Michael G. Posner, M.D.
Leo Santamarina, M.D.
Syed A. Sami Karim, M.D.
Scott M. Goldstein, M.D.

John A. Godfrey, O.D.
Jordan J. Lubowitz, O.D.
Shawn D. Tubiello, O.D.
Alina Balasa, O.D.
Natalia Kobrenko, O.D.

We are happy to welcome you to Bucks-Mont Eye Associates and we thank you for choosing us for all your eye care needs.

After your visit, if there is anything that we can do for you, please do not hesitate to contact us. We are dedicated to being here for our patients.

It will help us to speed things up for you by filling out the attached paperwork and either mailing it to us in advance or if time does not allow for that, bring it with you to your appointment.

Please know that all new patients will be dilated. The drops used will enlarge your pupils to allow the Doctor to get a better view of the inside of your eye. These drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your Doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it’s best if you make arrangements not to drive yourself.

Lawn Avenue Professional Center – 711 Lawn Avenue – Sellersville, PA 18960 – 215-257-8053 Fax 215-257-2020

Bucks-Mont Eye Associates

PATIENT REGISTRATION

□ Miss □ Mrs. □ Ms. □ Mr. □ Dr.

PATIENT: ____ BIRTH DATE: ____________

Last Name First Name Middle

ADDRESS: ____

Street Apt/Box City State Zip Code

HOME PHONE: _________________________ WORK PHONE: _____________________________

CELL PHONE: __________________________ EMAIL ADDRESS: ____________________________

SOCIAL SECURITY #: _______________________ SEX: □ Female □ Male

RACE: __________________ LANGUAGE: __________________ ETHNICITY: □ Hispanic □ Non-Hispanic

STATUS: □ Single □ Married □ Widowed □ Separated □ Divorced

EMPLOYER: __________________________________ OCCUPATION: _______________________

HOW WERE YOU REFERRED TO US? ____

PHYSICIAN INFORMATION (ADDRESS AND PHONE NUMBERS ARE VERY HELPFUL)

REFERRING PHYSICIAN:___________________________________ PHONE:__________________

ADDRESS:____

PRIMARY CARE PHYSICIAN:________________________________ PHONE:__________________

ADDRESS:____

OTHER PHYSICIAN'S NAME: _______________________________ PHONE: _________________

ADDRESS: ____

INSURANCE INFORMATION

Responsible Party if other than patient: _________________________ RELATIONSHIP: _____________

Address if different from patient: ____

Street Apt/Box City State Zip Code

Primary Insurance:________________________ Subscriber:__________________ DOB:__________

ID#:___________________Group ID#:_____________ Relationship to Subscriber: □ Self □ Spouse □ Child

Secondary Insurance:______________________ Subscriber:_________________ DOB:__________

ID#:___________________Group ID#:_____________ Relationship to Subscriber: □ Self □ Spouse □ Child

IF INJURED: PLACE INJURY OCCURRED: □ Home or School □ Work □ Auto Accident

Date of Injury: ____________ Contact Person: __________________________ Phone: ____________

Assignment and Release: I hereby authorize my insurance and government benefits to be paid directly to Bucks-Mont Eye Associates. I am financially responsible for any balance due because of co-pay, deductible, referral/authorization not obtained prior to visit or incorrect insurance information. I agree to the terms of the BMEA financial policy. The policy has been posted and a copy is available upon request.

SIGNED: **X**____ DATE: _______________

Bucks-Mont Eye Associates

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.

Bucks-Mont Eye Associates respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information of Treatment, Payment and Health Operations

For Treatment:

- Information obtained by our technicians, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For Payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For Health Care Operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review by your health plan;
    - Accounting, legal, risk management, and insurance services
    - Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of Bucks-Mont Eye Associates. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, however, we will comply with any request that is granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request;
- You have to right to access your PHI in an electronic form if you specifically request it.
- Have us review a denial of access to your health information – except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months;
- Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing;
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. You revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance;
- We will not use or sell your PHI for any marketing purposes without your written authorization.

