DELAWARE EYE SURGEONS, P.A.

2710 Centerville Rd. Suite 102
Wilmington, DE 19808

Name: ______________________ Birthdate: ____________ Age: ______

Address: ______________________ Sex: ______ SS# ______________

______________________ Email: ______________________

Home Phone: ______________________ Marital Status: ______________________

Cell Phone: ______________________ Race: __________ Language: ____________

Emergency Contact: ______________________ Phone #: ______________________

Employer/Occupation: ______________________ Phone #: ______________________

Referring Doctor: ______________________ Referred By: ______________________

Primary Care Doctor: ______________________ Phone #: ______________________

Pharmacy: ______________ Location: ______________ Phone#: ______________

INSURANCE INFORMATION- *Please fill in line 1,2, and 3 coverage is through a spouse or a patient. Line 1 if self.*

1. Primary Insurance: ______________________ ID#: ______________________ Group #: __________
2. Policy Holder: ______________________ Birthdate: ______________________
3. Social Security #: ______________________ Relation to Patient: ______________________

INSURANCE INFORMATION- *Please fill in line 1,2, and 3 coverage is through a spouse or a patient. Line 1 if self.*

1. Secondary Insurance: ______________________ ID#: ______________________ Group #: __________
2. Policy Holder: ______________________ Birthdate: ______________________
3. Social Security #: ______________________ Relation to Patient: ______________________

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION AND THE FILING OF INSURANCE CLAIMS PERTAINING TO THE SERVICES RENDERED TO ME BY DELAWARE EYE SURGEONS, P.A.

Patient or Legal Guardian Signature: ______________________________ Date: ______________________

S. Gregory Smith, M.D. & Associates

Cornea & Anterior Segment Surgery
Intraocular Lens Complications
Cataract & Refractive Surgery

Delaware Eye Surgeons, P.A.

2710 Centerville Road
Suite 102
Wilmington, Delaware 19808
302-993-1300
Fax 302-993-1400

9111 Antique Alley
Unit 3
Bridgeville, Delaware 19933
302-629-2333
Fax 302-629-8229

Health Insurance Portability and Accountability Act

Patient Privacy Right and Disclosure

Delaware Eye Surgeons, P.A. and its employees disclose information given to us by the patient to, the patient's insurance company, primary care physician, or other medical professionals for the purpose of treatment, payment of services rendered, or health care options.

We **do not** sell to mailing list or disclose personal information about our patients except that which is needed to carry out our objective, patient care.

Incompliance with HIPAA guidelines the patient understands that they have the right to review any information which is documented in the patient's record and the right to add an addendum to such records and the right to add an addendum to such records, if the record is disputed.

By signing this consent, you agree to allow Delaware Eye Surgeons, P.A. to use and disclose personal information about you for the reason above.

You have the right to revoke this consent at any time, but be aware that we cannot guarantee care unless we can communicate with the other health professionals.

I have read and understand the above policies:

______________________________ ________________________

Patient or Legal Guardian Signature Date

FINANCIAL POLICY FOR DELAWARE EYE SURGEONS, P.A.

INSURANCE- It is the patient's responsibility to supply **ALL** insurances at the time of visit. Failure to do so may result in claim denials which then becomes the patient's liability. It is also the patient's responsibility to fully understand their insurance coverage.

REFERRALS- If your insurance requires you to have a referral to see a specialist, you are required to have your referral prior to your visit. If the referral is **not** provided you will be asked to either reschedule or pay for the visit at the time of service.

CO-PAYS- ALL co-payments are due at the time of service. Failure to pay copay at the time of service may result in a late fee when billed. Any past due and payable balances are collected at the time of service.

SELF PAY ACCOUNTS- Self-pay accounts are patients with no insurance who pay out of pocket, an estimated amount for service is $150. Payment is required at the time of service for all services including surgeries.

NON-PARTICIPATING INSURANCE PLANS - The insurance company will be billed as a non-assigned claim as a courtesy to the patient with the patient's payment to the practice in full at the time of service. The insurance company may reimburse the patient or non-assigned claims. If the practice receives payment from the insurance company for a non- assigned claim, the patient will be refunded the amount paid. The following criteria must be met prior to issuing a refund: There are no outstanding insurance claims on the patient's account and there are not outstanding balances on the account.

AUTOMOTIVE ACCIDENT & WORKERS COMPENSATION CASES - The patient will be treated as a self-pay account unless all information is received and verified through the insurance carrier.

CHILD CUSTODY CASES - The parent with custodial custody is usually the parent who the child lives with and usually accompanies the child to the practice for care. The custodial parent is responsible for the payment at the time of service whether the account is considered self-pay, participating insurance, or non-participating insurance. If the non-custodial parent carries the child's insurance the practice will bill the insurance company. The practice does **not** get involved with divorce specific's e.g., one parents pays 80% and the other pays 20%. It is the parent's obligation to work out an agreement between each other.

REFRACTIONS- Refractive services of routine eye exams are **NOT** covered by most medical insurances. Routine eye exams are **NOT** covered by Medicare; therefore, they are **NOT** subject to the waiver of liability provision. Advance notification to the beneficiary is not required.

This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification on any of the above policies, please feel free to contact us.

______________________________________ Date: __________________

Patient or Legal Guardian Signature

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ABOUT YOUR INSURANCE

There are two types of insurances that may help pay for your eye care services and materials. You may have both for example 1. Medical Insurance (Ex. Medicare and BC/BS) and 2. Vision Insurance (Ex. VSP and Eye Med). Our practice will verify if we accept your insurance before your appointment, Patient should understand that while insurance may confirm benefits, confirmation of benefits is not a guarantee of payment.

