalmic group, insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature (if spouse/guardian, please check here: _____)

For insurance purposes, please indicate by circling one of the following:

Minor Married Divorced Single Widow

Race: American Indian Alaska Native Asian Black or African American Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Gender: Male Female

Preferred Language: English Italian Spanish Portuguese French German

Date of birth of policy holder: _____ **Relationship to policy holder** _____

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [we will] [we usually will not] ask you for special written permission.

[We will ask for special written permission in the following situations: _____.]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photo copies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photo copies if we send you a written notice of the extension. If you want to review or get photo copies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing.

If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of _____ O.D., Notice of Privacy Practices. Date _____

Patient name _____ Signature _____

REVIEW OF SYSTEMS FORM

Name: _____ Today's Date: _____

DOB: _____ Patient #: _____

Instructions: *Please circle all symptoms that apply to you, or check "Negative"*

Category	Negative	Symptoms
General		Drowsiness, Insomnia, Sleep Disturbance, Restless Legs, Nightmares, Fatigue, Fever, chills, Sweats, Change in Appetite, Weight Gain/Loss
Eyes		Eye Injury, Light Sensitivity, Eye Surgery, Floaters, Flashing Lights, Pressure in Eyes, Cataracts, Double Vision, Eyes itch, Burn & Water, Eye Pain, Irritation
Ears, Nose, Mouth, Throat		Difficulty with: Hearing, Smell, Swallowing, Taste, Voice Pain: Throat, Nose, Ears, Mouth
Cardiovascular		Pain: Chest, Calf, Jaw, Lightheadedness, Ankle Edema (swelling) Chest Palpitations, Difficulty Breathing When Lying Flat, Shortness of Breath with Exertion
Respiratory		Shortness of Breath, Cough, Sputum Production, Rapid Breathing, Elevate Head to Sleep, TB Exposure, Choking
Gastrointestinal		Nausea, Vomiting, Diarrhea, Constipation, Abdominal Pain, Bloody or Black Stool, Fecal Incontinence, Pain with Swallowing
Genitourinary		Pain with Urination, Difficulty Urinating, Blood in Urine, Sexual Dysfunction, Kidney Stones, Chronic Pelvic Pain, Urgency, Frequency
Musculoskeletal		Pain: Neck, Back, Joint, Hip, Knee, Muscle Twitching, Hammertoes Swelling, Immobility, Arthritis, Muscle Cramps, Weakness
Skin		Hair Loss, Rash, Dryness, Discoloration, Itching, Eczema Bleeding Spot on Skin, Shingles, Bites, Nail Changes, Moles
Neurological		Headache, Seizure, Loss of Consciousness, Dizziness, Slurred Speech, Tremors, Weakness, Numbness, tingling, Gait Difficulty, Problem with: concentration, Memory, Word Finding
Psychiatric		Depression, Sadness, Crying Spells, Thoughts of Suicide, Paranoia, Irritability, Anxiety, Panic Attacks, Inability to Make Decisions, Visual or Auditory Hallucination, Hyperactivity, Behavioral Changes
Endocrine		Cold or Heat Intolerance, Excessive thirst, Hunger, Urination, Menstrual Irregularity, Diabetes, Thyroid Disease, Weight Gain or Loss
Hematologic/ Lymphatic		Easily Bruised, Rib Pain, Bone Pain, Enlarged Lymph Nodes, Anemia Clotting Problems, Bleeding from: Nose, Mouth, Rectum
Allergenic/ Immunologic		Hay Fever, Sneezing, Itching Eyes, Nasal Congestion, Post Nasal Drip, Sore Throat, Seasonal Allergies, Persistent Infections, Tick Bites
Smoking History		Current every day smoker, Current some day smoker, Former smoker, Never smoker, current status unknown, unknown if ever smoked

Latex Allergy Yes No

Send copies to (Please provide full name of Doctor):

PCP (Family Doctor) _____

Referring Doctor: _____ Other: _____

Patient Signature: _____ Provider Signature: _____

COMMUNICATION CONSENT

NAME _____

John P. Boscia, O.D.
2020 Sullivan Trail
Easton, PA 18040

Phone 610-258-6666

The office policy of John P. Boscia, O.D. and staff is not to release confidential and/or unauthorized information by home, telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize John P. Boscia, O.D. and/or their staff to leave medical information pertaining to my care by the following methods and will assume full responsibility to notify this office whenever this information changes.

- Home Telephone Yes No
- Answering Machine Yes No
- Work Telephone Yes No
- Voice Mail Yes No
- Cell Phone/Voice Mail Yes No
- Fax medical records to another entity Yes No

If you would like to have information released to someone other than yourself please complete the following names of authorized people:

Spouse _____

Parent _____

Other _____

Print Name _____

Patient/Guardian Signature _____

Date _____

Optomap Retinal Exam

Dr. Boscia, Dr. Pellerite and Dr. Rinehart are proud to present our patients with the **most highly advanced technology in retinal screening today**. Our Doctors are concerned about retinal problems such as **macular degeneration, glaucoma, retinal holes or detachments and diabetic retinopathy**. All of these can lead to loss of vision or blindness. Additionally, systemic diseases such as High Blood Pressure and Diabetes can be detected during a retinal exam. Because we continuously strive to provide to our patients the very best in eye care service, we recommend this following test as an enhancement to your basic examination:

(I) Optomap Retinal Exam, which provides:

- An eye wellness scan
- The Ability to review your Optomap images with your Doctor during your exam
- An annual, permanent record for your Medical file, which gives your Doctor a better way

to compare and look for change year after year.

The Optomap Retinal Exam is fast, easy and comfortable, and **does not require dilating drops**. (You will not have blurred vision or light sensitivity). It is recommended **for all patients**.

Insurance does not cover advanced screening tools such as the Optomap. **It is recommended that this exam be done annually**. If you have any questions about this exam, please do not hesitate to ask.

Optomap Retinal Exam: \$ 40.00

I understand that by declining the Optomap I am limiting the Doctors' ability to accurately determine the health of my eyes.

I choose to: _____Accept _____Decline

Print Name _____

Signature _____

Date _____