Welcome to Our Practice!

MISSION STATEMENT

We are Total Eye Care & Cosmetic Laser Centers, a group of caring individuals working together as a team to support our practice mission of providing our patients the highest quality of eye care in a friendly and efficient environment. We feel privileged to serve our patients by utilizing the most advanced technology available.

We are ***"Dedicated to a Lifetime of Healthy Vision and the Aesthetics of Skin Rejuvenation."*** Our goal is not only to meet every aspect of our patients' needs, but also to exceed their expectations. It is an attitude that separates excellence from mediocrity.

OUR DOCTORS

Harmon C. Stein, MD
Judith B. Lavrich, MD
Chirag Shah, MD
Angana Shah, MD

Vincent F. Sardi, MD, FACS
Raymond M. Cianni, OD
Christine R. Nicholson, OD
Louisa Gaiter-Johnson, OD

- Comprehensive Adult and Pediatric Eye Care
- Management of Ocular Disease
- Laser Vision Correction – Custom LASIK, Bladeless LASIK, PRK
- Laser and Surgical Treatment of Glaucoma
- No Stitch Cataract Surgery
- Crystalens® "Center of Excellence"
- Visian Implantable Collamer Lens (ICL)
- Adult and Pediatric Eye Muscle Surgery
- Vision Therapy for Focusing and Convergence Problems
- Management of Dry Eye
- Macular Degeneration and Diabetic Retinopathy Therapy
- Medical and Surgical Treatment of the Retina
- Full-Service Optical - Latest in Designer Eyewear
- Contact Lenses – Specialty-Fit, including Custom Design for Hard to Fit Patients
- Cosmetic Procedures & Eyelid Surgery
- Botox® & Dermal Fillers (Juvéderm®, Restylane®, Radiesse®, Sculptra®)
- Skin Rejuvenation - Laser Skin Resurfacing, Chemical Peels, Skin Tightening Procedures, Medical Grade Skin Care Products, and Facials
- Waxing, Reiki & Oncology Skin Care

OFFICE LOCATIONS

1568 Woodbourne Road, Levittown, PA 19057
P: 215.943.7800 F: 215.943.7993

451 South State Street, Newtown PA, 18940
P: 215.968.5000 F: 215.968.5520

2999 Princeton Pike, Lawrenceville, NJ 08648
P: 609.873.3000

2495 Brunswick Pike, Lawrenceville, NJ 08648
P: 609.882.8828 F: 609.530.0317

website: www.totaleyecarecenters.com
e-mail: info@totaleyecarecenters.com

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____understand that as part of my health care, **TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Policies** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC change their notice, they will send a copy of any revised notice to the address I've provided (whether US Mail or, if I agree, email) prior to implementation.

[ ] **I authorize** TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to call in prescription renewals, when I so request, and recognize that the office arrangement may allow for other patients to inadvertently overhear my name and the prescription name(s). I understand if I choose not to permit this activity, TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC may be unable to telephone prescription orders and refills and will provide me with written prescriptions, or will require the pharmacist to call the practice for refill orders.

[ ] **I authorize** TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to provide prescriptions and prescription refills to other members of my immediate family.

[ ] **In the event that I need to be admitted to any hospital**, I understand that TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC will be required to call ahead and make admission arrangements for me. In this event, I understand that the office arrangement may allow for other patients to inadvertently overhear my name and the admission information. I understand if I choose not to permit this activity, TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC may incur delays with my admission information.

[ ] **I understand** that the practice of TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC is to call me to advise me of the results of laboratory tests or for other purposes. I hereby authorize TOTAL EYE CARE CENTERS, PC and/or WOODBOURNE OPTIK, INC to leave telephone messages at my home phone number that may include negative test results and requests for me to call the office to obtain test results or to make office appointments.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept / decline** the terms of this consent. (Please circle one).

Patient / Legal Guardian Signature:_____ Date: _____

In the Case of a Minor, Relationship to Patient: _____

FINANCIAL POLICY

Revised 1-27-17

total eye care & Cosmetic laser centers
vision care . lasik . aesthetic eyelid surgery . skin rejuvenation

Your Visit to Our Office: Please bring your current insurance card with you to your appointment. Please complete all registration forms prior to your visit to our office, if possible, as this will expedite the check-in process. (Patient forms are available for download and print on our website at www.totaleyecarecenters.com) **It is extremely important that your registration forms are kept up-to-date for billing purposes.** In the event that any of it has changed, you will be responsible to advise us so we may update your records.

