OFFICE POLICIES

Reiff Eye Center

William M. Reiff, M.D.
Diplomate American Board of Ophthalmology

Thank you for choosing Reiff Eye Center for your eye care needs. This letter is to familiarize you with our practice and office policies. William M. Reiff, M.D. is a board certified ophthalmologist who specializes in providing a full spectrum of eye care. We take pride in providing the best treatment possible to our patients and charge what is usual and customary for our service area. Your clear understanding of our office policies and procedures is an important part of the doctor/patient relationship. We look forward to assisting you with your healthcare needs.

Appointment Info & Informed Consent for Dilation

Complete annual eye exams usually take about an hour. Be sure to allow ample time. If for any reason you are unable to keep your appointment, please call our office to reschedule within a reasonable amount of time so that we are able to utilize that time for other patients. All missed/canceled appointments without 24 hours notice will incur a $25 fee. Eye drops are normally used to enlarge the pupils of your eyes in order to get the best possible view of your retinas. They often blur vision and cause an increased sensitivity to light for a few hours. Because driving may be difficult immediately after an examination, it may be best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered by the dilating drops. This is extremely rare and treatable with immediate medical attention. By signing this agreement, you authorize Dr. William Reiff and/or designated assistants to administer dilating eye drops.

Insurance Coverage

We are providers for Superior Vision and Vision Service Plan (VSP) insurance, which offer great benefits and discounts toward routine exams and glasses and/or contacts. We participate with *most* major medical insurance companies such as Medicare, Aetna, Blue Cross and Blue Shield, Cigna, Humana, and United Healthcare.
Exams fall into two categories: routine vision exam or medical eye exam. Examples of what is considered to be a routine vision exam include: annual glasses prescription, farsightedness, nearsightedness, and blurriness. A few examples of a medical eye exam are: injury/infection, diabetes, headache, tearing insufficiency, cataracts and glaucoma. It is important to confirm whether the specific services you require are covered. Please check with your employer and call your insurance company directly for details on offered benefits and coverage information.

Payment Agreement

It is understood and agreed that Reiff Eye Center will be reimbursed for the cost of any applicable co-payments, coinsurance, deductibles, and non covered services upon request or at the time services are rendered, as stated in the terms of your insurance contract. As a courtesy, insurance claims are filed on your behalf, however, you are responsible for the timely payment of your account. Payment is due in full at the time of service if you do not have insurance coverage. It is understood that should Reiff Eye Center be required to take legal action to recover payments for your services, you are responsible for all collection, legal, and court costs incurred in that effort. Payment methods include cash, personal check, Visa, MasterCard, and Discover. We also have financing options available.

Notice Regarding Refunds

Optical orders are processed electronically through our outside lab within minutes to provide the best service to you. A 50% deposit is required on all orders. Eyeglass lenses are made with your individual prescription and personally elected treatments, cut specifically for the frame you choose. Once an order for glasses or contacts has been processed, understandably, we are not able to cancel or credit. Complete optical policy details are on display in the optical area for review and available in hard copy upon request.

I have read and understand the information regarding appointments, consent for dilation, payment and collection agreements, and refund policies.

X______________________________ ______________________

Signature of Patient or Legal Guardian Date

REGISTRATION INFO

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PATIENT INFORMATION

Last	First	Middle Initial
Address, City, State, & Zip		
Cell Phone	Home Phone	Work Phone
Email: ☐ Male ☐ Female	SSN	Date of Birth Age
Emergency Contact Name, Relation & Phone		
Occupation, Employer & Location		
Primary Physician, Location & Phone		

Referred by: ☐ Primary Physician ☐ Other Patient ☐ Walk-In ☐ Other: ______________________
☐ Insurance Co. ☐ Internet/Website ☐ Optometrist : ________________________________

PERSON RESPONSIBLE FOR PAYMENT

☐ SELF	Name & Relation	Address (if different than patient)	Phone

POLICYHOLDER INFORMATION

☐ SELF	Name & Relation	Date of Birth	SSN

Health Insurance Company**:** Member/ID# Group #

Routine Vision Benefits *(check one)* ☐ None ☐ **V**ision **S**ervice **P**lan ☐ Superior Vision ☐ Out of Network

RELEASE OF INFORMATION As a courtesy, Reiff Eye Center will submit a claim to my insurance company using the billing information I have provided. I authorize the release any medical information to my insurance company that is necessary for the processing of my insurance claim. I certify the information I provided is true and correct to the best of my knowledge and it is my responsibility to notify the office in the event of any changes. **NOTICE OF PRIVACY PRACTICES** Reiff Eye Center's Notice of Privacy Practices under HIPPA is posted in the office waiting room and is available in hard copy form at my request. **ASSIGNMENT OF INSURANCE BENEFITS** I authorize and request that payment of my insurance benefits for any professional services rendered be made on my behalf directly to Reiff Eye Center.

