SCHEIN ERNST MISHRA EYE

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Welcome to Our Practice!

Your appointment:

Name: _____Day: _____Date: _____/_____/_____ Time: _____

Location: ☐ Harrisburg ☐ Lemoyne

Physician: ☐ Dr. Ernst ☐ Dr. Mishra ☐ Dr. Klombers ☐ Dr. Herbst ☐ Dr. Miller ☐ Dr. Sieber ☐ Dr. Paden

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Thank you for scheduling an appointment with Schein Ernst Mishra Eye, recognized by Bausch & Lomb as a center of excellence. For over 65 years, we have been working to provide state-of-the-art medical and surgical eye care in Central Pennsylvania. Our mission is to provide the highest level of service possible. The following packet is designed to help you on your first visit to Schein Ernst Mishra Eye.

The day of your appointment, it may last 1-3 hours. This can depend on your need for special testing, surgery scheduling, or procedures. Our staff makes every attempt to see patients in a timely manner, but unforeseen emergencies can cause delays.

Please arrive at least 10 minutes before your scheduled appointment time and bring the following:

- **New patient paperwork you have completed**
- **Insurance cards, Photo ID, form of payment**
- **Notes that you have hand carried from your referring doctor**
- **Prior approval from your primary care doctor if required by your insurance company**
- **Medication list including dosages and frequency of use**

During your first visit, you may receive dilating drops. These drops will make your near vision blurry and you will be sensitive to sunlight for several hours. We recommend sunglasses. If you do not have sunglasses, disposable pairs will be provided to you.

If you have suggestions on how we can improve our service, we encourage you to comment to our doctors or our staff. We may provide a survey to you. If you receive a survey, please help us by completing and returning this form. Please like us on Facebook to stay up to date on promotions, give-a-ways and general practice information.

We look forward to providing you with the best possible eye care.

Sincerely yours,
The Doctors and Staff of Schein Ernst Mishra Eye

Patient Demographic Form

Name: _____ Today's Date: _____
Last First MI

Address: _____
Street City State Zip

Phone: _____ _____ _____
Best # Daytime # Cell #

Date of Birth: _____ Gender: ❒ Male ❒ Female ☐ Non-binary ☐ Decline to Answer

Employer: _____ Occupation: _____

Social Security #: _____ Email: _____

Emergency Contact Name: _____ Best #: _____

Primary Care Physician _____
Address _____ Phone _____

Optometrist/Eye Doctor _____
Address _____ Phone _____

Health Insurance Information

(Please have **ALL** cards ready to provide)

Do You Have Health Insurance? ❒ Yes ❒ No Do You Have Medicare? ❒ Yes ❒ No
Do You Have Vision Insurance? ❒ Yes ❒ No Do You Have Medical Assistance? ❒ Yes ❒ No
If Other Than Yourself, who is the Subscriber of the Insurance: _____

Subscriber's Date of Birth: _____
Do You Have Secondary Health Insurance? ❒ Yes ❒ No

The following information is collected per the Federal Government regulation in the Health Information Technology Act (HITECH ACT). Your responses are optional.

☐ Decline all questions in this section

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

Race: ☐Asian ☐African American ☐Caucasian ☐Native American ☐Other: _____

How Did You Hear About Us? (Please check all that apply)

❒ Patient Referred _____ ❒ Current Doctor _____ ❒ Event _____ ❒ Yellow Pages
❒ Insurance ❒ PennLive ❒ Radio ❒ Google ❒ Facebook/Instagram ❒ Billboard ❒ TV ❒ Email
❒ Other _____

For office use only
Account #_____
Date: _____ Initials: _____

Health History Form

For Office Use Only: **Backfilled by**: _____
Date: _____

Patient information

Name _____
Last First MI
DOB _____ Occupation: _____

Gender: ☐ Female ☐ Male ☐Non-binary ☐ Decline to Answer

Pharmacy & Location: _____

Family Physician: _____

Location: _____
Are there any other doctors we should include in your care?
(Ex. Rheumatologist, Neurologist, etc.)
_____
_____
_____

The following information is collected per the Federal Government regulation in the Health Information Technology Act (HITECH ACT). Your responses are optional.
☐ Decline all questions in this section
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Preferred Language: _____
Race: ☐Asian ☐African American ☐Caucasian
☐Native American ☐Other: _____

Past Medical History

Have you ever received a pneumonia vaccination? ☐Yes ☐ No
Do you have/Have you had the following: (check)

☐ Diabetes If Yes, Were/Are you on Insulin? ☐ Yes ☐ No
☐ High Blood Pressure ☐ Heart Disease ☐ High Cholesterol

Please specify the following:

☐ **Blood Disorders** _____
_____
☐ **Stomach or Digestive Orders**: _____
_____
☐ **Neurological Disorders:**(ex. Alzheimer's/Multiple Sclerosis, Stroke, Parkinson's)
_____
_____
☐ **Psychological Disorders** (ex. Anxiety/Depression)
_____
_____
☐ **Lung Disorders** (ex. Asthma/Emphysema/COPD)
_____
_____
☐ **Thyroid Disorders**: _____
_____
☐ **Arthritis/Joint Disorders**: _____
_____
☐**Liver/Kidney/Prostate Disorders:** _____
_____
☐**Other Medical Issues (Please List)** _____
_____
_____
_____

Eye History (Check if Yes)

☐ Contact Lens ☐ Eyeglasses
☐ Lazy Eye ☐ Glaucoma
☐ Cataracts ☐ Cataract Removal Surgery
☐ Retinal Tear ☐ Retinal Detachment
☐ Eye Injury ☐ Eye Surgery (please list)
_____

Family History (Blood Relatives)

☐ Glaucoma/ High Eye Pressure Relation: _____
☐ Retinal Detachment Relation: _____
☐ Macular Degeneration Relation: _____
☐ Cataracts Relation: _____
☐ Diabetes Relation: _____
☐ Blindness Relation: _____
☐ Heart Disease Relation: _____
☐ Stroke Relation: _____

List all current medications including eye drops

Medication	Dosage/Quantity/Times per Day
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

List all Allergies (Medications and Environmental)
_____
_____
_____

List All Surgeries:
_____
_____
_____
_____

List All Previous Hospitalizations:
_____
_____
_____
_____

Social History

Alcohol ☐ Yes ☐ No Frequency: _____
Tobacco ☐ Yes ☐ No Frequency: _____

REVIEW OF SYSTEMS

Constitutional
□ Chills
□ Fatigue
□ Fever
□ Headaches
□ Loss of Appetite
□ Night sweats
□ Weight gain
□ Weight loss
□ Unexplained weight loss

Head/Ear/Nose/Throat
□ Ear ache
□ Hearing loss
□ Jaw claudication
□ Mouth sores
□ Nosebleeds
□ Runny nose
□ Sinus problems
□ Sore throat
□ Stuffy nose

Cardiovascular
□ Hypertension
□ Arrhythmia
□ Chest pain
□ Heart attack
□ Heart murmur
□ Heart trouble
□ Irregular heart beat
□ Racing pulse
□ Shortness of breath
□ Swelling of the feet

Respiratory
□ Congestion
□ Cough
□ Coughing up blood
□ Difficulty breathing
□ Dyspnea on exertion
□ Severe or frequent colds
□ Shortness of breath
□ Sleep apnea
□ Wheezing
□ Wheezing or asthma attacks

Gastrointestinal
□ Abdominal pain
□ Bloody stools
□ Change in bowel movements
□ Constipation
□ Diarrhea
□ Heartburn
□ Jaundice or yellow skin

Gastrointestinal (cont.)
□ Nausea
□ Stomach ulcers
□ Trouble swallowing
□ Vomiting

Genitourinary
□ Bladder trouble
□ Blood in urine
□ Dialysis
□ Frequent urination
□ Genital sores or ulcers
□ Kidney problems
□ Kidney stones
□ Pain or burning on urination
□ Prostatitis
□ Testicular pain
□ Urinary discharge

Psychiatric
□ ADHD
□ Anxiety
□ Autism
□ Bipolar disorder
□ Confusion
□ Dementia
□ Depression
□ Loss of memory
□ PTSD
□ Schizophrenia

Integumentary
□ Bruises
□ Loss of hair
□ Rash
□ Skin lesions
□ Skin sores
□ Skin cancer
□ Severe itching
□ Tick or insect bite

Neurological
□ Dizziness
□ Fainting
□ Headaches
□ Numbness
□ Numbness & tingling
□ Paralysis in parts of body
□ Paralysis of extremities
□ Scalp tenderness
□ Seizures or convulsions
□ Stroke
□ TIA

Neurological (cont.)
□ Tremor
□ Weakness

Musculoskeletal
□ Arthritis
□ Back pain while sleeping or awakening
□ Joint pain
□ Muscle aches
□ Painful or swollen joints
□ Stiffness
□ Swelling

Endocrine
□ Cold intolerance
□ Diabetes
□ Hair loss
□ Heat intolerance
□ Insomnia
□ Loss of menstrual period
□ Thyroid disease

Hematology / Oncology
□ Blood clots
□ Anemia
□ Cancer
□ Frequent or easy bleeding
□ Frequent or easy bruising
□ Phlebitis
□ Received blood transfusion
□ Swollen lymph nodes

Allergy / Immunologic
□ Arthritis
□ Autoimmune disease
□ HIV
□ Immune deficiency
□ Lupus
□ Seasonal allergies
□ Sjogren's syndrome
□ Unspecified

Refraction Information Sheet

Effective for all refractions done
1 year from signed date on this form

Refraction is the measuring of the current "refractive-error." A refraction is done to determine whether a patient is nearsighted, farsighted, has astigmatism, and whether glasses are necessary or need to be changed. Refraction is a necessary part of a work up for many reasons including blurred vision, eye strain, cataract, and YAG evaluation. The refraction is critical to helping us determine precisely how well you can see. If your vision cannot be corrected with glasses, you may have some form of an eye disease, and refraction is the only way we can effectively determine this.

Most medical insurance companies, including **Medicare**, do not cover the refraction charge. They require that we charge it as a separate charge item, apart from the medical exam. If you have vision insurance, your insurance may cover this refraction. Insurance companies require we obtain your signature as verification that you are aware of the billing policies. The fee for refractions is **$35.00**, and will be due at time of service.

This is an acknowledgement of a service that may or may not be performed during your evaluation. Please speak to your technician if you wish to decline as they will inform you of the refraction before it is performed.

Printed Name: _____

I have read and understand the policy as written above. I acknowledge that if, in the case of a medical diagnosis, my insurance may not cover the refraction and agree to pay the fee of $35.00.

Signature: _____ Date: _____

Patients Account Number: _____ (for office use)

Patient Financial Policy

Thank you for choosing **Schein Ernst Mishra Eye** as your eye care provider. We are committed to provide each of our patients with quality health care in a way that is financially responsible for both our patients and our practice. Your clear understanding of our Financial Policy is important to our professional relationship.

Consent for Treatment
By signing this form, I consent to and authorize my eye care provider to treat me. I understand that my provider is available to explain the treatment and I have the right to refuse treatment.

Insurance Billing
We participate in most major health insurance plans as well as many vision plans. As a courtesy to our patients, we will submit insurance claims to your carrier; however, we expect you to:

- Be responsible for understanding the details of your insurance coverage requirements, including routine vs. medical coverage for eye exams, pre-authorization for procedures, and annual deductible and copay/coinsurance amounts.
- Provide us with a current copy of your insurance card and notify us of any changes in your insurance coverage. If we do not have current insurance billing information, we will expect full payment at the time of service.
- If my insurance plan **requires a referral** and I arrive without one, I understand that I am financially responsible for payment of services.
- **Pay your copay/coinsurance/deductible at the time of service.**

Assignment of Insurance Benefits
I authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to me or my dependents by **Schein Ernst Mishra Eye**. I also authorize payment of benefits directly to **Schein Ernst Mishra Eye** for services provided to me or my dependents. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered.

No insurance
Patients without insurance, and only those patients without insurance, currently receive a **50%** discount off of our regular fees**. Payment for services rendered is due on the day of service unless other arrangements have been made.** This discount applies to all services rendered by our physicians only. It does not apply to any other provider of services, drug fees, or elective services such as LASIK, Lid surgery, or Botox. Patients with insurance already receive discounted rates through their insurance carrier and are not eligible to receive this discount.

Flip to back for more information & signature

Non-covered services
Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. An example is Refraction, which is a test required to measure visual acuity and to prescribe lenses. Although an important part of your eye exam, it is excluded from Medicare and many medical insurance plans. We are required to charge your refraction fee separately from your exam**. Payment for these services must be paid at the time of your visit.**

Minors
The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have an authorization for medical treatment signed by a parent or guardian and is responsible for providing current insurance information for self and/or payment in full for services provided.

Missed Appointments
We would appreciate your help and the courtesy of a phone call if you are unable to keep your appointment. At **Schein Ernst Mishra Eye** we work hard to meet the busy schedules of our patients when scheduling their appointments. Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require **48 hours advance notice** if you need to cancel or reschedule your appointment. If you cancel or reschedule late for consecutive appointments or fail to notify us for consecutive appointments, we will no longer be able to schedule an appointment in one of our offices. Appointment reminders calls or texts will be sent as a courtesy.

Patient's Right to Privacy
In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we have our Notice of Privacy Practices on display in the reception area and copies available at the front desk upon request. This document describes in detail how information about you, the patients, can be used within our office and with others who need to know the reason for treatment, payment, and/or health care operations.

Returned Checks
A $40 fee will be assessed to your account for each returned check. This fee and the original check amount must be paid in full with cash, credit card, or money order prior to your next appointment. After receiving two (2) returned checks, we will no longer accept checks as a method of payment.

By signing below, I attest I have read the above and authorize **Schein Ernst Mishra Eye** to treat, bill, and share my medical information as discussed above.

Signature of Patient / Parent or Guardian (if minor)

X _____ Date: _____

If Minor, please print patient Name: _____
Relationship to Patient: _____

Authorization for Disclosure of PHI to Family/Friends

This form is optional. Please print information if you would like to include someone in your care. Sign and Date at bottom. Please note, if a person is not listed on this form, we will be unable to relay to them any of your health information including test results, appointments, prescriptions, etc.

Patient Name: _____

SEME Account #: _____ Date of Birth: _____

I authorize the Schein Ernst Mishra Eye to discuss my appointment and/or medical information with another person, please list their name(s) and relationship below. **If you have a Power of Attorney, please document below. A copy of POA papers must be on file as well.**

_____
Name of Person Authorized Relationship

_____
Name of Person Authorized Relationship

_____
Name of Person Authorized Relationship

I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:
Entire patient record; **or**, check **only** those items of the record to be disclosed:

□ **All Medical Records**

□ Lab results, pathology reports □ Eyeglass Prescriptions

□ Visual Testing □ Contact Lens Prescriptions

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

□ Patient Request □ other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

_____ _____
Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.