Health Insurance: If you will be using your health insurance to settle your account, you must present your **CURRENT** insurance card to each visit. This is a requirement of your insurance company. Your health insurance is a contract between you, your employer, and the insurance company. We are not a port of that contract. Not all services are covered in all insurance contracts. Any non-covered service will be the patient's responsibility. **Co-payments and deductibles are to be paid at time of your visit or your appointment will be rescheduled. If we do not participate with your insurance, payment is required in another form.** We will provide you with an itemized bill so that you may submit the charges to your carrier for reimbursement.

Refraction: $50.00 A refraction is the part of the exam that checks a patient to see if they need a prescription or change in a current prescription. This is usually optional, unless your doctor feels it needs to be done. If you DO NOT wish to be refracted, please tell the technician when you go back for your exam. Be aware that refractions are often non-covered services.

Self-Pay: If you are self-pay, you will be expected to pay the day's charges on the day of the service. If you are having surgery, you will be expected to make mutually agreeable payment arrangements prior to receiving the service. If the service is considered elective (LASIK, refractive, and cosmetic procedures), payment must be made in full prior to the services being performed.

Auto Insurance / Legal Claims / Workman's Compensation: If you are seeing a physician as a result of an auto accident or other injury related to a legal claim against a third party, you will be considered self-pay. We will not file a claim with your auto insurance company or await a court settlement to be resolved. Also, several of our physicians provide services under workers compensation plans. If you need to see a physician for an injury related to your employment, please have your employer or workers compensation case manager make the appointment. Should you make the appointment yourself, be advised we must confirm your injury with your employer before being seen. You will need to provide us with the case number as well as the address to which the bill is to be sent.

Miscellaneous Forms: There will be a minimum processing fee of **$15.00** for all forms requiring a doctor's signature. Please remember to bring all forms at the time of your visit. More complex forms may have an additional charge.

Past Due Accounts: Should your balance extend beyond thirty days of your initial statement date you may receive a courtesy collection call from our accounts receivable staff to resolve the amount. Should your balance extend sixty days or more past your initial statement date, collection procedures will commence, and you will be charged a **25% late/collection fee**. Past-due accounts cost both time and money; therefore, patients with delinquent accounts will be required to make payment at the time of service. Should your account be sent to a collection agency you must pay all past due amounts or make agreeable payment terms before subsequent appointments can be scheduled. Additionally, patients may be dismissed from our practice for financial matters.

Un-Cancelled, Missed or No-Show Appointments: Your appointment time is reserved for your care. In the event that you must cancel or re-schedule, please give the office at least 24 to 48 hours' notice if you will not be able to keep your appointment. This will allow us the opportunity to offer your time to another patient. **In the event that you do not provide appropriate notice, you will be charged $45.00 for the missed or no-show appointment.** Payment of this fee is your responsibility and not a service reimbursed by your insurance company.

Records Release: Should the need arise to have your confidential medical records released our processing fee varies based on the size of the records. Allow five (5) business days for preparation and duplication. Appropriate HIPPA complaint corms must be signed and personal photo identification is required for pick up.

CONFIRMATION OF NOTICE: I understand the Financial Policies at Total Eye Care Center.

Patient or Authorized Responsible Party's Signature_____

Patient's Name:_____ **Date:**_____

total eye care & Cosmetic laser centers
vision care . lasik . aesthetic eyelid surgery . skin rejuvenation

MEDICAL HEALTH QUESTIONNAIRE

Name:_____ **Date:** ____/_____/____ **DOB:** ____/_____/____ **Age:** _____

Reason for visit:_____

Do you have any allergies to any medications, including Latex and Iodine? **YES NO**

If YES, please list the medications:

_____

List all major illnesses (diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

List any surgeries you have had (cataract, appendectomy):_ _____

Children under 5: Birth Weight ____lbs____oz Gestation _____weeks Pregnancy Normal / _____

Do you currently have any problems in the following areas? If **YES**, provide additional information:

	Y	N	Details
Eyes (poor vision, eye pain, tearing, redness, etc.)			
General/Constitutional (fever, heat stroke, weight loss/gain, tiredness)			
Ears/Nose/Throat (hard of hearing, ear ache, cough, dry mouth, etc.)			
Cardiovascular (high BP, racing pulse, etc.)			
Respiratory (congestion, wheezing, short of breath)			
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
Genital/Kidney/Bladder(painful urination, frequency, impotence, jaundice, etc.)			
Females – Are you pregnant or nursing?			
Muscles/Bones/Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, Rosacea, etc.)			
Neurological (numbness, headache, seizures, paralysis)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, insomnia)			
Blood/Lymph (bleeding, anemia, blood transfusion, etc.)			
Allergic/Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History: Has any member of your family (Mother, Father, Grandparent, Sibling) had any of these diseases?
(Circle all that apply & indicate family member)

