Pediatric Ophthalmology & Strabismus Associates

Cynthia L. Alley, M.D.

Welcome to our practice!

We would like to thank you for choosing Pediatric Ophthalmology & Strabismus Associates for your eye care. We are committed to providing you with the best possible care in a friendly, comfortable environment. The following information is meant assist you with any questions, and help you prepare for your visit with us.

To help prevent delays on the day of your appointment, please read the enclosed information and fill out the required forms ahead of time. Please bring the completed forms with you to your appointment. We ask that you arrive 15 minutes prior to your scheduled appointment time. Please note that if you arrive more than 15 minutes **after** your scheduled appointment time, you may be asked to reschedule. We will make every effort to see you at your scheduled appointment time. Sometimes emergencies, or other situations that are out of our control may arise, resulting in us running behind schedule. We will make every effort to notify you upon your arrival if we are running behind.

If for any reason you need to cancel your appointment, please give us at least 24 hours notice. If you fail to show up for your appointment, or cancel with less than 24 hours notice, you will be charged a $25.00 cancellation fee, which must be paid prior to your next appointment.

If someone other than a parent or legal guardian will be accompanying your child to their appointment, we require that you send a note stating the name of the person who will be bringing your child, and that it's OK for us to treat your child and instill dilating drops. For your convenience, we have included an authorization form that you can fill out, giving permission for your child to be accompanied to their appointment by a specified adult. The person bringing your child will be required to present a photo ID. We also need to have a number to reach you (the parent or legal guardian) during the exam. Please note, we have to refuse examination or treatment if we have any concerns with who is accompanying the child to the appointment.

WHAT TO EXPECT AT YOUR FIRST VISIT

Your exam will begin with an evaluation by an ophthalmic assistant. She/he will perform a detailed history, visual acuity, confrontational visual fields, ocular motility, pupil assessment and binocular vision testing. If there are motility (strabismus) issues, the doctor will see the patient prior to dilation. None of these tests will hurt or surprise the child. After that, drops will be instilled to dilate the pupils. It usually takes approximately 30 – 45 minutes for the drops to work. This is done so that the doctor can see details about the back of the eye, and also assess the need for glasses.

The initial appointment will last approximately 2 hours and will include dilation. Dilation typically lasts about 12-24 hours. The patient may be light sensitive and have some difficulty seeing small details up close (usually within arms distance) during that time. However, some people have difficulty seeing at farther distances and have difficulty driving. Children can return to school with their pupils dilated. We can give you a note for school explaining that the vision may be blurry after the eye exam. **Please note, with the exception of some adults with strabismus, it is necessary to perform a dilated eye exam on the initial visit. Otherwise, the doctor will not have all of the information necessary to provide advice or treatment suggestions**.

Again, thank you for choosing our office. We are looking forward to meeting you. If you have any questions prior to the visit, please feel free to call us, or visit our website at www.posa-pa.com.

3855 West Chester Pike ● Suite 335 ● Newtown Square, PA 19073 ● P: 610-347-7672 ● F: 610-347-7673
www.posa-pa.com

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BRING TO YOUR FIRST APPOINTMENT

- Cash, check or credit card (MasterCard, Visa or Discover) for copays and any services not covered by your insurance company.
- All medical insurance cards (even if we don't participate)
- Driver's license or state identification.
- Completed New Patient Forms
- If applicable: Glasses, contact lenses, contact lens box and/or name.
- A referral from your primary doctor, if required by your insurance company.
- Authorization for child to be accompanied by adult other than parent (if applicable)

YOU AND YOUR INSURANCE

MEDICAL vs VISION INSURANCE Our ophthalmologists are medical doctors and will be providing you with a very comprehensive, medical eye exam. Therefore, our services will be billed through your medical insurance. We do not accept vision insurance plans. Please be aware that some plans have clauses in their policies about some eye problems and classify them as non-payable. We will make every effort to appeal these types of rejections and educate your plans about ocular pathology and needed evaluation/treatment. However, we can't guarantee success in every scenario and you will be responsible for the bill if we can't obtain appropriate payment. Please remember that we didn't choose your plan for you and it is impossible for us to know every detail and clause in your plan.

CO-PAYS AND DEDUCTIBLES Our contract with your insurance company requires that we collect any known co-pays and/or deductibles. We are in violation of our contract if we don't collect these fees. We will be collecting these fees at your visit. Please be prepared to pay at this time.

REFRACTIONS A refraction is a specialized service performed to determine the prescription for glasses. Many eye conditions require a refraction for proper diagnosis and treatment. If a refraction is required, we will bill your insurance company for the service. Some insurance companies may not pay for refractions, therefore, it could be an out-of-pocket cost to patients. Our current fee for this service is $30.00.

INSURANCE REFERRALS If your insurance company requires that you obtain referrals or authorizations from your primary care physician (i.e. pediatrician, internist), it is your responsibility to request the referral prior to your visit. You may need to pick the referral up from their office - check with your primary care physician. Also, please remember you will need a referral for every visit. If we do not have your referral at the time of your appointment, you will be asked to reschedule.

I have read the above and understand that none of the Ophthalmologists of Pediatric Ophthalmology & Strabismus Associates participate with vision plans. Instead, my medical plan will be billed. I also recognize that some insurance companies will not pay for an exam for every ocular diagnosis, and some insurances may not pay for certain tests like refractions. I understand that I am responsible to pay for services not covered by my insurance. I also understand that it is my responsibility to request a referral from my doctor prior to my scheduled appointment, if required by my insurance company.

