NORWALK EYE CARE
5 Eversley Avenue Suite 301
Norwalk, CT 06851
(203) 853-1010

Welcome to our office!

Enclosed are the forms you need to bring with you at the time of your appointment. Please fill them out in advance.

We would appreciate it if you would also bring to your appointment the following:

- All current glasses and sunglasses
- Contact lenses or information regarding your contact lens prescription. (if applicable)
- A list of all medications including vitamins and any other supplements you are taking.
- Your vision and medical insurance cards.

We thank you for scheduling an appointment with our office and look forward to seeing you soon.

NORWALK EYECARE

PHONE (203)853-1010 5 Eversley Avenue Suite 301 Norwalk, CT 06851 FAX (203)866-0767

PERSONAL INFORMATION:

(Dr.__Mr.__Mrs.__Ms.__Miss__) Patient'sName_____ Date_____

(Single___ Married___ Divorced___Widowed___) (M__F__Trans___Other__ Prefers not to say___) DOB____/___/_____

Address_____ Email Address_____

City_____State_____Zip_____ Occupation_____Employed By_____

Home Phone #_____ Family Physician Name: _____

Business Phone #_____ Address:_____PH: _____

Cell Phone #_____ Emergency Contact _____ PH: _____

Social Security #_____ Referred by? Friend (name) _____
Internet _____ Insurance _____ Doctor _____Other_____

INSURANCE INFORMATION

Primary Insurance _____ Co-Insurance _____

Policy holder's name_____Relationship _____ Policy holder's name_____DOB___/___/____

Last four Policy holder's SS#_____DOB___/___/____ Relationship to patient_____

ID#_____ Group# _____ ID# _____Group#_____

MEDICAL HISTORY

Reason for Your visit today: _____

Please list any medications you are currently taking: _____

Please state any medications you are ALLERGIC to: _____

Please list any Surgeries you have had: _____

Please CIRCLE: Are you CURRENTLY, have you PREVIOUSLY or have you NEVER worn contact lenses?

If CURRENT please list what type and how long you have worn them _____

Social History:

Do you use nutritional supplements (vitamins etc.)? Yes No Do you engage in Regular Exercise? Yes No

Do you Smoke or chew tobacco? Yes No If yes how many packs a day? _____ Year quit: _____

Hobbies/Interests: _____

Statement: I agree to pay for all services rendered that are not covered by insurance.

Patient (parent or guardian) Signature: _____

Eye History

Yes ◯	No ◯	Glaucoma
Yes ◯	No ◯	Cataract
Yes ◯	No ◯	Macular Degen.
Yes ◯	No ◯	Retinal Detachment
Yes ◯	No ◯	Color Blindness
Yes ◯	No ◯	Headaches
Yes ◯	No ◯	Light Sensitivity
Yes ◯	No ◯	Tired Eyes
Yes ◯	No ◯	Amblyopia
Yes ◯	No ◯	Burning
Yes ◯	No ◯	Dryness
Yes ◯	No ◯	Excess Tearing
Yes ◯	No ◯	Eye Pain
Yes ◯	No ◯	Foreign Sensation
Yes ◯	No ◯	Infection Eye/Lid
Yes ◯	No ◯	Itching
Yes ◯	No ◯	Mucous Discharge
Yes ◯	No ◯	Drooping Eyelid
Yes ◯	No ◯	Redness
Yes ◯	No ◯	Sandy/Gritty Feeling
Yes ◯	No ◯	Strabismus(eye turn)
Yes ◯	No ◯	Blur Vision Distance
Yes ◯	No ◯	Blur Vision Near
Yes ◯	No ◯	Distorted Vision
Yes ◯	No ◯	Double Vision
Yes ◯	No ◯	Floaters/Spots
Yes ◯	No ◯	Fluctuating Vision
Yes ◯	No ◯	Loss of Vision
Yes ◯	No ◯	Loss of Side Vision

General Health Condition

Yes ◯	No ◯	Fever
Yes ◯	No ◯	Weight Loss
Yes ◯	No ◯	Other Symptoms
Yes ◯	No ◯	Ears, Nose ,Throat
Yes ◯	No ◯	Cardiovascular
Yes ◯	No ◯	Respiratory
Yes ◯	No ◯	Gastrointestinal
Yes ◯	No ◯	Kidney
Yes ◯	No ◯	Muscles, Bones, Joints
Yes ◯	No ◯	Skin
Yes ◯	No ◯	Neurological (MS)
Yes ◯	No ◯	Anxiety/Depression
Yes ◯	No ◯	Thyroid, Diabetes
Yes ◯	No ◯	Blood/Lymph
Yes ◯	No ◯	Nursing or Pregnant?

