Bannett & Della Torre Eye Physicians

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Board Certified Ophthalmologic Surgeon

PLEASE BRING ALL YOUR EYE MEDICATIONS WITH YOU IN A PLASTIC BAG**.**

Dear Patient:

Welcome To Our Practice!

In an effort to efficiently serve you, we are sending you these papers prior to your appointment. PLEASE BE SURE ALL PAPERS ARE FILLED OUT AND SIGNED BEFORE YOUR APPOINTMENT. PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT.

You will need to bring the following to your appointment:

- Medication list
- All insurance cards
- Referrals – if you do not have a required referral, you will need to reschedule
- Copay, if your insurance requires

.

Please note that one of our doctors is allergic to fragrance, so we ask that you please refrain from wearing perfume, cologne, or scented lotions on the day of your exam. Also, since your eyes will be dilated for the exam, we recommend that you have someone drive you home, as the dilating drops can compromise your vision. We also recommend that you bring sunglasses with you for comfort from sun glare.

PLEASE BE AWARE THAT WE DO NOT DO CONTACT LENS FITTINGS. .

If you have Medicare and need a refraction, there will be a $50 charge which you should be prepared to pay at your visit. REFRACTIONS ARE NOT COVERED BY MEDICARE. If you have a secondary insurance that covers refractions, we will refund your payment after your secondary pays. If your secondary insurance follows Medicare guidelines, they will NOT pay for refraction because Medicare does not pay for refraction.

PLEASE RESCHEDULE YOUR APPOINTMENT IF YOU HAVE COLD OR FLU SYMPTOMS

IF YOU ARRIVE TO YOUR APPOINTMENT WITHOUT YOUR PAPERWORK COMPLETED WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT

Wills Eye Institute affiliate

Custom Cataract Surgery, Advanced Implant Technology, Diabetic Retinopathy and Macular Degeneration Treatment Center, Laser Surgery, Glaucoma, Dry Eye Care, Comprehensive Eye Care

Bannett & Della Torre Eye Physicians

Last Name: _____ First Name: _____Mid. In_____
Dr/Mr/Ms/Miss/Mrs (circle one) Date of Birth: _____ Sex: M ☐ F ☐
Marital Status: Single Married Divorced/Widow(er)
Home Address_____ Apt#: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____-_____ Cell Phone: (_____) - _____ - _____
Email:_____@_____Social Security #:_____ --- _____ --- _____
Occupation: _____ Retired: Yes ____ No ____
Work Phone#: (____) _____Present Employer:_____
Employer's Address: _____
Referred By: _____
Name of Family Physician: _____ Phone#: (____) _____-_____
Physician's Address: _____
Optometrist: _____ Phone#: (_____) _____ - _____
Name of Spouse/Parent: _____ Date of Birth: _____
Spouse or Parent's Social Security #: _____---_____---_____
Spouse's Employer: _____ Retired: Yes No

PRIMARY INSURANCE:

Insurance Name: _____
ID#: _____ Group #_____
Subscribers Name (If Different from patient):_____
Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other (check one)
Subscriber's Address (If Different from patient): _____
Subscriber's Date of Birth: _____Subscriber's Social Security#: _____---_____---_____
Phone#: _____Retired: ☐ Yes ☐ No

SECONDARY INSURANCE:

Secondary Insurance Name: _____
ID#: _____Group#: _____
Subscribers Name (If Different from patient):_____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other (check one)
Subscriber's Address (If Different from patient): _____
Subscriber's Date of Birth: _____Subscriber's Social Security#: _____---_____---_____
Phone#: _____ Retired: ☐ Yes ☐ No

PATIENT OR AUTHORIZED SIGNATURE:

ALL INSURANCE: I authorize the release of any medical information necessary to process this claim and request payment of benefits to Bannett Eye Centers. I understand I am financially responsible for all fees and will be billed for any balance & deductible my insurance does not cover.