Stroke _____ Heart Attack _____ Retinal Detachment _____ Glaucoma _____ Eye that turns _____
Diabetes _____ Hypertension _____ Macular Degeneration _____ Blindness _____ Lazy Eye _____
Arthritis _____ Thyroid Disease _____ Cancer (Type?) _____ Wore a patch when younger _____

Social History: Does your vision limit any activities of daily living (driving, reading, sports, work, etc.?) **YES NO**
Have you ever been exposed to HIV or Hepatitis? **YES NO**
Do you drink alcohol? **YES NO** If YES, how much? _____
Do you smoke? **YES NO** If YES, how much? _____

Visual History:
Date of Last Exam: _____ Previous Eye Doctor: _____ Do you wear eyeglasses? **YES NO**
Have you ever had an injury to your eye? **YES NO -** What/When? _____
Do you wear contact lenses? **YES NO**

Do you have (Check all that apply):
□ Glaucoma □ Cataracts □ Retinal Disease □ Trouble Reading □ Headaches □ Dry Eyes □ Itchy Eyes □ Red/Watery Eyes
□ Trouble Seeing Distance □ Eye Fatigue When Using Computer □ Eye That Turns or Wore a Patch When You Were Younger

ARE YOU INTERESTED IN? (Check all that apply):

□ Wearing Contact Lenses/Bi-Focal Contacts
□ Options for Dry Eye
□ Skin Rejuvenation for the Eyes or Face
□ Botox® for facial lines
□ Dermal Fillers to Add Volume to the Face
□ LASIK – Laser Vision Correction
□ Cosmetic Eyelid Surgery
□ Latisse® for Growing Longer Eyelashes
□ Removing Facial Vessels/Skin Tags
□ Removing/Reducing Brown, Liver or Age Spots

Would you like a complimentary consultation with our medical aesthetician to discuss skin care advice or products?
□ YES □ NO

total eye care & Cosmetic laser centers

PATIENT REGISTRATION – CONFIDENTIAL

PLEASE COMPLETELY PRINT THE FOLLOWING AND SIGN BELOW

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	SSN#	BIRTHDATE	SEX

ADDRESS	APT, SUITE	CITY, STATE, ZIP

HOME PHONE	WORK PHONE	CELL PHONE	MARITAL STATUS	LANGUAGE

EMAIL ADDRESS (*FOR APPOINTMENT REMINDERS & COMMUNICATIONS*)	PHARMACY NAME AND PHONE NUMBER

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

HOW WOULD YOU LIKE YOUR APPOINTMENT CONFIRMED?

☐ AUTOMATED PHONE CALL ☐ EMAIL ☐ TEXT

HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	GUARDIAN LAST NAME	GUARDIAN FIRST NAME

EMERGENCY CONTACT RELATIONSHIP	PATIENT EMPLOYER NAME

GUARANTOR INFORMATION

GUARANTOR LAST NAME	GUARANTOR FIRST NAME	PATIENT RELATIONSHIP TO GUARANTOR

ADDRESS (IF DIFFERENT FROM PATIENT)	APT, SUITE	PHONE NUMBER

CITY, STATE, ZIP	GUARANTOR SSN#	GUARANTOR EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER	POLICY HOLDER NAME	POLICY HOLDER SSN#	DATE OF BIRTH

PATIENT RELATIONSHIP TO POLICYHOLDER	PRIMARY INSURANCE ID#	GROUP#

SECONDARY INSURANCE CARRIER	POLICY HOLDER NAME	DATE OF BIRTH

PATIENT RELATIONSHIP TO POLICY HOLDER	SECONDARY INSURANCE ID#	GROUP #

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION "HIPPA"

THE FOLLOWING PERSONS MAY RECEIVE AND DISCUSS INFORMATION REGAURDING MY HEALTH CARE:

NAME	PHONE NUMBER

NAME	PHONE NUMBER

NAME	PHONE NUMBER

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO **TOTAL EYE CARE CENTERS PC** FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTER FOR MEDICARE SERVICES (CMS) AND ITS AGENTS OR OTHER AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____ _____/_____/_____

Signature of Patient/Patient's representative Date

total eye care & Cosmetic laser centers

MEDICATION LIST

PATIENT NAME: _____ **DATE:** _____

Name of Medication	Dosage (mg, microgram, etc.)	How Many Times a Day

TELEPHONE CONSUMER PROTECTION

PLEASE READ AND SIGN BELOW

You agree, in order for us to service your account or to collect monies you may owe, Total Eye Care Centers, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Total Eye Care Centers, P.C., its employees and/or agents may contact me/us as described above.

_____ _____/_____/_____

Signature of Patient/Patient's representative Date