PATIENT HISTORY (Pediatric)

Last Name_____First Name_____ Age ____ M/F Occupation_____

Who may we thank for referring you to our office? _____How did you hear about us?_____

Primary Physician_____Physician Phone#_____ Fax#_____

MEDICAL INFORMATION

(Please circle Y or N)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
Allergic/immunologic	Y/N	Other	Y/N		

Please explain _____

Last Physical Exam _____
Headaches frequent/rarely/never Any recent changes in headaches? Y/N Explain_____
Diabetes Y/N Type ____Date of Diagnosis _____ Last Fasting Glucose_____ Last A1C____ Last Triglyceride ____
Hypertension Y/N Last Blood Pressure _____ HIV Y/N
Allergies Y/N To What?_____ What happens?_____
Medication Allergy Y/N To What?_____What happens?_____
Current Medication(s) _____Dosage:_____
_____ Dosage:_____
Have you had any Operations? Y/N Kind?_____When?_____
Cigarettes/Tobacco: Smoker: Every Day/Some Days Former Smoker Never Smoked
Alcohol frequent/occasional/never Other substance(s) _____

FAMILY HISTORY

(please circle Y or N)

Glaucoma Y/N Relation _____ Macular Degeneration Y/N Relation _____
Cataracts Y/N Relation_____ Retinal Detachment Y/N Relation _____
Diabetes Y/N Relation_____ High Blood Pressure Y/N Relation _____
Other Eye Condition(s) Y/N Type _____ Relation _____

PERSONAL EYE INFORMATION

Last Eye Exam Date and Doctor's Name:_____

Do you wear glasses? Y/N Distance/Reading/Both Blur at distance or near without glasses? Y/N
Blur while wearing glasses for distance? Y/N Blur while wearing glasses for reading? Y/N
Contact Lenses Y/N Type _____ Blurry Vision with contact lenses Y/N
Are your contact lenses comfortable? Y/N Normal wearing time _____ Solution Type _____
Contact Lens Replacement Schedule daily/2 weeks/monthly/ quarterly/ yearly/other_____
Have you had an eye operation? Y/N Type _____ Date _____
Have you had an eye injury? Y/N Type_____ Date_____
Glaucoma Y/N Cataracts Y/N

Additional Information _____

Signature _____Date _____

Children's Vision Questionnaire

Name_____ Age_____ Date _____

Pediatrician _____

Pediatrician Address & Phone# _____ Fax#_____

BINOCULAR
VISION & VISUAL EFFICIENCY HISTORY
(Please circle Y or N)

Complains of blurred vision	Y or N	Holds things very close	Y or N
Complains of blurred vision		Loses place often	Y or N
when looking near to far or far to near	Y or N	Complains of eyestrain	Y or N
Complains of headaches	Y or N	Must use finger to guide and keep place	Y or N
Rubs eyes	Y or N	Skips lines and words often	Y or N
Inattentive	Y or N	Misreads parts of words	Y or N
Avoids reading	Y or N	Covers or closes one eye when reading	Y or N
Poor reading comprehension	Y or N	Complains of double vision	Y or N
Is tired after reading	Y or N	Complains of words moving on the page	Y or N
Slow worker	Y or N	Complains of words running together	Y or N
All above negative	Y or N		

GENERAL BEHAVIOR		**SIGNS OF VISUAL PROCESSING DISORDERS**	
High activity level	Y or N	Reverses letters and numbers	Y or N
Poor attention span	Y or N	Mistakes words with similar beginnings	Y or N
Impulsivity	Y or N	Can't recognize same word	
Frustrates easily	Y or N	repeated on the page	Y or N
Doesn't listen when spoken to	Y or N	Poor recall of visually presented materials	Y or N
Poor memory	Y or N	Trouble with spelling	Y or N
More active than other		Sloppy writing skills	Y or N
children his(her) age	Y or N	Erases Excessively	Y or N
All above negative	Y or N	All above negative	Y or N

Does your child like school? Y or N
How are his(her) grades? Excellent, Good, Fair, Poor
Please list any academic area(s) of difficulty _____
Do you feel your child is achieving up to potential? Y or N

Freehold Eye & Vision Care LLC
Dr Carolyn LoBocchiaro, OD
FINANCIAL RESPONSIBILITY

Healthy eyes are necessary for good vision. As part of her thorough comprehensive eye exam, Dr. LoBocchiaro concentrates on evaluating eye health. Please be advised, if ocular medical conditions are diagnosed or if there are medical concerns which need to be addressed during the "routine" exam, the patient will be responsible for their medical co-payment and/or deductible even if they are using a vision plan.

A visual field screening and ocular photography are essential components for a complete ocular health assessment.
VISUAL FIELD tests your peripheral vision and neurologic health. It is extremely important for detecting underlying causes for headaches, even if they are only occasional, detecting early glaucoma and monitoring peripheral vision for patients who drive.

OCULAR PHOTOGRAPHY is important for baseline testing and monitoring of the internal and external eye health. It is especially important in aiding the diagnosis of early glaucoma and managing diabetes, hypertension, macula irregularities and ocular freckles. Detecting and monitoring for changes in the future is much more accurate when a photo is available as a baseline for comparison.