X_____ Date: _____

MEDICARE ONLY: I request that payment of authorized Medicare benefits be made to Bannett Eye Centers for any services furnished me by that physician. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____Date of Birth: ____/____/_____ Date: ____/_____/_____
Primary Care Physician: _____Referring Dr._____
Email address: _____@_____ Local Pharmacy: _____
Location(street & city) _____Phone #_____
Mail Order Pharmacy: _____
Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White or Caucasian □ Other _____ □ Unknown
Ethnicity: □ Hispanic □ Not Hispanic
Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese □ Russian □ Spanish

Allergies:	**Reaction:**	**Severity:**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular Health (please check all that apply):

□ Overall Healthy	□ Diabetic Retinopathy	□ Iritis	□ Optic Neuritis
□ Amblyopia (Lazy eye)	□ Dry Eye	□ Keratitis Sicca	□ Retinal Detach
□ Cataracts	□ Glaucoma	□ Macular Degeneration	□ Retinal Disesase
□ Conjunctivitis	□ Injury/Trauma	□ Uveitis	

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery	□ Foreign Body Removal	□ Punctal Plugs	□ Yag Capsulotomy
□ Blepharoplasty	□ Glaucoma Surgery	□ Retinal Laser (□ Rt eye □ Lt eye)	
□ Cataract Surgery (□ Rt eye □ Lt eye)	□ Intravitreal Injections	□ Vitrectomy	□ Strabismus surgery
□ Laser surgery for glaucoma	□ Radial Keratotomy	□ Corneal Transplant	□ PRK/LASIK (refractive surgery)

Other_____

Current Eye Medications: (Please list)

_____

Systemic Illnesses that currently have or have had in the past:

□ Acid Reflux	□ Carotid Artery disease	□ Heart Attack	□ Lupus
□ Ankylosing Spondylitis	□ Congestive Heart Failure	□ Heart Disease	□ Migraine
□ Anxiety Disorders	□ COPD	□ Hepatitis	□ Multiple Sclerosis
□ Arrhythmia	□ Deep Vein Thrombosis	□ High Blood Pressure	□ Rheumatoid Arthritis
□ Arthritis	□ Depression	□ High Cholesterol	□ Seasonal allergies
□ Asthma	□ Diabetes	□ HIV/AIDS	□ Stroke/TIA
□ Autoimmune Disease	□ Gastric ulcers	□ Kidney Disease	□ Thyroid Disease
□ Cancer	□ Headache		

Active Infections for which you are being treated:

_____

Other_____

Major Surgeries: (Please list)

_____

_____

_____

Patient Name: _____ **Date of birth:** _____

Current Medications: **(Please list, or reference a list you provide to us)**

_____

_____

Family History **(Indicate relation as maternal grandmother/father, paternal grandmother/father, parent, sibling,or child):**

Disease	*Relation*	*Living or Deceased*	*Approx. Age at Onset*
□ Arthritis	_____	_____	_____
□ Blindness	_____	_____	_____
□ Cancer	_____	_____	_____
□ Cataract	_____	_____	_____
□ Glaucoma	_____	_____	_____
□ Heart Disease	_____	_____	_____
□ High Blood Pressure	_____	_____	_____
□ Kidney Disease	_____	_____	_____
□ Lazy Eye	_____	_____	_____
□ Macular Degeneration	_____	_____	_____
□ Multiple Sclerosis	_____	_____	_____
□ Retinal Disease	_____	_____	_____
□ Stroke	_____	_____	_____
□ Tuberculosis	_____	_____	_____

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Circle applicable: cigarettes/pipe/cigar □ 1 pack/day □1/2 pack/day explain other quantities: _____

Alcohol Use: □ Yes □ No If yes, how much and how often?_____

Recreational Drug Use: □ Yes □ No If yes, what drug and how often?_____

Patient Name: _____ **Date of birth:** _____

Review of Systems:

Eyes
Previous Surgery
□ Contact Lens
□ Pain
□ Double Vision
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Dry Eyes
□ Flashes
□ Floaters

Ear, Nose, and Throat
□ Hard of Hearing
□ Ringing in Ears
□ Vertigo

Cardiovascular
□ Chest Pain
□ Dizziness
□ Fainting Spells
□ Shortness of Breath
□ Irregular Heartbeat
□ Difficulty Lying Flat

Constitutional
□ Fatigue / Weakness
□ Fever
□ Weight Gain / Loss

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma

Gastrointestinal
□ Heartburn
□ Nausea / Vomiting
□ Jaundice / Hepatitis

Genito-Urinary
□ Pain / Difficulty
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

