Facchina Eye Center

43 S. Washington Street
Greencastle, PA 17225
Phone: (717) 895-3950
Fax: (717) 895-3172
www.facchinaeyecenter.com

CONSENT FOR MEDICAL TREATMENT AND RELEASE OF INFORMATION

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Facchina Eye Center.

2. **Authorization for Release of Information:** Facchina Eye Center may release information from my medical records to any health care provider involved in my care and treatment. Facchina Eye Center may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Facchina Eye Center is no longer responsible for the confidentiality of any information known or possessed by the payer.

3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Facchina Eye Center which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Facchina Eye Center, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Facchina Eye Center. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.

4. **Pre-authorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Facchina Eye Center charges.

5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Facchina Eye Center.

6. **Charge for No Show/Cancellation without 24 hour notice:** I understand that 24 hour notice is required for canceling an appointment, and I will be charged a $25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

7. **Charge for Refraction:** I understand that a refraction may be necessary for the doctor to fully evaluate my condition, and I will be charged $40.00 for this service by the Facchina Eye Center. I also understand that I will be responsible for this charge and that my insurance company will not be billed for this service.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices from Stephen Facchina, M.D..

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

Authorized Individuals: The person(s) listed are allowed or not allowed to have information concerning my health and conditions.

Name: _____ Relationship: _____ Allowed: _____Yes _____ No

Name: _____ Relationship: _____ Allowed: _____Yes _____ No

In case of Emergency please contact: Name: _____ Relationship: _____

Address: _____ Phone Number: _____

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of Facchina Eye Center HIPAA Policy.**

_____ _____
Signature of Patient or Legally Responsible Person Name (Please print)

_____ _____
Relationship/Reason Why Patient Is Unable to Sign Date

Facchina Eye Center

Comprehensive Medical History

Name		Today's Date			
Address					
Phone: Home:		Work:		Cell:	
Birthday:		Social Security Number:			
Email Address:		Employer:			
Last Eye Doctor:		Last Eye Exam Date:			
Family Doctor:		Last Family Doctor Visit Date:			
Marital Status: o Married o Divorced o Widowed o Single o Other _____					

How do you prefer to be communicated with? Phone Home Phone Cell Mail Email Text

Race:_____ Ethnicity: _____

Special Needs: Wheelchair Hearing Aid Translator

Review of Eye Conditions and Systems - Please indicate any problems you have or had below:

EYE CONDITIONS	N	Y	Details	SYSTEM	N	Y	Details
Blurry Vision Distance/Near				Appetite Changes Decreased/Increased			
Bulging Eyes				Constipation/Diarrhea			
Crossed Eyes				Fever/Fatigue/Chills			
Discharge or Crusty				Light Headedness			
Distorted Vision-Halos				Rash			
Double Vision				Sleep Pattern Change/Insomnia			
Droopy Eyelid(s)				Heart Problems			
Dryness of Eyes				High Blood Pressure			
Eye Infections				High Cholesterol			
Eye Pain				Ear, Nose, Mouth, Throat Problems			
Flashes				Asthma			
Floaters in Vision				Emphysema			
Headaches or Migraines				Lung Disease/Chronic Lung Conditions			
Injury				COPD			
Itching/Burning				Hepatitis/ Type A B C			
Light Sensitivity/Glare				Kidney or Bladder Disease			
Loss of Vision				Rheumatoid Arthritis/Muscle/Joint Pain			
Loss of Side Vision/Periphial				Dizziness/Migraines/Seizures			
Pupils Dilated				Psychiatric			
Pressure-Feeling Behind Eye				Thyroid/other gland issues			
Redness				Diabetes			
Retinal Disease				Anemia			
Tearing				Bleeding Problems			
Twitching				Allergic/Immune Deficiencies			
Wavy Lines in Vision							

If you answered YES to any of the above, or have a condition not listed, please explain: _____

_____

List any medications you take including oral contraceptives, aspirin, over the counter medications and home remedies: _____

_____

Do you have any allergies to medications? YES or NO; If yes, explain: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number: _____

Guarantor: _____ Guarantor D.O.B: _____

Secondary Insurance: _____ Policy Number: _____

Guarantor: _____ Guarantor D.O.B: _____

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Past Present Patient Family Social History

Please note any personal and family history (parents, grandparents, brothers, sisters, children; living or deceased) for the following:

Disease Condition	Yourself	Unknown	Family Members
Glaucoma			
Cataracts			
Macular Degeneration			
Eye Injury			
Retinal Disease			
Blindness			
Strabismus			
Amblyopia			
Diabetes			
Dry Eye			
Eye Surgeries			
Other			

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

Dilation: Are you willing to be Dilated today? YES or NO Are you pregnant / nursing/ or planning pregnancy? YES or NO

Height _____ Weight _____ Last BP _____

Do you wear glasses? YES or NO If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? YES or NO If yes, how old is your present pair of lenses? _____

Type of contact lenses: Gas Perm, Soft, Extended Wear, Other _____Are your lenses comfortable? YES or NO

Social History: (the following information is kept strictly confidential).
If you prefer only to discuss this information with the doctor directly circle the following "yes" YES

Do you drive? NO YES If yes, do you have vision problems when driving? _____ If yes, explain: _____

_____

Do you use tobacco? NO YES If yes, type/how much/how long:_____

Do you drink alcohol? NO YES If yes, type/how much/how long:_____

Do you use illegal drugs? NO YES If yes, type/how much/how long: _____

Have you ever been exposed to or infected with Gonorrhea, Hepatitis, HIV, or Syphilis. YES NO

Additional Notes: _____

_____

Dr. Signature or Initials _____ Date _____