For your convenience, Freehold Eye & Vision Care will bill your medical insurance company for these tests even if you are using your vision insurance for your exam. These tests are normally covered in full but on occasion, a co-payment is required, especially if you haven't met your deductible. If that is the case, we will bill you after your insurance claim is processed.

REFRACTION (determination of a spectacle lens prescriptions) most medical insurance companies do not cover this part of your examination, if this information has been determined prior to your visit, **you will be responsible for the Refraction fee of $60.00 at the time of the visit as well as any insurance specialist copayment**.

CONTACT LENS FITTING (this is a separate service) this is not part of a comprehensive eye exam. Extra testing is involved to properly fit contact lenses and monitor your corneal health even if you are an established contact lens wearer. Additional fees also apply even if you have a vision plan. Payment of this fee is expected on the date of service. **Contact lens fitting fees range from $100 to $250 depending on the complexity of the fit and if instruction is required. Rigid contact lens fittings are $250.**

PRESCRIPTIONS
I consent to having my contact lens/eyeglass prescription released electronically if necessary.

TELEHEALTH SERVICES are offered for your convenience. Billing standards apply. Patient will be responsible for all applicable co-payments and/or deductibles.

I certify that I and/or my dependent(s) have insurance coverage that has been provided directly to Dr. Carolyn LoBocchiaro for all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am responsible for providing the office with a referral if necessary. I authorize the use of my signature on all insurance submissions. I acknowledge responsibility for accruing interest as well as the fees associated with the collections of my account should it become delinquent. The above-named physician may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.
I am aware that if the charges are not paid at the time of service, I am subject to a $25.00 late fee. I am aware that there is a $20.00 bounced check fee.

Name of Patient _____ Date_____

Signature of Patient/Legal Guardian _____

Freehold Eye & Vision Care
Carolyn LoBocchiaro, O.D.
555 Iron Bridge Road, Suite 16
Freehold, NJ 07728

Demographics

Patient Information

Patient Name:	DOB:	Sex: M F
Address:		
Town:	State:	Zip:
Social Security Number:	Driver's License Number:	
Home Phone Number:	Cell Phone Number:	Prefer: Home/Cell
Email:		

Insurance Information

Primary Insurance Name:		
Insurance ID Number:	Group Number:	
Insurance Company Address/Telephone:		
Policy Holder:	Relationship to Patient:	DOB of Policy Holder:
Social Security Number:	Policy Holder's Driver License Number:	
Secondary Insurance Name:		
Insurance Company Address/Telephone:		
Insurance ID Number:	Group Number:	

Vision Information

Vision Insurance Name:
Vision Insurance ID Number:
Name of Policy Holder:

NOTICE OF PRIVACY PRACTICES
FREEHOLD EYE &VISION CARE, LLC
CAROLYN LOBOCCHIARO, O.D.

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misused personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be or interest to you.

We may communicate with you by telephone or other media devices to provide care or monitor your progress.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain and we have the obligation to provide to you a paper copy of this notice form us at your first service delivery date.

- The right to provide and we're obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2010 and we are required to abide by the terms of the Notice of privacy Practices currently in effect. We resolve the right to change the terms of our Notice of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. Yu have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Carolyn LoBocchiaro – Privacy Officer
Freehold Eye & Vision Care, LLC
555 Iron Bridge Road, Suite #16
Freehold, NJ 07728
(732) 677 2710

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619 0257
Toll Free: 1 877 696 6775

Notice of Privacy Practices Acknowledgement
Freehold Eye & Vision Care, LLC
555 Iron Bridge Road
Suite #16
Freehold, NJ 07728

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third-party payers;
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials	Reason

Patient Contact Authorization

Freehold Eye & Vision Care, LLC
555 Iron Bridge Road
Suite #16
Freehold, NJ 07728

I, _____, authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to leave messages regarding my medical information status and/or treatment on the following telephone (s).

Home: _____

Cell: _____

I authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to communicate with the following physicians regarding my medical status and/or treatment:

Name: _____ Specialty: _____

Name: _____Specialty: _____

I authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to communicate with the following people regarding my medical status and/or treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Parent Guardian Name: _____

Signature: _____ Date: _____

Freehold Eye & Vision Care, LLC
555 Iron Bridge Road, Suite 16
Freehold, NJ 07728
Carolyn LoBocchiaro, O.D.
Optometric Physician

Dilated Fundus Exam

This important diagnostic procedure involves instilling medication into the eyes to dilate (open up) the pupil. This allows the health of the entire retina (the tissue located behind the eye) to be assessed. In the non-dilated state, only the central portion of the retina and the optic nerve can be seen. Viewing the entire retina is important in detecting certain diseases that may only show up in areas not usually seen during a regular evaluation.

This test is strongly recommended for the following:

- any patient with moderate or high nearsightedness (>3 units of myopia)
- any patient with systemic diseases especially diabetes or hypertension
- any patient with complaints of flashes or floaters
- all first-time patients in order to establish a baseline

The side effects of the drops are blurry vision at near, sometimes far, and an increased sensitivity to light. The medication takes 4-6 hours to wear off completely but starts to wear off after 2 hours.

I understand the importance of the dilation but I am **NOT** interested in having it today. If I decide to return for this test, I will be responsible for any fees associated with an additional office visit.

Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Date: _____