



## Welcome to Family Eye Group

**Michael R. Pavlica, MD**

*Diseases & Surgery of the Retina  
& Vitreous, Diabetic Eye Disease,  
Macular Degeneration & Macular  
Holes, Retinal Detachments*

**David M. Armesto, M.D.**

*Cataract & Refractive Eye Care  
& Corneal/External Disease*

**Garry L. Leckemby, OD**

*Management of Ocular Diseases  
& Contact Lenses*

**Anh T. Nguyen, OD**

*Management of Ocular Diseases  
& Contact Lenses*

Thank you for choosing Family Eye Group for your eye care. Please review our welcome packet and complete the forms on the front and back prior to coming to the office for your first appointment.

Also, please bring to your appointment:

- Your insurance card(s)
  - Driver's license or other form of photo ID
- A referral form if required by your insurance
  - Your insurance co-payment
- Signed financial policy form that is included in this packet
  - A list of your medications and the containers for any current eye medications

Please contact your insurance company should you have any questions regarding your coverage. You will be responsible for any balances not covered by your insurance plan.

Please note that vision plans do not generally cover medical portions of the exam or testing. You or your medical insurance co-pay may be responsible for these charges.

We look forward to seeing you on \_\_\_\_\_ at \_\_\_\_\_. Please arrive 15 minutes prior to your appointment time so that we may complete any additional information that is needed when checking in.

**Phone**

717-299-9232

**Patient Fax**

717-299-6532

**Lancaster Office**

LGH Health Campus  
2110 Harrisburg Pike, Ste. 215  
Lancaster, PA 17601

**Ephrata Office**

155 North Reading Road  
Ephrata, PA 17522

If you have any questions or are unable to keep this appointment, we ask that you please give us a call well in advance.

We are committed to providing you with the best possible care and look forward to meeting you.

Sincerely,

***The Doctors and Staff of Family Eye Group***



## What Happens in a Typical Appointment with a Family Eye Group Doctor?

### **Upon Arrival:**

You will be greeted at our front desk where you will be checked in for your appointment. If you are a new patient your completed registration forms will be collected and this information will be entered into our practice management system. If you are a returning patient, we will confirm that the information we have on file is accurate and up to date. Your insurance card will also be reviewed to make sure that we have your current insurance information on file.

### **Patient Financial Responsibility (Time of appointment):**

We will collect any co-pays, co-insurance and deductibles when you check-in. If you cannot pay your co-payment, we will reschedule your appointment to a later time in the day or to another day. Since your appointment time was scheduled specifically for you, out of respect for our providers and other patients who may have needed your appointment time, we kindly ask that you give our office a 24 hour notice if you are unable to keep your appointment. You may be charged for a No Show appointment if you fail to provide a 24 hour notice to inform us that you are unable to keep your appointment.

### **Your appointment:**

An ophthalmic technician will take you from the reception room to a screening room where the technician will:

- Record your medical history and current symptoms
- Check your near and distance vision and eye pressure
- Check peripheral vision, eye muscles and pupils
- Check glasses prescription
- Depending upon your symptoms, other tests might be performed

After the technician completes your screening and testing, your eyes will be dilated and you will be seated in a small waiting area. The dilation is very important because it makes it possible for the doctor to see the backs of your eyes to assist the doctor in diagnosing your condition. After you are fully dilated, the technician will seat you in the doctor's examination room where the doctor will:

- Examine your eyes
- Review your diagnosis with you
- Prescribe needed medications
- Order any follow-up testing
- Tell you when you need to come in for your next appointment
- Answer any questions you might have

This obviously is a very eventful appointment; therefore, you should always plan on being in our office for an extended period of time, sometimes up to two hours. Please remember to bring dark glasses to assist you in seeing following your dilation. Fully dilated eyes may cause you to experience temporary sensitivity to bright lights and sunshine until your pupils return to normal.

Please do not hesitate to contact our office at **717-299-9232** should you have any questions prior to your appointment. We look forward to seeing you!