Family History

Yes ◯	No ◯	Amblyopia (Lazy Eye)
Yes ◯	No ◯	Blindness
Yes ◯	No ◯	Cataract(s)
Yes ◯	No ◯	Color Blindness
Yes ◯	No ◯	Glaucoma
Yes ◯	No ◯	Macular Degeneration
Yes ◯	No ◯	Retinal Detachment
Yes ◯	No ◯	Strabismus (Eye Turn)
Yes ◯	No ◯	Arthritis
Yes ◯	No ◯	Cancer
Yes ◯	No ◯	Diabetes
Yes ◯	No ◯	Heart Disease
Yes ◯	No ◯	High Blood Pressure
Yes ◯	No ◯	Kidney Disease
Yes ◯	No ◯	Lupus
Yes ◯	No ◯	Stroke
Yes ◯	No ◯	Thyroid Disease
Yes ◯	No ◯	Others

Notice of Privacy Practices

Effective date of notice: April 14, 2012

Norwalk Eye Care
5 Eversley Avenue
Norwalk, CT 06851
Ph: (203) 853-1010
Fax: (203) 866-0767
info@norwalkeyecare.com

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for treatment purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for treatment purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for payment purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.

- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for healthcare operations in a number of ways. Healthcare operations means, those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

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

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the 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, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosure 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 relating to workers' compensation programs.
- Disclosures to business associates, who perform healthcare operations for us, and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

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 healthcare 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 **Norwalk Eye Care** at the address, fax or email shown at the beginning of this notice.
- You can 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 email to your personal email 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 **Norwalk Eye Care** at the address, fax or email shown at the beginning of this notice.
- You can 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. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies 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 required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to **Norwalk Eye Care** at the address, fax or email shown at the beginning of this notice.
- You can 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 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 **Norwalk Eye Care** at the address, fax or email shown at the beginning of this notice.
- You can 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), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, 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 **Norwalk Eye Care** at the address, fax or email 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 in compliance with and 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 or have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 **Norwalk Eye Care** at the address, fax or email 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 **Norwalk Eye Care** at the address or phone number shown at the beginning of this notice.

Acknowledgement of Receipt of Notice of Privacy Practices

Norwalk Eye Care • 5 Eversley Avenue • Norwalk, CT 06851 • (203) 853-1010

Patient Name: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Dr. Mark S Feder, Dr. Jennifer L. Stewart, and Dr. Danielle J. Feder.

_____ _____

Signature Date

If signing as a personal representative of the patient, please describe your relationship to the patient:

_____ _____

Relationship to Patient Print Name

□ Please check this box if you are willing to allow us to share information with your spouse or other members of your immediate family.

A. Notifier: Norwalk Eye Care

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

Note: Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the **testing circled in box "D"** below.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
Exam Copay		Exam Copay $ _____
Contact Lens Exam Fees/Copays		New fit $250-$325Exist $99-$149
		$ _____ Copay or _____ % off
(MPOD) Macular Pigment Ocular Density		$27
OCT (Retinal, Optic Nerve, Angle)		$99 Medicare $54
OCT (Well Vision Screening)		$29
Ocular photos/OPTOS		$53 (VSP/Eyemed/Blueview $39)
Pachymetry		$45
Refraction		$79
Tear Lab		$79 Medicare $45
Visual Field		$99-129

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the **Test(s) circled in box "D"** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but we are not required to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **Test(s) circled in box "D" listed above**. I will pay now, but I also want my insurance billed for an official decision on payment, which will be sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I will not be refunded but **I can appeal to my insurance** by following the directions on the EOB. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **Test(s) circled in box "D" listed above**. I understand it is not covered by my insurance and am responsible for payment now. **I understand I cannot appeal if my insurance is not billed.**

☐ **OPTION 3.** I don't want the **Test(s) circled in box "D" listed above**. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call your insurance company. The phone number should be located on the back of your insurance card. Signing below, means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: