WELCOME TO

Joseph Eye & Laser Center

Patient Name:_____

Appointment Date & Time_____ (Time noted allows for paperwork)

Welcome Joseph Eye & Laser Center. We are excited to announce Dr. Christopher Joseph has relocated to a new address as of July 1, 2019. Our goal is to make your experience here as pleasant as possible. Everything we do here is geared towards providing you, our patient, the highest quality medical and surgical care possible.

You should plan to be here 1.5 to 2.5 hours, depending on the extent of your examination and any additional tests, studies, or procedures that might be required.

PHYSICIANS:
Our physician is trained in the diagnosis and treatment of all eye diseases. He has a minimum of 5 years of specialized medical and surgical training between the D.O. degree, fellowship trained in advanced cataract and glaucoma surgery, with interest in pediatric and oculoplastic surgery.

OFFICE WEBSITE:
Please visit our website at: www.josepheyeandlaser.com

PLEASE BRING WITH YOU TO THE APPOINTMENT:

Medications - please either bring a current list of all medications you are taking or the medications in the bottles as received from the pharmacy.

Eye Glasses - please bring your best or most recent eyeglasses, even if they no longer improve your vision. The glasses will provide important information about the past condition of your eyes.

Contact Lenses - remove soft contact lenses two weeks prior to your exam if you are planning a cataract or Lasik evaluation. Gas permeable lenses must be removed minimum of 2 weeks or 1 week per decade of wear. (Ex: 30 years = 3 weeks removal).

Insurance Cards - please bring all current insurance cards with you to the appointment. We will bill your medical insurance, primary and secondary, for the medical eye exam and any additional tests, studies, or procedures performed. Any unpaid visits due to invalid insurance cards will become the patient's (parent/guardian) responsibility.

Photo ID - We are required to obtain a copy of your photo ID. This is to protect you from someone else using your medical insurance (a type of identity theft).

INSURANCE AND PAYMENT: (please refer to your insurance handbook for rules):

Self-Pay - If you are not covered by medical insurance, you will be expected to pay in full at the time of service.

Medicare - We accept assignment on Medicare. If you are a Medicare beneficiary and do not have secondary coverage, you will be responsible for payment of 20% of the Medicare allowed amount.

Deductible - Be prepared to pay your medical insurance deductible if it has not been met for the year.

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Copays - You are required to pay your insurance copay at the time of service. The copay amount is usually noted on your insurance card or can be found in your insurance handbook. Your copay will be collected upon check in.

HMO/Managed Care/OHP - If you are insured through a HMO, Managed Care, or PHP, you may need a referral-authorization from your primary care physician before your appointment. It is you responsibility to check with your insurance carrier prior to your visit regarding this and request from your primary physician if required. We will be forced to reschedule your appointment if referral is not received prior to your visit. Any unpaid visits due to invalid or non-referral will become the patient's (parent/guardian) responsibility.

Non-Covered Services: Some services might not be covered by your insurance. Most medical insurance plans, including Medicare, do not pay for "routine eye exams". Routine eye exams are exams which **do not** result in a medical diagnosis. For examples, diagnoses such as myopia (near-sightedness), hyperopia (far-sightedness), astigmatism, presbyopia (aging eyes) would not be considered medical. Routine eye exams also include "screening for eye disease" which does not result in a medical diagnosis. In the event of service not covered by your medical insurance, you will be responsible for the charges.

Payment Options - We accept Cash, Check, Debit, Visa, Mastercard, and Discover.

REFRACTION:
Refraction is a measurement of near-sightedness, far-sightedness, and astigmatism. Refraction is part of a complete eye exam and will be done at the initial visit. Medicare and most medical insurances do not cover refraction, but it is frequently necessary, to establish what a patients best corrected vision is. The refraction fee is **$30** and due at the time of service, whether or not it results in a prescription for eyeglasses.

DILATION:
Your pupils will probably be dilated during the initial visit. Dilation lasts several hours and may blur your vision. If you have not previously driven with dilated pupils, you should bring a driver.

GENERAL INFORMATION:
Our office hours are Monday - Friday 8:00 am to 4:30 pm (except holidays). We encourage you to call us anytime you have a question or problem with your eyes. Non-emergency calls are best handled during business hours. Emergency and after-hour calls are handled by our answering service or forwarded to the physician on call.