# Medical Review Of Systems

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

## DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

EYES	
Loss of Vision	<input type="checkbox"/> Yes
Loss of Side Vision	<input type="checkbox"/> Yes
Distorted Vision or Halos	<input type="checkbox"/> Yes
Fluctuating Vision	<input type="checkbox"/> Yes
Flashes	<input type="checkbox"/> Yes
Floaters	<input type="checkbox"/> Yes
Eye Pain or Soreness	<input type="checkbox"/> Yes
Light Sensitivity	<input type="checkbox"/> Yes
Double Vision	<input type="checkbox"/> Yes
Crossing or Drifting of Eyes	<input type="checkbox"/> Yes
Redness	<input type="checkbox"/> Yes
Discharge	<input type="checkbox"/> Yes
Foreign Body Sensation	<input type="checkbox"/> Yes
Sandy or Gritty Feeling	<input type="checkbox"/> Yes
Dryness	<input type="checkbox"/> Yes
Itching	<input type="checkbox"/> Yes
Burning	<input type="checkbox"/> Yes
Excess Tearing/Watering	<input type="checkbox"/> Yes
Glare	<input type="checkbox"/> Yes
Styes	<input type="checkbox"/> Yes
Other _____	
CONSTITUTIONAL	
Fever	<input type="checkbox"/> Yes
Fatigue	<input type="checkbox"/> Yes
Weight Loss	<input type="checkbox"/> Yes
Weight Gain	<input type="checkbox"/> Yes
SKIN	
Rashes or Color Changes	<input type="checkbox"/> Yes
Itching or Dryness	<input type="checkbox"/> Yes
Hair or Nail Changes	<input type="checkbox"/> Yes

EARS, NOSE, MOUTH & THROAT	
Hearing Difficulty	<input type="checkbox"/> Yes
Ringing	<input type="checkbox"/> Yes
Vertigo	<input type="checkbox"/> Yes
Sinus Congestion	<input type="checkbox"/> Yes
Runny Nose	<input type="checkbox"/> Yes
Post-Nasal Drip	<input type="checkbox"/> Yes
Nosebleeds	<input type="checkbox"/> Yes
Dry Throat/Mouth	<input type="checkbox"/> Yes
Hoarseness	<input type="checkbox"/> Yes
Jaw Pain	<input type="checkbox"/> Yes
CARDIOVASCULAR	
Chest Pain	<input type="checkbox"/> Yes
Palpitations	<input type="checkbox"/> Yes
Other _____	
RESPIRATORY	
Cough	<input type="checkbox"/> Yes
Shortness of Breath	<input type="checkbox"/> Yes
Wheezing	<input type="checkbox"/> Yes
GASTROINTESTINAL	
Swallowing Difficulty	<input type="checkbox"/> Yes
Vomiting	<input type="checkbox"/> Yes
Heartburn	<input type="checkbox"/> Yes
Diarrhea	<input type="checkbox"/> Yes
Constipation	<input type="checkbox"/> Yes
Nausea	<input type="checkbox"/> Yes
GENITO-URINARY	
Urinary Frequency	<input type="checkbox"/> Yes
Urinary Pain or Blood	<input type="checkbox"/> Yes
<b>Males</b>	
Discharge	<input type="checkbox"/> Yes
Lesions or Masses	<input type="checkbox"/> Yes
<b>Females</b>	
Currently Pregnant	<input type="checkbox"/> Yes
Breast Masses	<input type="checkbox"/> Yes
Breast Discharge	<input type="checkbox"/> Yes
Vaginal Bleeding/Discharge	<input type="checkbox"/> Yes