_____ _____

Signature Date

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Patient Privacy Notice

We are required by Federal Law under HIPAA (Health Insurance Portability and Accountability Act) to notify you of our Patient Health Information Privacy Policy. A copy of the policy is available at our front desk, and also on our website. You may review it there at any time, or request a copy to take with you. We are also required to obtain your signature indicating that we have offered you a copy of our Policy.

By signing below, you are confirming that you understand that a copy of our Patient Health Information Privacy Policy is available any time upon request or on our website, www.posa-pa.com.

Patient Name_____

Signature _____
(Parent or Guardian signature if patient is a minor)

Relationship to Patient _____ Date_____

Authorization to Disclose Medical Information

It is the policy of our office to send a summary with the pertinent information to your/your child's primary care physician, or other physicians involved in your care, after each visit, or periodically for three reasons:

1. To document the visit for referrals which may be required by your insurance company
2. To keep your primary care physician updated as to the diagnosis and treatment of your eye condition
3. In response to consultation requests by your primary care physician or another physician who referred you to this office for consultation, second opinions or treatments

☐ I AGREE to the release of medical information to my/my child's primary care physician or other physicians involved in my/my child's medical care as outlined above.

☐ I DO NOT AGREE to the above release of medical information, with the exception of:

_____

Signature: _____

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Patient Registration

Patient's Name :_____ ☐ MALE ☐ FEMALE

DOB: _____ Social Security #: _____

Address:_____

City/State/Zip:_____ Phone #: _____

Parent / Guardian Information (if patient is a minor)

Mother's Name:_____DOB:_____SS#:_____

Address: _____

City/State/Zip:_____Phone #: _____

Place of Employment:_____Phone #: _____

Email Address: _____

*Is it ok to call you at work? ☐ YES ☐ NO *Is it ok to email you appointment reminders, paperwork, etc? : ☐ YES ☐ NO

Father's Name:_____DOB:_____SS#:_____

Address: _____

City/State/Zip:_____Phone #: _____

Place of Employment:_____Phone #: _____

Email Address: _____

*Is it ok to call you at work? ☐ YES ☐ NO *Is it ok to email you appointment reminders, paperwork, etc? : ☐ YES ☐ NO

Emergency Contact Information

Name:_____ Phone #: _____

Address: _____

City/State/Zip:_____ Relationship to Patient: _____

Insurance Information

Primary Insurance: _____

Name of Policy Holder:_____ Relationship to Patient: _____

DOB Of Policy Holder:_____ Policy Holder's SS #: _____

Policy #: _____Group #: _____

Place of Employment: _____

Secondary Insurance: _____

Name of Policy Holder:_____ Relationship to Patient: _____

DOB Of Policy Holder:_____ Policy Holder's SS #: _____

Policy #: _____Group #: _____

Place of Employment: _____

Please provide your insurance card to copy for our records. Insurance co-pay/deductible and referral (if applicable) are due at the time of service. By signing below, you agree to these terms and authorize Pediatric Ophthalmology & Strabismus Associates to bill your insurance.

_____ _____

Patient/Parent/Guardian Signature Date

Patient Information - Adult

Please complete all questions on this form

Name: _____ Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____ Sex: M / F (circle one)

Do you wear glasses or contact lenses? ☐ Yes ☐ No How old is your current prescription? _____

Reason for today's visit:_____

_____

When was the approximate onset of the problem? _____

Are you **currently** experiencing any of the following? Please check all that apply.

☐ Abnormal Head Position	☐ Droopy Eyelid	☐ Eye Misalignment
☐ Double Vision	☐ Dry Eyes	☐ Headaches
☐ Blurry/ Decreased Vision	☐ Eye Injury	☐ Other_____

General Medical History (Please check all that apply)

☐ High Blood Pressure	☐ Brain Tumor	☐ Hearing Loss
☐ Diabetes	☐ TIA/ Stroke	☐ Bell's Palsy
☐ COPD/ Emphysema/ Asthma	☐ Neurologic Disorder	☐ Myasthenia Gravis
☐ Arthritis	☐ Seizures	☐ Thyroid Problems
☐ Heart Disease	☐ Parkinson's Disease	☐ Multiple Sclerosis
☐ Bleeding Disorder	☐ Headache/ Migraine	☐ Sjogren's Syndrome
☐ Cancer	☐ Psychiatric Disorder	☐ Genetic Disease
☐ Kidney Disease	☐ Drug/ Alcohol Addiction	☐ Other _____

List all medications currently being taken: _____

_____

Are you allergic to any medications? ☐ No ☐ Yes Please List: _____

Previous Surgery: _____

Ocular History (Please check all that apply)

☐ Amblyopia (Lazy Eye)	☐ Macular Degeneration	☐ Glaucoma Surgery
☐ Strabismus (eye misalignment)	☐ Retinal Detachment	☐ Keratoconus
☐ Eye Muscle Surgery	☐ Diabetic Retinopathy	☐ Corneal Transplant
☐ Cataracts	☐ Retinal Surgery	☐ LASIK / PRK
☐ Cataract Surgery	☐ Glaucoma	☐ Other _____

Primary Doctor		Referring Doctor (if different from primary doctor)	
Name		**Name**	
Address		**Address**	
Phone	**Fax**	**Phone**	**Fax**