Psychiatric
□ Anxiety / Depression
□ Mood Swings
□ Difficulty Sleeping

Endocrine
□ Increased Thirst
□ Increased Hunger
□ Increased Urination
□ Increased Sweating
□ Fingernail Changes

Blood / Lymph Nodes
□ Easy Bruising
□ Gums Bleed Easy
□ Prolonged Bleeding
□ Heavy Aspirin Use

MusculoSkeletal
□ Stiffness
□ Arthritis
□ Joint Pain / Swelling

Skin
□ Rash / Sores
□ Lesions
□ Hives / Eczema

Neurological

□ Seizures

□ Weakness / Paralysis

□ Numbness
□ Tremors

Immunologic
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure

Have you had 2 or more falls in the past year? ___Yes ___No

Have you had your flu vaccine this year? ___Yes ___No

Have you had your pneumonia vaccine this year? ___Yes ___No

Have you had your Covid-19 vaccine? ___Yes ___No

Name: Date of Birth:

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

EYE RELATED PROBLEMS	YES	NO	EXPLAIN
Loss of Vision			
Blurred Vision			
Distorted Vision (Halos)			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy/Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing/Watering			
Occasional Tearing			
Glare/Light Sensitivity			
Eye Pain/Soreness			
Styes/Chalazion			
Fluctuating Visual Acuity			

If possible please bring your pharmacy plans formulary booklet with you to your appointment

Bannett & Della Torre Eye Physicians

Social History

Current Occupation:_____

SOCIAL HISTORY	YES	NO	EXPLAIN
Do you drive?			
Do you have visual difficulty driving?			
Do you have a problem w/ vision at night?			
Have you ever tried wearing contacts?			
Do you currently wear glasses?			
Have you ever had a blood transfusion?			
Have you ever been in contact w/ someone who had an STD?			

History Reviewed : No Changes Additions as noted above

Physicians Signature: _____ Date:_____

Bannett & Della Torre Eye Physicians

NOTICE OF PRIVACY

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you have received in our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice serves to inform you that we have a policy regarding the ways in which we may use and share medical information about you. This policy includes a description of your rights and certain duties that we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY:

1. **To keep your medical information private**
2. **To make this notice available which describes our legal duties, privacy practices, and your rights regarding your medical information.**
3. **To follow the terms of the notice that is now in effect.**

WE HAVE THE RIGHT TO:

1. **Change our privacy policies and the terms of this notice at any time, provided that the changes are permitted by law.**
2. **Make the changes in our privacy policies and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.**

NOTICE OF CHANGES TO PRIVACY POLICIES:

1. **Before we make an important change to our privacy policies, we will change this notice, and make the new notice available upon request.**

I understand that this serves only as an overview, and a more detailed policy is available for my review upon my request:

X_____ Date:_____

I do hereby give my permission to Bannett Eye Centers, P.A to release some confidential medical information such as appointments, test results, medical prescriptions, refills and instructions, referral information and billing questions to my immediate family members or other concerned individuals involved in my healthcare. All other medical information will not be discussed without my expressed permission. Information may be conveyed by phone, fax, or in person.

X_____ Date:_____

PERMISSION TO LEAVE MESSAGES ON ANSWERING MACHINE/VOICEMAIL? _____

Bannett & Della Torre Eye Physicians

PATIENT OR AUTHORIZED SIGNATURE:

ALL INSURANCE: I authorize the release of any medical information necessary to process this claim and request payment of benefits to Bannett Eye Centers. I understand I am financially responsible for all fees and will be billed for any balance & deductible my insurance does not cover.

X_____ Date:_____

PATIENT CONDUCT AGREEMENT: I understand that no form of harassment, bullying, discrimination, threatening, abusive language, or conduct will be tolerated toward staff, visitors, patients or medical providers of Bannett Eye Centers.

