FAMILY EYE GROUP

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.

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

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

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!

FAMILY EYE GROUP

Medical Review Of Systems

Patient Name_____ Birth Date _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

EYES

Loss of Vision	❑ Yes
Loss of Side Vision	❑ Yes
Distorted Vision or Halos	❑ Yes
Fluctuating Vision	❑ Yes
Flashes	❑ Yes
Floaters	❑ Yes
Eye Pain or Soreness	❑ Yes
Light Sensitivity	❑ Yes
Double Vision	❑ Yes
Crossing or Drifting of Eyes	❑ Yes
Redness	❑ Yes
Discharge	❑ Yes
Foreign Body Sensation	❑ Yes
Sandy or Gritty Feeling	❑ Yes
Dryness	❑ Yes
Itching	❑ Yes
Burning	❑ Yes
Excess Tearing/Watering	❑ Yes
Glare	❑ Yes
Styes	❑ Yes
Other _____	

CONSTITUTIONAL

Fever	❑ Yes
Fatigue	❑ Yes
Weight Loss	❑ Yes
Weight Gain	❑ Yes

SKIN

Rashes or Color Changes	❑ Yes
Itching or Dryness	❑ Yes
Hair or Nail Changes	❑ Yes

EARS, NOSE, MOUTH & THROAT

Hearing Difficulty	❑ Yes
Ringing	❑ Yes
Vertigo	❑ Yes
Sinus Congestion	❑ Yes
Runny Nose	❑ Yes
Post-Nasal Drip	❑ Yes
Nosebleeds	❑ Yes
Dry Throat/Mouth	❑ Yes
Hoarseness	❑ Yes
Jaw Pain	❑ Yes

CARDIOVASCULAR

Chest Pain	❑ Yes
Palpitations	❑ Yes
Other _____	

RESPIRATORY

Cough	❑ Yes
Shortness of Breath	❑ Yes
Wheezing	❑ Yes

GASTROINTESTINAL

Swallowing Difficulty	❑ Yes
Vomiting	❑ Yes
Heartburn	❑ Yes
Diarrhea	❑ Yes
Constipation	❑ Yes
Nausea	❑ Yes

GENITO-URINARY

Urinary Frequency	❑ Yes
Urinary Pain or Blood	❑ Yes
Males	
Discharge	❑ Yes
Lesions or Masses	❑ Yes
Females	
Currently Pregnant	❑ Yes
Breast Masses	❑ Yes
Breast Discharge	❑ Yes
Vaginal Bleeding/Discharge	❑ Yes

MUSCULOSKELETAL

Joint Pain	❑ Yes
Joint Swelling	❑ Yes
Redness	❑ Yes
Muscle Pain	❑ Yes
Muscle Cramps	❑ Yes

NEUROLOGICAL

Headaches	❑ Yes
Numbness	❑ Yes
Tingling	❑ Yes
Weakness	❑ Yes
Paralysis	❑ Yes
Fainting	❑ Yes
Blackouts	❑ Yes
Slurred Speech	❑ Yes

PSYCHIATRIC

Anxiety	❑ Yes
Depression	❑ Yes
Other _____	

ENDOCRINE

Heat Intolerance	❑ Yes
Cold Intolerance	❑ Yes
Excessive Thirst	❑ Yes
Excessive Hunger	❑ Yes

HEMATOLOGICAL

Easy Bruising	❑ Yes
Easy Bleeding	❑ Yes
Blood Transfusions	❑ Yes
Swollen Lymph Nodes	❑ Yes

ALLERGY

Seasonal Allergies	❑ Yes

Additional Notes/Comments:

FAMILY EYE GROUP

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
Alzheimers	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No	
Asthma/COPD/Bronchitis	❑ Yes ❑ No	
Cancer – type _____	❑ Yes ❑ No	
COVID-19	❑ Yes ❑ No	
Diabetes – type _____	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
Hepatitis/Jaundice	❑ Yes ❑ No	
Heart Disease	❑ Yes ❑ No	
Head Injury	❑ Yes ❑ No	
HIV positive/AIDS	❑ Yes ❑ No	
Kidney Disease	❑ Yes ❑ No	
Lupus	❑ Yes ❑ No	

Condition	Please ✓	Date
Migraine Headaches	❑ Yes ❑ No	
Rheumatic Fever	❑ Yes ❑ No	
Sarcoidosis	❑ Yes ❑ No	
Seizures	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No	
Syphilis / Gonorrhea	❑ Yes ❑ No	
Thyroids Disease	❑ Yes ❑ No	
Tuberculosis	❑ Yes ❑ No	

Other Medical Problems (Please List)

_____

_____

_____

_____

SURGICAL HISTORY

Have you had **general** surgery? ❑ Yes ❑ No

Please list:

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? ❑ Yes ❑ No

Please list (including laser and lid surgery):

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	❑ Yes ❑ No	
Macular Degeneration	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No	
Cataracts	❑ Yes ❑ No	
Amblyopia/Strabismus	❑ Yes ❑ No	

Other (list): _____

SOCIAL HISTORY

Are you pregnant?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Do you drink caffeine?	❑ Yes ❑ No
Do you use illegal drugs?	❑ Yes ❑ 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** _____

FAMILY EYE GROUP

Patient Registration Form

PATIENT INFORMATION:

Last Name:	First Name:	MI:	Birth Date:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Email Address:	Age:	Sex ❑ M ❑ F	Social Security #
Occupation:	Employer:	Employer Phone:	
Employer Address:	City:	State:	Zip:
Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ 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? ❑ Yes ❑ No If yes, please complete Workman's Comp Insurance section on the next page.	

PLEASE COMPLETE BACK SIDE

FAMILY EYE GROUP

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?	❑ Yes	❑ No
2. Are you entitled to Medicare because of disability or End-Stage Renal Disease?	❑ Yes	❑ No
3. Is the illness or injury the result of an automobile accident or other injury?	❑ Yes	❑ No
4. Has the treatment for the accident or illness been authorized by the Veteran's Admin?	❑ Yes	❑ No
5. Are you entitled to any benefits under the Federal Black Lung Program?	❑ Yes	❑ No

PRIMARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ 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?: ❑ Yes ❑ 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: _____

FAMILY EYE GROUP

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**

FAMILY EYE GROUP

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**.

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** _____

FAMILY EYE GROUP

Lancaster Optique Hours
Monday 8:30 a.m. - 5:00 p.m.
Tuesday - Thursday
8:30 a.m. - 4:30 p.m.
Friday 8:30 a.m. - 4:00 p.m.

Ephrata Optique Hours
Tuesday and Friday
8:30 a.m. - 2:00 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 $68.00 but if paid at the time of service the charge will be reduced to $55.00. 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