Office Phone Number: (330) 619-3155

Office Fax number: (330) 619-3175

Location & Parking: Brookfield Family Medicine Center
7264 Warren-Sharon Road
Brookfield Township, Ohio 44403

PLEASE USE ENTRANCE NEAR FRONT OF BUILDING - PARKING IS ALONG THE FRONT ENTRANCES; HOWEVER THERE IS ADDITIONAL PARKING IN REAR.

WE HAVE PROVIDED REGISTRATION FORMS FOR YOUR COMPLETION PRIOR TO ARRIVAL. PLEASE BRING COMPLETED PAPERWORK WITH YOU TO YOUR APPOINTMENT.

Joseph Eye
& Laser Center

Patient Info

Patient Name: _____Date_____
Date of Birth: _____Sex: Male / Female Age: _____ Marital Status: Single Married Divorced Widowed
Address: _____
Social Security Number: _____
Home Phone #: _____Cell Phone #:_____May we leave a voicemail? Y / N Text? Y / N
Email Address: _____
Spouse Name (Parent Name if Minor) _____Spouse/Parent Phone_____
Employer/Parent's Employer_____Occupation_____
Person to notify in case of Emergency (other than Spouse):_____
Best Contact Phone number: _____ Relationship: _____

Referred By? _____Family Doctor_____

Insurance Info

Primary Insurance Company:		
ID#:	Group #:	Effective Date:
Subscriber Name: (Person who carries the insurance)		Relationship to Patient:
Social Security #:	Date of Birth:	Employer:

Secondary Insurance Company:		
ID#:	Group #:	Effective Date:
Subscriber Name: (Person who carries the insurance)		Relationship to Patient:
Social Security #:	Date of Birth:	Employer:

I certify that I (or my dependent) have coverage as stated above and agree to have insurance payments made directly to Joseph Eye and Laser Center or Dr. Chris Joseph to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware that there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare, the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

Patients Signature _____ Today's Date _____

Patient Name: _____Date_____

Date of Birth:_____ Date of Last Eye Exam:_____

List any medications you currently take (RX and over-the-counter):_____

_____

Do you have allergies to any medications? YES NO If **Yes**, please list the medications:_____

_____

List ALL major illnesses (glaucoma, diabetes, high blood pressure, heart attacks, etc) or injuries (concussion, etc):

_____

List ANY surgeries you have had (cataract, appendectomy, etc): _____

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

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, etc)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc)			
CARDIOVASCULAR (high BP, racing pulse, etc)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc)			
GENITAL, KIDNEY, BLADDER (painful urinations, frequent urination, impotence, yellow jaundice, etc)			
FEMALES (Are you pregnant? Nursing?)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc)			
SKIN (pimples, warts, growths, rash, etc)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc)			
PSYCHIATRIC (anxiety, depression, insomnia, etc)			
ENDOCRINE (diabetes, hypothyroid, etc)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc)			

FAMILY HISTORY: (Mother, Father, Grandparent, Sibling)
Has any member of your family had any of the following diseases? YES / NO / UNKNOWN
(Circle all that apply): Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, or Other (If Other, please list: _____)

SOCIAL HISTORY: Have you ever had a blood transfusion? YES / NO
Do you drink alcohol? YES / NO (If yes, how much_____)
Do you smoke? YES / NO (If yes, how much_____ How many years_____)
Does your vision limit any activities of daily living? (Driving, reading, sports, work, etc) YES / NO

Physician's Signature_____ Date_____

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& Laser Center

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	**YES**	**NO**
May we leave a message on your answering machine at home or on your cell phone?	**YES**	**NO**
May we discuss your medical condition with any member of your family?	**YES**	**NO**

If YES, please name the members allowed:_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Joseph Eye
& Laser Center

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

DR. CHRISTOPHER JOSEPH OF JOSEPH EYE AND LASER CENTER
Name of Person/Organization Receiving Information

7264 WARREN - SHARON ROAD BROOKFIELD, OHIO 44403
Address City / State / Zip

(330) 619-3155 (330) 619-3175
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

__X__ Complete Medical Record
_____ Medical Records for Specific Dates of Service (please list) from _____ to _____
_____ Other (please list) _____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____ X _____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____
Description of Personal Representative's Authority (attach necessary documentation)

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Date Sent: _____ **By:** _____ **Via:** _____
(9/2013)

PLEASE SEND COMPLETE RECORDS