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For help with these rights during normal business hours, please contact:
Andrea English, Administrator at 215-257-8053

Our Responsibilities
We are required to:
- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice;
- We are required to give you notification if there is a breach of security of your PHI.
- We will restrict disclosures to health plans IF you choose to pay out-of-pocket in full for your health care services.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact Andrea English at 215-257-8053.

- If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Sue Loen at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.
- We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.
- Other Disclosures and Uses of Protected Health Information

Notification of Family and Others
- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief effort.
- Hospital information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
    - Your name
    - Location
    - General condition
    - Religion (only to clergy)

    You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:
- **With Medical Researchers** – if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations** (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration** (FDA) relating to problems with food, supplements and products.
- **To Comply With Workers' Compensation Laws** – if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public
    - To public health or legal authorities
        - To protect public health and safety
        - To prevent or control disease, injury or disability
        - To report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information
- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

BUCKS-MONT EYE ASSOCIATES

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. You may obtain a copy of this at any time.

I authorize the disclosure of my protected Health Care Information, including billing/financial information, to the persons listed below. This authorization will remain in effect until revoked.

NAME: ___________________________________ NAME: ______________________________________

PHONE:_____________ Relationship___________ PHONE:______________ Relationship____________

☐ Caregiver ☐ Emergency Contact ☐ Next of Kin ☐ Caregiver ☐ Emergency Contact ☐ Next of Kin

As a patient at our practice, from time to time we may need to communicate with you. To preserve your privacy, please indicate your preferred method for us to communicate medical information to you:

☐ Do **NOT** leave any medical information on my answering machine or voicemail

☐ I give my permission to Bucks-Mont Eye Associates to leave medical information on my answering machine or voicemail at the numbers listed: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

X____ ______________________

Patient Signature (or signature of legally authorized individual) Date

____ ______________________

PRINT Patient name Date of Birth

____

PRINT name if signed on behalf of the patient

Bucks-Mont Eye Associates, P.C.

FINANCIAL POLICY

(updated 7/18/2016)

Welcome and thank you for choosing BMEA for your eye care. We are committed to providing you with the highest quality eye care possible in a cost effective manner. We are pleased to discuss with you any questions you may have concerning your bill.

- **PAYMENT:** Payment is due when services are rendered. As a courtesy to our patients we accept cash, personal checks, money order, Visa, Mastercard and Discover. If insurance is being filed, you will be responsible for paying any co-pay, co-insurance or deductible amounts at the time of service. If you are unable to pay these amounts at the time of service, we are willing to bill you for the amount due with a $20.00 billing fee, or your appointment can be rescheduled.
- **INSURANCE CARDS**: Please make sure the insurance cards presented are current and accurate. We cannot be responsible if the wrong information is presented to us. You are ultimately responsible for providing the correct information.
- **REFERRALS**: Some insurance plans require a referral for services by a specialist. If your insurance plan requires a referral, it is your responsibility to obtain the referral prior to your visit. If you do not obtain a referral prior to your visit, we may ask you to sign a waiver that you are responsible for payment for this visit if a referral is not obtained. Alternatively, your appointment can be rescheduled.
- **PARTICIPATING INSURANCE PLANS:** If BMEA doctors do not participate in your insurance plan, you will be responsible for filing your own claims and paying in full at the time service is rendered.
- **NON-COVERED SERVICES/DENIED CHARGES:** Certain services may be considered non-covered services or may be denied as investigational, experimental, or not medically necessary by your insurance carrier. If your doctor feels these services are needed and they are performed, you are obligated to pay for these services in full should your insurance carrier deny payment.
- **MEDICAL PLANS WITH VISION BENEFITS**: Please be advised that some medical plans do have routine vision benefits. However, sometimes these vision benefits are with a different carrier. BMEA may participate with your medical plan but not your vision plan. Please contact your carrier to verify your benefits and whether BMEA is a provider for both your medical and vision plan. Please present all insurance cards at check-in.
- **VISION PLANS**: BMEA participates in a very limited number of vision plans. BMEA cannot file claims to both a vision plan and a medical plan for the same visit. Your diagnosis will determine if your exam is to be considered a Routine eye exam or a Medical eye exam. If your exam is determined to be a routine eye exam and BMEA does not participate in your vision plan, you will be responsible for paying in full at the time of service
- **REFRACTIONS**: A refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses. Medicare and most medical insurance carriers **do not** cover the fee for refractions. You are responsible for the refraction fee and it is payable at the time of service. We can, at your request, file your refraction charge with your insurance plan. If your insurance policy pays this refraction fee, we will issue a refund to you for the refraction charge. Medicare replacement plans (e.g. Humana, United Healthcare) do not cover refractions through their medical plan.
- **MEDICAID & KEYSTONE MERCY:** BMEA participates in these programs only for medical eye exams. BMEA does not participate in the routine vision portion of these plans. Patients over the age of 21 who have traditional Medicaid coverage, are allotted a number of office visits annually. If you have traditional Medicaid coverage and exceed your number of visits annually, you will be responsible for all charges. The Medicaid fiscal year is July 1st – June 30th.