- Vision insurance only covers **ROUTINE VISION EXAMS** along with eye glasses and contact lenses.
- Medical insurance **must be used** if you are diagnosed with any health problems that have ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your medical history.
- We will bill your insurance plan for services if we are participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits in the attempt to let you know what is covered. It is patient responsibility to know if insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services received therefore payment is due in full.

I have read and understand the above policies:

____________________________________ ____________________

Patient or Legal Guardian Signature Date

PAST MEDICAL HISTORY

Name____Date______________

OCULAR HISTORY

Please indicate if you have been diagnosed with any of the following:

______ Cataracts
______ Glaucoma
______ Retinal detachment
______ Macular degeneration

Please *indicate the RELATIONSHIP* of any immediate family members (Mother, father, brother sister even if deceased) who have been diagnosed with the following:

______ Glaucoma
______ Retinal detachment
______ Macular degeneration
______ Cataracts
______ Cancer
______ Strabismus
______ High blood pressure
______ Heart problems
______ Diabetes

GENERAL MEDICAL HISTORY

Please indicate if you have been diagnosed with any of the following:

______ Diabetes For how many years: ________________ A1C Level ____________
______ Cancer - What type: ________________________
______ Asthma
______ Hypertension
______ Arthritis
______ Cholesterol
______ Thyroid conditions
______ Neurological conditions
______ Ear, nose, throat conditions
______ Heart disease
______ Heart attack When: ______
______ Shortness of breath
______ Gastric intestinal conditions
______ Urinary conditions
______ Hepatitis/HIV
______ Infectious disease
______ Sleep apnea – Cpac machine Yes or No

Please list any other medical conditions:

____
____
____
____
____

SURGICAL HISTORY

Have you had eye surgery? Yes No (Circle one)
If yes, please supply the dates and procedures ______________________________
Have you had facial surgery? Yes No (Circle one)
If yes, please supply the dates and procedures ______________________________

SOCIAL HISTORY:

Smoking History: Current ______________ Former______________ Never______________
Drinking History: Current ______________ Former______________ Never______________
Height ______________ Weight ________________ Blood pressure ________________

MEDICATION HISTORY

Please fill out attached form OR if you have a written list we can make a copy.

Please list all medication allergies:______________________________________

Dear Patient,

Here at the Delaware Eye Surgeons we take medication delivery very seriously. We believe that you are the key member of the team involved in your treatment. In order to provide the highest quality of care we would like for you to document the most accurate and complete list of the medications you are taking, including name, dose, and frequency of each medication. You may also inquire about a current list of medications from your primary care physician. Please feel free to contact us at (302)993-1300 with any questions.

Medication or Supplement	Amount Taken (Dose)	How Taken (Route)	How Often (Frequency)
Example: Aspirin	*Example: 80 mg*	*Example: By Mouth*	*Example: Once a day*

Name:________________________________

Date:________________________________

Vision Questionnaire

Activity	Unable	Very Difficult	Difficulty	Trouble	No Trouble
Driving at night	☐	☐	☐	☐	☐
Driving during the day	☐	☐	☐	☐	☐
Reading small print, such as medicine bottle labels, a telephone book, or labels	☐	☐	☐	☐	☐
Reading a book, newspaper, or numbers on a telephone	☐	☐	☐	☐	☐
Recognizing people	☐	☐	☐	☐	☐
Seeing steps, stairs or curbs	☐	☐	☐	☐	☐
Watching television	☐	☐	☐	☐	☐
Reading traffic signs, street signs or store signs	☐	☐	☐	☐	☐
Doing fine handwork like sewing, knitting, crocheting, carpentry	☐	☐	☐	☐	☐
Writing checks or filling out forms	☐	☐	☐	☐	☐
Seeing a golf ball	☐	☐	☐	☐	☐

Name: Date:

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Informed Consent:

COVID-19

I understand that I am consenting to an appointment/elective treatment that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the appointment/elective treatment can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my appointment/elective treatment may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. After my elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this appointment/elective treatment may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the appointment/elective treatment listed below.

I have been given the choice to have my appointment/elective treatment at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Name of patient:

Patient date of birth:

Name of provider: Dr. Smith Dr. Simmerman Dr. Williams Dr. Menear

Appointment/Treatment

Signatures:

Patient: ______________________ Date : __________

Witness : ______________________ Date : __________

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DIRECTIONS TO DELAWARE EYE SURGEONS P.A.

We are in the 2 story red brick building, on the 1st floor

I-95 NORTH

FROM I-95 NORTH, take exit #5 for Route 141N
Take Route 141N to Exit #5, Boxwood Road
Stay Straight on Centerville Road, Pass the GM plant on your right. Cross Faulkland Road.
We are ½ mile up on the right.

I-95 SOUTH

FROM I-95 SOUTH, take exit #5 for Route 141N
Take Route 141N to Exit #5, Boxwood Road
Stay Straight on Centerville Road, Pass the GM plant on your right. Cross Faulkland Road.
We are ½ mile up on the right.

FROM 202

Astra Zeneca is your landmark on 202
Turn right onto Route 141S, follow to Lancaster Pike (Route 48W)
Make a right onto Route 48W
At the first light, turn left onto Centerville Road
On Centerville Road, Travel ½ mile to building on left

FROM KIRKWOOD HIGHWAY, ROUTE 2

Take Route 141N Fairfax
Follow 141N to Lancaster Pike (Route 48W)
Make a left on Route 48W
At first light, turn left onto Centerville Road
On Centerville Road travel ½ Mile to building on left.