I have read and understand the information regarding the release of medical information, assignment of insurance benefits and notice of privacy practices.

X____ ________________________

Signature of Patient or Legal Guardian Date

MEDICAL HISTORY QUESTIONNAIRE - *Adapted from the American Academy of Ophthalmology*

Patient Name: ____

Primary reason for today's (first) visit: ____

REVIEW OF SYSTEMS:

Do you presently have any problems in the following areas? If **"YES"**, give an explanation.

	NO	YES	EXPLANATION OF PROBLEM
Ears, nose, mouth, throat	[ ]	[ ]	________________________________
Cardiovascular, (heart, blood vessels)	[ ]	[ ]	________________________________
Respiratory (lungs/breathing)	[ ]	[ ]	________________________________
Gastrointestinal (stomach/intestines)	[ ]	[ ]	________________________________
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	________________________________
Musculoskeletal (muscles/joints)	[ ]	[ ]	________________________________
Integument (skin/breast)	[ ]	[ ]	________________________________
Neurological	[ ]	[ ]	________________________________
Psychiatric	[ ]	[ ]	________________________________
Endocrine (hormones, glands)	[ ]	[ ]	________________________________
Hematologic/Immunologic (blood)	[ ]	[ ]	________________________________
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	________________________________

PERSONAL HISTORY:

List any medications (other than eyedrops) that you are currently using: ____________________________

____

Check major illnesses: Diabetes _______ Hypertension _______

List all other major illnesses: ____

____

List any major surgical procedures: ____

____

Do you have any medication allergies? [ ] **NO** [ ] **YES** □ Penicillin □ Sulfa

List all other medication allergies: ____

Other allergies (list) [ ] **NO** [ ] **YES** ______________________________

Have you ever had a blood transfusion? [ ] **NO** [ ] **YES** ______________________________

Have you ever used **Flomax** or any other drugs related to the prostate? If so, list name. [ ] **NO** [ ] **YES** ______________________________

I certify the information I provided is true and correct to the best of my knowledge and it is my responsibility to notify the office in the event of any changes.

X____ ______________________

Signature of Patient or Legal Guardian Date

History reviewed [ ] No changes [ ] Additions as noted

EYE HISTORY

Patient Name:____

1. Do you wear glasses? ☐ Yes ☐ No

If yes, when? ☐ Distance ☐ Reading ☐ All of the time

2. Do you wear contact lenses? ☐ Yes ☐ No

VISION PROBLEMS WITH:

☐ Driving ☐ Night vision ☐ Reading ☐ Sports/Outdoor activities

CURRENT EYE SYMPTOMS	NO	YES	Explanation of problem
Loss or blurred vision	[ ]	[ ]	______________
Loss of side vision, double vision	[ ]	[ ]	______________
Itching, burning or discharge	[ ]	[ ]	______________
Redness	[ ]	[ ]	______________
Gritty feeling, dryness or tearing	[ ]	[ ]	______________
Glare/light sensitivity, or halos	[ ]	[ ]	______________
Eye pain or soreness	[ ]	[ ]	______________
Infection of eye lashes or lid, styes	[ ]	[ ]	______________
Floaters	[ ]	[ ]	______________

PERSONAL HISTORY	NO	YES	Explanation
Eye drops currently in use	[ ]	[ ]	List: ______________
Allergies to eye drops	[ ]	[ ]	______________
Tried wearing contacts before	[ ]	[ ]	When? ______________
History of cataract	[ ]	[ ]	______________
History of glaucoma	[ ]	[ ]	______________
History of cross/lazy eye	[ ]	[ ]	______________
Eye injury or other disease	[ ]	[ ]	______________
Eye surgery	[ ]	[ ]	______________
Do you have or get headaches?	[ ]	[ ]	How often? ______________

FAMILY HISTORY

Ocular	NO	YES	Explanation / Relationship
Blindness	[ ]	[ ]	______________
Cataract	[ ]	[ ]	______________
Glaucoma	[ ]	[ ]	______________
Macular Degeneration	[ ]	[ ]	______________
Retinal Detachment	[ ]	[ ]	______________
Medical			
Diabetes	[ ]	[ ]	______________
Arthritis, lupus, etc.	[ ]	[ ]	______________
Other (list)	[ ]	[ ]	______________
SOCIAL HISTORY			
Do you drink alcohol?	[ ]	[ ]	How much per day? ______________
Do you smoke?	[ ]	[ ]	How much per day? ______________

PLEASE CIRCLE ANY TOPICS THAT YOU WOULD LIKE MORE INFORMATION ABOUT:

LASIK Dry Eyes Contact Lenses Cataracts & Cataract Surgery

Transition Lenses Anti-glare Coating for Glasses