Consent to Treat & Financial Policy Statement 051120

Conestoga Eye PC
2104 Spring Valley Road, Lancaster, PA 17601
717-541-9700 www.conestogaeye.com

Thank you for choosing Conestoga Eye for your complete eye care. Dr. Silbert and the Conestoga Eye team value the trust and responsibility you place in us, and we look forward to establishing a long-term relationship with you and your family.

Consent to Treatment & Release of Medical Information

By signing above, I consent to examination and treatment with Conestoga Eye PC. I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician.

Medicare Patients

I request that payment of authorized Medicare benefits be made either to me on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to be released to the Center for Medicare and Medicaid Services and its agents to release any information needed to determine these benefits payable for related services. If Medicare denies payment, I agree to be personally and full responsible for payment.

Consent to Dilate

Dilating drops are used to enlarge the pupils of the eyes which allows the ophthalmologist or optometrist to view the health of your eye. Dilating drops are also used to for special testing, such as cycloplegic refractions.

The side affects of dilating drops can include blurry vision, light sensitivity, and trouble reading. These symptoms usually wear off in 4-48 hours depending on the strength of the drops and the individual patient. The drops can cause driving to be difficult. If you are not sure how the drops will affect you we suggest you bring a driver to take you home after your appointment.

On rare occasion patients may have a more severe adverse reaction to the drops, such as acute angle-closure glaucoma. This is rare and can be treated with immediate medical attention. Some patients may also experience facial flushing or change in mood.

When I child attends a screening appointment, it is possible that the undilated testing can indicate there is no refractive error and that the only reason to dilate would be to look in the back of the eye. In this event, our office recommends a iWellness OCT test. This test is not covered by insurance. I understand that not dilating my child and not getting the iWellness test means I/my child risk(s) having a sight threatening disorder or other disease left undiagnosed. I also understand that if my/my child's medical history or a finding during the examination warrants dilation, my doctor may request I schedule a follow up visit within 30 days.

I authorize Conestoga Eye (the doctor or assistant as may be designated by the doctor) to administer the dilating drops. The drops are necessary for a full comprehensive eye exam.

Financial Policy Statement

Registration and Financial Information

To process a claim on your behalf, it is important for you to provide your complete health care insurance coverage information, your employment information, and your guarantor (another individual responsible) information. It is our policy to update and/ or confirm the accuracy of this information at each office visit.

It is also your responsibility to inform us in a timely manner of any changes with your health care insurance. If an insurance company denies payment of a claim for incomplete or inaccurate information, it will then be your responsibility to make payment in full. If your insurance requires a referral form or prior authorization, it is your responsibility to obtain this form from your primary care physician prior to your appointment.

Payment at the Time of Service

Your insurance company will be billed for services rendered; however, please be prepared to pay any co-payments and non- covered services, including deductible charges, at the time of your visit. If you cannot pay your co-payment, we will reschedule your appointment to later in the day or to another day. All previous outstanding patient balances will be collected at the beginning of your visit unless other arrangements have been made.

Credit Cards

Conestoga Eye accepts Visa, MasterCard, American Express, and Discover. We offer the option to authorize payment of balances due after insurance payment is received. Please contact our office in advance to request this option. You may also pay your bill online at conestogaeye.com.

Self-Pay Patients

We offer a reasonable discount for our cash-paying patients. Cash-paying patients are asked to speak to our office at 717-541- 9700 for an estimate of what will be due at the time of service.

Payment Plans

Please contact the office at 717-541-9700 to discuss establishing a payment plan for large balances. The office will arrange for monthly payments or authorized automatic credit card transactions until the balance is paid in full.

Insurances, Health Plans, and Medical Benefit Programs

Conestoga Eye participates with many insurance companies. Contact your insurance company to inquire if we participate with them. A customer service number can be found on your insurance card. If we are non-participating, you can find out if you are authorized to receive care from an "out of network provider" and if any additional costs will be incurred. For a full list of insurances accepted by Conestoga Eye, visit conestogaeye.com.