Bucks-Mont Eye Associates, P.C.

FINANCIAL POLICY

(updated 7/18/2016)

- **RETURNED CHECKS & PAST DUE AMOUNTS:** Returned checks will be subject to a **$25.00** insufficient funds charge. All accounts are considered past due if not paid within 30 days of service. However, any outstanding balance after 90 days of the date of service may be referred to an outside collection agency for assistance with collecting the debt. Accounts referred to an outside collection agency may be subject to a collection fee of **33%**, which will be added to the total balance due at the time of write-off
- **SURGERY CHARGES:** BMEA will make every effort to determine your insurance benefits prior to your scheduled surgery. BMEA will notify you of the amount you will be responsible for paying prior to your scheduled surgery. Please keep in mind that this is just an estimate. You may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory and/or radiologist.
- **MEDICAL RECORDS RELEASE:** After written authorization is received, your medical record may be released. BMEA follows the Pennsylvania guidelines for charges applied for the release of these records.
- **AUTO ACCIDENTS:** Motor Vehicle Accidents (MVA's) can be filed to your auto insurance as a courtesy to you if requested. However, payment is due from you at the time of service. If the claim is then paid to BMEA, we will issue a refund to the patient.
- **WORKER'COMPENSATION**: Our office will send appropriate workers' compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full from you within 30 days of receipt of our bill.
- **PAYMENT PLAN:** Our office will be happy to work with you in order to pay any balance due to our practice. Please contact our billing department 215-258-5115 to work out a payment plan with our practice. Please allow 5 mail days prior to each due date for each payment to be received by our practice.

By signing BMEA patient registration form, I understand and consent to Bucks Mont Eye Associates, P.C. to use an automatic dialer to reach me. I will cooperate with the billing department of BMEA to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

MEDICAL HISTORY QUESTIONNAIRE

BUCKS-MONT EYE ASSOCIATES
711 Lawn Avenue • Sellersville, PA 18960
P 215-257-8053 • F 215-257-2020

Name: **Date of Birth:** **Date:**

Referring Doctor: ______________________ **Phone:** ______________
Family Doctor: ______________________ **Phone:** ______________
Specialists: ______________________

Review of Symptoms of Current Health Issues: (Please circle all that apply)

EYES: **Circle which eye**

Blurred Vision: Right Left **Eye Pain:** Right Left **Floaters:** Right Left
Loss of Vision: Right Left **Flashes of Light:** Right Left **Shadows:** Right Left
Distortion or Wavy Vision: Right Left **Glare:** Right Left
Do you currently wear glasses? Yes No **How old are your present pair?** ______________
Do you currently wear contact lenses? Yes No **Type of contact lenses:** ______________