MUSCULOSKELETAL	
Joint Pain	<input type="checkbox"/> Yes
Joint Swelling	<input type="checkbox"/> Yes
Redness	<input type="checkbox"/> Yes
Muscle Pain	<input type="checkbox"/> Yes
Muscle Cramps	<input type="checkbox"/> Yes
NEUROLOGICAL	
Headaches	<input type="checkbox"/> Yes
Numbness	<input type="checkbox"/> Yes
Tingling	<input type="checkbox"/> Yes
Weakness	<input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> Yes
Fainting	<input type="checkbox"/> Yes
Blackouts	<input type="checkbox"/> Yes
Slurred Speech	<input type="checkbox"/> Yes
PSYCHIATRIC	
Anxiety	<input type="checkbox"/> Yes
Depression	<input type="checkbox"/> Yes
Other _____	
ENDOCRINE	
Heat Intolerance	<input type="checkbox"/> Yes
Cold Intolerance	<input type="checkbox"/> Yes
Excessive Thirst	<input type="checkbox"/> Yes
Excessive Hunger	<input type="checkbox"/> Yes
HEMATOLOGICAL	
Easy Bruising	<input type="checkbox"/> Yes
Easy Bleeding	<input type="checkbox"/> Yes
Blood Transfusions	<input type="checkbox"/> Yes
Swollen Lymph Nodes	<input type="checkbox"/> Yes
ALLERGY	
Seasonal Allergies	<input type="checkbox"/> Yes

Additional Notes/Comments:



# Medical Information Form

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you wear glasses or contact lenses?  Yes  No If Yes, for how long? \_\_\_\_\_

**Please ✓ yes if any of the following apply to you and list the date it first occurred:**

MEDICAL PROBLEMS					
Condition	Please ✓	Date	Condition	Please ✓	Date
Alzheimers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma/COPD/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Sarcoidosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer – type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
COVID-19	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes – type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Syphilis / Gonorrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Thyroids Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis/Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<b>Other Medical Problems (Please List)</b>		
Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____		
HIV positive/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____		
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____		
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____		

SURGICAL HISTORY					
Have you had <b>general</b> surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Please list:</b>			Have you had <b>eye</b> surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Please list (including laser and lid surgery):</b>		
Surgery	Date	Surgeon/Hospital	Surgery	Date	Surgeon/Hospital
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATIONS (Please List)	
Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

---

Do you require antibiotics prior to dental work or surgery?  
 Yes  No

FAMILY MEDICAL PROBLEMS		
Do any family members have:	Please ✓	Relative
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Retinal Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Amblyopia/Strabismus	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other (list): _____		

SOCIAL HISTORY	
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink caffeine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

This is to certify that, I the undersigned, consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize Family Eye Group to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to Family Eye Group for services, treatment, supplies or surgeries provided by physicians or staff. I understand that **I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



# Patient Registration Form

## PATIENT INFORMATION:

Last Name:		First Name:		MI:	Birth Date:	
Address:			City:		State:	Zip:
Home Phone:			Cell Phone:			
Email Address:			Age:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	
Occupation:		Employer:		Employer Phone:		
Employer Address:			City:		State:	Zip:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			Spouse's Name:			
Spouse's Birth Date:		Spouse's Social Security #:		Spouse's Employer:		Phone Number:

## PLEASE COMPLETE IF PATIENT IS UNDER AGE 18 OR A COLLEGE STUDENT:

Father's Last Name:		Father's First Name:		MI:	Father's Birth Date:	
Father's Employer:			Father's Employer Phone:			
Father's Address:			City:		State:	Zip:
Father's Home Phone:		Father's Cell Phone:		Fathers' Social Security #:		
Mother's Last Name:		Mother's First Name:		MI:	Mother's Birth Date:	
Mother's Employer:			Mother's Employer Phone:			
Mother's Address:			City:		State:	Zip:
Mother's Home Phone:		Mother's Cell Phone:		Mother's Social Security #:		

## REFERRAL INFORMATION:

Name of Optometrist:		Name of Family Physician:	
Were you referred here today by any of your physicians? If so, whom?:			
Is the reason for today's visit due to Workman's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete Workman's Comp Insurance section on the next page.			