Additional Charges, Fees, and Appointment Policies
There will be a $25 fee assessment for all checks returned unpaid by your bank.
Completion of disability forms and employer forms are not a medical service and are not paid by insurance companies. There is a $25 fee for completion of these forms.

There is a fee for copying medical records based on guidelines established by the Commonwealth of PA. A legal release is required.

Patients who cancel appointments with less than 24 hours notice OR no show for an appointment will be charged a $50 cancelation/no show fee. Patients who cancel 3 appointments or more OR no show for 2 appointments with our office, may be subject to discharge.

Patients are only able to reschedule an appointment 3 times with our office. Adults who reschedule more than 3 times may be subject to discharge from our office. Pediatric patients who have appointments rescheduled 3 times and must reschedule again, will only be given the option to reschedule at our KinderSee clinic. Should the patient cancel or no show the appointment at the KinderSee clinic, they will be subject to discharge.

If your account is not paid within 60 days, the account may be turned over to a collection agency. Collection and/or legal fees will be added to the balance of your account.

Lab/Hospital Charges
Any service provided by a lab, outpatient surgery center, or hospital is a contract between you and that lab, surgery center, or hospital. Any billing dispute is not the responsibility of our practice. It is your responsibility to know which procedures or services your insurance company will or will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

Thank you for choosing Conestoga Eye for your healthcare needs. Our mission is to provide you and your family with unparalleled eye care in a caring environment. If you have any questions about this information, please feel free to contact us by phone at (717) 541-9700 or by email with eyes@conestogaeye.com.

Patient Name: ________________________ Patient DOB: ____/____/_____

Patient Signature: ___________________________________ Date: _____________

Parent Signature: ___________________________________ Date: _____________

Community Chart Consent & SureScripts Consent

The Community Chart is a two-way communication with other offices and hospital systems. It allows us to pull information from LGH's Epic system as well as other systems.

SureScripts enables us to pull your medication history from your pharmacy.

I give my consent to Conestoga Eye to access the Community Chart in order to access and share my medical records if available through other entities operating under the CareQuality Interoperability Framework, including SureScripts. This includes demographic information as well as other relevant clinical documentation.

Patient Name: ________________________ Patient DOB: ____/____/_____

Patient Signature: ___________________________________ Date: _____________

Parent Signature: ___________________________________ Date: _____________

Patient Registration Form

Patient Information

First Name	Last Name	MI	Birth Date
Address	City	State	Zip
Home Phone	Cell Phone	Age	Sex M F	SSN
Email Address	Yes! Contact me by: (Select all that apply)	Email Phone Text
Occupation	Employer	Employer Phone
Employer Address	City	State	Zip
Marital Status: Single Married Widowed Divorced	Spouse's Name
Spouse's Birth Date	Spouse's SSN	Spouse's Employer	Spouse's Phone Number

Please complete if patient is under age 18 or a college student

Parent 1: First Name	Parent 1: Last Name	Relationship F M G	Parent 1: Birth Date
Parent 1: Home Phone	Parent 1: Cell Phone	Parent 1: Email Address	
Parent 1: Address	City	State	Zip	Parent 1: SSN
Parent 1: Employer	Parent 1: Employer Phone	Yes! Contact me by: (Select all that apply) Email Phone Text	
Parent 2: First Name	Parent 2: Last Name	Relationship F M G	Parent 2: Birth Date
Parent 2: Home Phone	Parent 2: Cell Phone	Parent 2: Email Address	
Parent 2: Address	City	State	Zip	Parent 2: SSN
Parent 2: Employer	Parent 2: Employer Phone	Yes! Contact me by: (Select all that apply) Email Phone Text	

Referral Information

Name of Family Physician	Name of Physician's Practice
Name of Optometrist	Name of Optometrist's Practice
Name of Preferred Pharmacy — Pharmacy Phone Number ( ) -	Pharmacy Addresss
Were you referred here today by any of your physicians? If so, whom?	
How did you hear about our practice?	

Patient Name ____ Patient Birth Date ______/_____/______

We ask the following questions for information gathering purposes only.
The answers have no bearing on patient care.
It helps us in our pursuit to provide better services to all patients.

1. Do you consider yourself to be Hispanic or Latino (see definition below) **?** **YES** **NO**

Hispanic or Latino: *A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".*

2. What race do you consider yourself to be? (If more than one race, select all that apply.)

- ○ **American Indian or Alaska Native** A person having origins in any of the original peoples of North, Central, or South America, and who maintain tribal affiliations or community attachment.
- ○ **Asian** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, or the Philippine Islands.
- ○ **Black or African American** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American".
- ○ **Native Hawaiian or other Pacific Islander** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ○ **White** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- ○ **Uncertain**

CONESTOGA EYE

Medical Review of Systems

Patient Name ______________________________ Patient Birth Date ______/______/______

Do you currently have any problems in the following areas?

Please circle **YES** if you have one of the issues/conditions listed below.

CONSTITUTIONAL	
Fever	Yes
Fatigue	Yes
Weight Loss	Yes
Weight Gain	Yes
EYES	
Loss of Vision	Yes
Loss of Side Vision	Yes
Distorted Vision or Halos	Yes
Fluctuating Vision	Yes
Flashes	Yes
Floaters	Yes
Eye Pain or Soreness	Yes
Light Sensitivity	Yes
Double Vision	Yes
Crossing or Drifting of Eyes	Yes
Redness	Yes
Discharge	Yes
Foreign Body Sensation	Yes
Sandy or Gritty Feeling	Yes
Dryness	Yes
Itching	Yes
Burning	Yes
Excess Tearing/Watering	Yes
Glare	Yes
Styes	Yes
Other	
EARS, NOSE, MOUTH, & THROAT	
Hearing Difficulty	Yes
Ringing	Yes
Vertigo	Yes
Sinus Congestion	Yes
Runny Nose	Yes
Post-Nasal Drip	Yes
Nosebleeds	Yes
Dry Throat/Mouth	Yes
Hoarseness	Yes
Jaw Claudication	Yes

CARDIOVASCULAR		
Chest Pain		Yes
Palpitations		Yes
Other		
RESPIRATORY		
Cough		Yes
Shortness of Breath		Yes
Wheezing		Yes
GASTROINTESTINAL		
Swallowing Difficulty		Yes
Vomiting		Yes
Heartburn		Yes
Diarrhea		Yes
Constipation		Yes
Nausea		Yes
GENITO-URINARY		
Urinary Frequency		Yes
Urinary Pain or Blood		Yes
MALES	Discharge	Yes
	Lesions or Masses	Yes
FEMALES	Currently Pregnant	Yes
	Breast Masses	Yes
	Breast Discharge	Yes
	Vaginal Bleeding/ Discharge	Yes
MUSCULOSKELETAL		
Joint Pain		Yes
Swelling		Yes
Redness		Yes
Muscle Pain		Yes
Muscle Cramps		Yes
SKIN		
Rashes or Color Changes		Yes
Itching or Dryness		Yes
Hair or Nail Changes		Yes

NEUROLOGICAL	
Headaches	Yes
Numbness	Yes
Tingling	Yes
Weakness	Yes
Paralysis	Yes
Fainting	Yes
Blackouts	Yes
Slurred Speech	Yes
PSYCHIATRIC	
Anxiety	Yes
Depression	Yes
Other (list)	
ENDOCRINE	
Heat Intolerance	Yes
Cold Intolerance	Yes
Excessive Thirst	Yes
Excessive Hunger	Yes
HEMATOLOGIAL	
Easy Bruising	Yes
Easy Bleeding	Yes
Blood Transfusions	Yes
Swollen Lymph Nodes	Yes
ALLERGY	
Seasonal Allergies	Yes
ADDITIONAL NOTES/COMMENTS	

ADULT Medical Information Form

Patient Name ____ Patient Birth Date ______/______/______

What do you wear? Glasses Contact Lenses

Please circle the yes if you have one of the conditions listed below.

Medical Problems

Condition	Please Circle	Date	Condition	Please Circle	Date
Alzheimer's	Yes		Lupus	Yes	
Arthritis	Yes		Migraine Headaches	Yes	
Asthma/COPD/Bronchitis	Yes		High Cholesterol	Yes	
Cancer: Type __________	Yes		Sarcoidosis	Yes	
Diabetes: Type ________	Yes		Seizures	Yes	
High Blood Pressure	Yes		Stroke	Yes	
Hepatitis/Jaundice	Yes		Syphilis/Gonorrhea	Yes	
Heart Disease	Yes		Thyroids Disease	Yes	
Head Injury	Yes		Tuberculosis	Yes	
HIV Positive/AIDS	Yes		*Other Medical Problems (Please List)*		
Kidney Disease	Yes				

Surgical History

Have you had **general** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Social History

Are you pregnant?	Yes
Do you smoke?	Yes
Do you drink alcohol?	Yes
Do you drink caffeine?	Yes
Do you use illegal drugs?	Yes

Family Medical Problems

Family members have	Please Circle	Relative
Glaucoma	Yes	
Macular Degeneration	Yes	
Diabetes	Yes	
Retinal Detachment	Yes	
Cataracts	Yes	
Amblyopia/Strabismus	Yes	
Other (list)		

Medications (Please List)

Name	Dosage

Are you allergic to any medications, iodine, latex, or anesthesia? Yes No If **yes**, please list below:

CONESTOGA EYE

PEDIATRIC Medical Information Form

Patient Name ______________________________ Patient Birth Date ______/______/______

What does your child wear? Glasses Contact Lenses

Please circle the yes if following apply to your child and the date it first occurred.

Medical Problems

Birth Information	Please Answer		Condition	Please Circle	Date
Gestational Age			Arthritis	Yes	
Delivery Type			Asthma/COPD/Bronchitis	Yes	
Emergency Delivery	Yes	No	Cancer: Type ______	Yes	
Birth Weight			Diabetes: Type _____	Yes	
Birth Abnormalities			Hepatitis/Jaundice	Yes	
Complications			Head Injury	Yes	
			Genetic Disorder	Yes	
Developmental Delays	None	Congnative	Migraine Headache	Yes	
	Delayed Motor Skills	Intellectual	Seizures	Yes	
	Learning	Motor	Stroke	Yes	
	Reading	Speech	Thyroid Disease	Yes	

Other Medical Problems (Please List)

Surgical History

Has your child had **general** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Has your child had **eye** surgery? Yes No

Surgery	Date	Surgeon/Hospital

Medications (Please List)

Name	Dosage

Is your child allergic to any medications, iodine, latex, or anesthesia? Yes No

If **yes**, please list below:

Family Medical Problems

Family members have	Please Circle	Relative
Glaucoma	Yes	
Macular Degeneration	Yes	
Diabetes	Yes	
Retinal Detachment	Yes	
Cataracts	Yes	
Amblyopia/Strabismus	Yes	
Other (list)		

Social History

Is your child pregnant?	Yes
Does your child smoke?	Yes
Does your child drink alcohol?	Yes
Does your child drink caffeine?	Yes
Does your child use illegal drugs?	Yes

CONESTOGA EYE HIPAA ACKNOWLEDGEMENT & RELEASE 051420

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Use information to solicit for marketing or fundraising purposes
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record.
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. - Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes

- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.
- Treat you. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research.
- Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions

CONESTOGA EYE HIPAA ACKNOWLEDGEMENT & RELEASE

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We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

This notice is effective for the date of signature forward.

If you have any questions, please contact HEATHER MODJESKY at 717-541-9700 ext 106 or heather@conestogaeye.com

Patient Name: ________________________ Patient DOB: ____/____/_____

Patient Signature: ___________________________________ Date: _____________

Parent Signature: ___________________________________ Date: _____________