Do you CURRENTLY have any problems in the following areas?	YES	NO	DETAILS
GENERAL/CONSTITUTIONAL: (headaches, fatigue, fever, insomnia, weight loss, weight gain, unusually tired, heat stroke)			
EARS / NOSE / THROAT: (hearing loss, stuffy nose, ear ache, cough, dry mouth, hoarseness, vertigo, etc.)			
CARDIOVASCULAR: (chest pain, high blood pressure, irregular heartbeat, palpitations, etc.)			
RESPIRATORY: (asthma, shortness of breath, sputum, TB Exposure, wheezing, etc.)			
GASTROINTESTINAL: (stomach upset, diarrhea, constipation, hernia, ulcers, nausea, vomiting, reflux, ulcer, etc.)			
GENITOURINARY: (painful urination, frequent urination, kidney stones, blood in urine, impotence, yellow jaundice, etc.)			
REPRODUCTIVE: Females: Are you Pregnant? Are you Nursing?			
MUSCULOSKELETAL: (arthritis, back pain, bone/joint pain, stiffness, swelling, cramps, etc.)			
DERMATOLOGIC: (acne, warts, growths, rash, etc.)			
NEURO/PSYCHIATRIC: (numbness, seizures, paralysis, Alzheimer's, anxiety, depression, dementia, Parkinson's, memory loss, etc.)			
METABOLIC/ENDOCRINE: (Diabetes, hypothyroid, hyperthyroid, increased thirst, increased urination, kidney failure, kidney removal, etc.)			
HEMATOLOGY: (bleeding, anemia, problems related to blood transfusion, bruises easily, blood clots, high cholesterol, etc.)			
ALLERGY/IMMUNOLOGIC: (sneezing, swelling, redness, itching, hives, lupus, etc)			

PLEASE CONTINUE ON OPPOSITE SIDE OF PAGE…………..

FAMILY HISTORY:

Are there any members of your immediate family (blood relatives) who have/had these diseases?

Disease/Condition:	Family Member				Disease/Condition:	Family Member			
Lazy Eye	Mother	Father	Sibling	Grandparent	Heart Disease	Mother	Father	Sibling	Grandparent
Arthritis	Mother	Father	Sibling	Grandparent	Hypertension	Mother	Father	Sibling	Grandparent
Blindness	Mother	Father	Sibling	Grandparent	Macular Degeneration	Mother	Father	Sibling	Grandparent
Cancer	Mother	Father	Sibling	Grandparent	Retinal Disorders	Mother	Father	Sibling	Grandparent
Cataracts	Mother	Father	Sibling	Grandparent	Stroke	Mother	Father	Sibling	Grandparent
Diabetes	Mother	Father	Sibling	Grandparent	Thyroid Disease	Mother	Father	Sibling	Grandparent
Glaucoma	Mother	Father	Sibling	Grandparent	Other Heritable Disease ________________				

SOCIAL HISTORY:

☐ **Does NOT Apply**

Have you ever been diagnosed with MRSA? YES NO

Do you Smoke? YES NO How many packs daily: _____ How many years: _____ ☐ Quit

Do you consume any alcohol? YES NO Amount: ____________ Frequency: ____________

Do you use illegal drugs? YES NO If yes, type/amount/how long: ____________

Do you drive? YES NO If yes, do you have visual difficulty when driving? YES NO Describe: ____________

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphillis

CURRENT MEDICATIONS:

☐ **NONE**

Please include ALL: Prescription, Over the Counter, Vitamins, Minerals, Herbs, Supplements, Eye Drops, Eye Vitamins

NAME OF MEDICATION	DOSAGE	DIRECTION

MEDICATION ALLERGIES:

☐ **NONE** ____________

PAST EYE HISTORY:

☐ **NONE**

CONDITION/DIAGNOSIS	PROCEDURE/SURGERY	EYE	DATE

PAST HISTORY OF ILLNESS AND/OR OPERATIONS:

☐ **NONE**

CONDITION/DIAGNOSIS	PROCEDURE/SURGERY	DATE

Physician's Signature: **Date:**