**PLEASE COMPLETE BACK SIDE**



**MEDICARE PATIENTS WHO HAVE PART B:**

Medicare Number:	Effective Date:
1. Do you or your spouse work for a company that provides you with health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you entitled to Medicare because of disability or End-Stage Renal Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the illness or injury the result of an automobile accident or other injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the treatment for the accident or illness been authorized by the Veteran's Admin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you entitled to any benefits under the Federal Black Lung Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PRIMARY INSURANCE**

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Date of Birth:	Subscriber's Social Security #:

**SECONDARY INSURANCE**

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Date of Birth:	Subscriber's Social Security #:

**WORKMAN'S COMP. OR AUTO INSURANCE:**

Where should bill be sent?:	Phone Number:		
Address:	City:	State:	Zip:
Claim or Policy Number:	Date of Injury:		

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_



**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Primary Language:** English   Y   N (circle one) Other \_\_\_\_\_

**We ask the following questions for information gathering purposes only. The answers have no bearing on patient care.**

**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, 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**



## Summary of Patient Financial Policy

### **Thank you for choosing Family Eye Group for your care.**

The physicians and staff of Family Eye Group value the trust and responsibility you placed in us and we look forward to establishing a long-term relationship with you. Following is a brief summary of our Patient Financial Policy that is intended to provide information and to open the lines of communication.

### **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 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. Please remember to bring your current insurance card with you. 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:**

Family Eye Group 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 billing office in advance to request this option. You may also pay your bill online at [www.familyeyegroup.com](http://www.familyeyegroup.com).

### **Self-Pay Patients:**

We offer a reasonable discount for our cash paying patients. Cash paying patients are asked to speak to our billing office at 717-621-2811 or 717-621-2832 for an estimate of what will be due at the time of service.

### **Payment Plans:**

Please contact the billing office at 717-621-2811 or 717-621-2832 to discuss establishing a payment plan for large balances. They will arrange for monthly payments or authorized automatic credit card transactions until the balance is paid in full.

Patient balances of less than five hundred dollars must be paid within sixty days of incurring the charge for the patient to be able to schedule an appointment. Patients with balances of five hundred dollars or more will be on a cash basis going forward. Patients with balances of five hundred dollars or more that are greater than sixty days old will not be able to schedule appointments until the balance is paid.

**PLEASE COMPLETE BACK SIDE**



**Insurances, Health Plans and Medical Benefit Programs:**

Family Eye Group 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.

**Additional Charges and Fees:**

- There will be a \$25 fee assessment for all checks returned unpaid by your bank.
  - Completion of disability forms, employer forms and certain other 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.
- If your account is not paid within 60 days, the account will 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.

We thank you for choosing Family Eye Group for your healthcare needs. Our primary purpose is to provide exceptional care to our patients. If you have any questions about this information, please feel free to contact our billing office at **717-621-2811 or 717-621-2832.**

I authorize Family Eye Group to furnish information to my insurance carrier, employer, referring physician or other physicians involved with my care.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**Lancaster Optique Hours**

Monday - Friday 8:30 - 5:30 p.m.  
Saturday by Appointment Only

**Ephrata Optique Hours**

Tuesday and Friday 8:30 - 12 p.m.  
(call ahead, hours subject to change)

## EYEGLASS PRESCRIPTIONS

You are here today for a comprehensive ophthalmological evaluation that consists of two distinct parts.

(1) The first part is the **ocular health** examination of your eyes. This is to determine the nature of any diseases such as glaucoma, cataracts, macular degeneration and others. This is usually a service that will be paid by your insurance.

(2) The second part is a **refraction**. A refraction is the test performed by the doctor to determine the prescription for glasses. Many insurances including Medicare will not cover this evaluation. Therefore, the fee is the responsibility of the patient. The cost is \$65.00 but if paid at the time of service the charge will be reduced to \$52.00. The prescription for glasses is **valid for two years**. If you have not had a refraction within the last two years, you will not be able to update your glasses if you encounter unforeseen breakage, scratch or loss.

If you purchase your eyewear from Optique, our onsite optical shop, please be aware that should you need your prescription changed, you have up to **60 days** from the original purchase date at no charge. If it is determined that an upgrade to the lenses is required, it is the patient's responsibility to pay for the cost of the lens replacement.

We hope this information helps you to understand the nature of today's evaluation.

Sincerely,

***The Doctors and Staff of Family Eye Group***