X_____ Date:_____

MEDICARE ONLY: I request payment of authorized Medicare benefits be made to Bannett Eye Centers for any services furnished me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____ Date:_____

WHAT YOU NEED TO KNOW ABOUT BILLING & INSURANCE

Bannett Eye Centers, P.A will be happy to submit an insurance claim form to your insurance for you for today's visit. If we participate with your particular insurance plan, our billing office will receive an Explanation of Benefits telling us what the allowable amount of the services are, how much the insurance company is paying, how much we have to write off, and what you owe. You will receive this same Explanation of Benefits (EOB) in the mail. If we do not participate with your particular insurance plan, we will still be happy to submit a claim form to your insurance, however, you will be responsible for all charges incurred. Because we do not participate with your plan, we may or may not receive an EOB, and your insurance company may pay you instead of us. You should receive an EOB. EVERY PLAN IS DIFFERENT. Please do not expect us to know the details of your plan- that is your responsibility. WE STRONGLY ADVISE YOU to call your insurance company prior to your appointment.

I, _____ understand I will be financially responsible for the following:

1. **All charges which my participating insurance company applied to my deductible, copay, and co insurance.**
2. **All charges which are deemed "not covered" by my plan.**
3. **All charges for which I should have gotten a referral, but did not.**
4. **"Routine Eye Care" exams that are not covered under my plan.**
5. **All charges, if I have a non-participating insurance plan/company or no insurance at all.**
6. **Not giving the office accurate and current insurance information.**
7. **Refractions are not covered by most insurance plans, including Medicare and Medicaid. A refraction is the part of the eye examination that determines if you need prescription eyeglasses to improve your vision, or whether there has been a change in your prescription since your last visit. While a refraction is usually only needed once a year, sometimes it may be necessary more frequently, especially if a patient notices and complains about a change in his/her vision. IF YOU DO NOT WISH TO HAVE A REFRACTION PLEASE ADVISE THE OPHTHALMIC TECHNICIAN WHO WORKS YOU UP. You will need to sign a waiver stating that, by refusing a refraction, you understand that you are taking away this crucial piece of information from the doctor, which may impact your exam. You should also be aware that, without a refraction, the doctor will be unable to update your eyeglasses prescription.**
8. **Our current fee for a refraction is $50.**

**** Many insurances, including Medicare, will only allow you to see an ophthalmologist if you have a medical diagnosis, not a "routine eye care" diagnosis. Examples of "routine eye care" diagnosis are myopia (nearsightedness), hyperopia (farsightedness) and presbyopia (difficulty reading). You are required to know whether your plan covers "routine eye care" by an ophthalmologist.**

**** If you do not give us accurate and current insurance information, our claims will not be properly processed. Every insurance company has their own "timely filing" period- some as little as 90 days. If our claims are delayed because you give us the wrong information, you will be responsible for our bill.**

**** Payment is due at the time services are rendered. If there is a balance due on your account, we will send you a bill. We will send four bills before we send your account to our collections agency. If your account is turned over to a collection agency, you will also be responsible for their fee. Your signature indicates that you have read and understood the information provided in this statement.**

Agreed & Understood: _____ Date:_____

Bannett & Della Torre Eye Physicians

Things you should know about your visit with our Ophthalmologists:

YOU ARE SEEING A MEDICAL SPECIALIST. New patient visits may take up to 3 hours. Please plan accordingly.

YOUR EYES WILL BE DIALATED. We recommend that you bring a driver & sunglasses with you to your appointment. Everyone reacts to dilating drops differently.

WE DO NOT DO CONTACT LENSES. We can recommend some wonderful optometrists to you who do contact lens fit.

WE MAY NEED TO DO DIAGNOSTIC TESTING DURING YOUR APPOINTMENT. Your insurance may apply a coinsurance or deductible to the testing over and above your copay for the office visit.

YOU WILL PROBABLY BE REFRACTED. One of the most important parts of your eye exam is a refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider refractions as a "vision" service not a "medical" service. Our office fee for refraction is $50, and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment/co-insurance your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly. If you are coming to us for a cataract evaluation, we WILL be doing a refraction, even if you had one recently at another provider's office. Payment is due at the time of service.

_____ I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

_____ I declined the refraction service today. I understand that with the refraction, Dr. H. Bannett, or Dr. Della Torre may not be able to fully assess the health and function of my eyes.

Signature:_____ Date:_____