TRI-CENTURY EYE CARE

Dear New Patient,

Welcome! Thank you for choosing Tri-Century Eye Care for your eye health care. To expedite your visit, please complete the enclosed forms and bring them when you come for your first appointment.

Your eyes may be dilated for your exam, which makes the pupils large for several hours and may cause light sensitivity, glare, and blurred vision. If you don't have dark glasses, please ask us for a pair!

When you arrive at our Southampton or New Britain office, you can expedite your visit by checking-in at one of our electronic registration kiosks. You'll be able to review and sign several forms, including our Notice of Privacy Practices, consent to disclose your health information to other family members, Financial Policy, and insurance authorizations. These forms are available on our website under "Patient Forms" for your review in advance if you wish.

Please bring the following to your appointment:
___ Completed Patient History Form, including a list of all medications and eye drops that you are taking
___ Current insurance cards (medical and vision insurances) and a valid photo ID
___ Payment for copays and deductibles (cash, check, American Express, Discover, MasterCard, Visa)
___ Ensure that your primary care physician has submitted a referral if required by your insurance
**Note*: Without the required referral, your appointment may need to be rescheduled.

Tri-Century Eye Care is a multi-specialty eye care practice. Our services include:

- Daytime, evening, and Saturday hours by appointment
- Comprehensive and subspecialty ophthalmology
- Routine vision exams, consultations, second opinions, and emergency care
- Laser-assisted refractive cataract surgery with advanced technology intraocular lens options
- Glaucoma evaluation and treatment
- Retina evaluation and treatment, macular degeneration, diabetic retinopathy and other conditions
- Corneal disease evaluation and treatment
- Laser vision correction (LASIK)
- Pediatric ophthalmology
- Pediatric and adult eye muscle disorder evaluation and treatment
- Oculoplastic and cosmetic facial surgery, Botox, eyelifts, and tearing evaluations
- Skin care and facial rejuvenation
- Optometry and contact lenses
- On-site optical dispensaries with diverse frame styles and lens options
- On-site Ambulatory Surgical Center

If you have any questions, please do not hesitate to call us at the numbers listed below. Visit us on the web at **www.tricenturyeye.com** for additional information and updates. Again, we extend our warmest welcome to you and your family.

Southampton
319 Second Street Pike
Southampton, PA 18966
P: 215.355.4428
F: 215.355.0790

Bristol
216 Mill Street
Bristol, PA 19007
P: 215.781.2020
F: 215.785.1230

Langhorne
1 Cornerstone Dr, Ste 200
Langhorne, PA 19047
P: 215.752.8888
F: 215.752.8915

New Britain
352 E Butler Avenue
New Britain, PA 18901
P: 215.355.4428
F: 215.230.9994

NOTICE OF PRIVACY PRACTICES
Tri-Century Eye Care, P.C.
Effective January 1, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

INTRODUCTION

At Tri-Century Eye Care, P.C., we are committed to using your health information responsibly. This Notice of Privacy Practices describes the nature of your protected health information ("PHI"), and how and when we use or disclose that information. It also describes your rights as they relate to your PHI.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests 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, the right to understand and control how your PHI is used. HIPAA provides penalties for covered entities and Business Associates that misuse personal health information.

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

UNDERSTANDING YOUR HEALTH INFORMATION

Protected health information is any information that relates to your past, present, or future physical or mental health or condition, including treatment and payment for services. Each time you come to our practice, we create a record of your visit. Typically, this record contains information about your personal demographics, medical exam, diagnoses, test results, treatment, and other pertinent data. Understanding what is in your health record and how your health information is used helps you ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

OUR RESPONSIBILITIES

Our practice is required to:

- Maintain the privacy of your health information and use, disclose, or request such information only to the extent minimally necessary to accomplish the intended purpose of the use, disclosure, or request.
- Provide you with this Notice and abide by its terms.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

- **Treatment**
  Your health information may be used by the staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, providing treatment, and coordinating your care. An example of this would include referring you to a retina specialist.
- **Payment**
  Your health plan (or other third-party payer) may request and receive information on dates of service, services provided, and the medical conditions(s) being treated in order to make payment, confirm coverage, billing or collection activities and utilization review under the relevant insurance policy. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- **Regular Health Operations**
  Your health information may be used, as necessary, to support the day-to-day activities and

management of our practice. These activities include, but are not limited to, quality assessments, employee training and reviews and other business and health operations. An example of this would be new patient survey cards or a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

- **Business Associates**
  In some instances, we have contracted separate entities to provide services for us. These "business associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples might be a billing service, answering service, or computer software provider. They are required to treat your PHI in the same manner that we do.
- **Communication with Family**
  Due to the nature of our field, we will use our best judgment when disclosing health information to a family member or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to receive your health information.
- **Research/Teaching/Training**
  We may use your health information for the purpose of research, teaching, and training.
- **Healthcare Oversight**
  Federal law requires us to release your information to an appropriate health oversight agency, public health authority, or other federal or state appointee if there are circumstances that require us to do so.
- **Public Health Reporting**
  Your health information may be disclosed to public health agencies as required by law.
- **Law Enforcement**
  The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible
- **Appointment Reminders**
  The practice may use your information to remind you about upcoming appointments by phone or in writing. Typically, a brief, non-specific message will be left on your answering machine.
- **Fundraising Communications**
  We may contact you, by phone or in writing, to provide information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

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

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

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.

YOUR RIGHTS
You have certain rights under the federal privacy standards with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

This notice is effective as of January 1, 2021 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

For More Information or to Report a Problem
If you have questions, complaints, or would like additional information regarding this notice or our privacy practices, please contact:

Privacy Officer
Tri-Century Eye Care, P.C.
319 Second Street Pike
Southampton, PA 18966

If you believe that your privacy rights have been violated, please contact the aforementioned Privacy Officer for Tri-Century Eye Care, P.C. You may also file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights.

TRI-CENTURY EYE CARE

Patient Name: _____
Date of Birth: _____

PATIENT CONSENT AND DISCLOSURE AUTHORIZATION

(Revised January 21, 2021)

- By signing this PATIENT CONSENT AND DISCLOSURE AUTHORIZATION, the patient or legal guardian of a minor patient understands and acknowledges that Tri-Century Eye Care, PC is committed to securing the privacy of health information. Accordingly, we have posted our **Notice of Privacy Practices** in our offices and the patient has been provided the opportunity to take a copy.
- The HIPAA Privacy Rule gives the individual the right to request the release of Protected Health Information (PHI) to identified individuals.
- I authorize my PHI to be disclosed to the following individuals only:

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

  Name: _____ Relationship: _____

Lifetime Signature on File and Assignment of Benefits:

I request that payment of any and all authorized insurance benefits be made on my behalf to Tri-Century Eye Care, PC for professional services rendered. I authorize Tri-Century Eye Care, PC to release information about me to any private insurance carrier and/or to the Centers for Medicare and Medicaid Services (CMS) required to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, including copays, coinsurance, deductibles, and non-covered services.

_____ _____ _____

Print Name Signature Date

Southampton
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F: 215.355.0790

Bristol
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Bristol, PA 19007
P: 215.781.2020
F: 215.785.1230

Langhorne
1 Cornerstone Dr, Ste 200
Langhorne, PA 19047
P: 215.752.8888
F: 215.752.8915

New Britain
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P: 215.355.4428
F: 215.230.9994

TRI-CENTURY EYE CARE

Patient Name: _____

Date of Birth: _____

Financial Policy

Insurance:

- It is important to understand that insurance is an agreement between ***you*** and ***your insurer***. It is your responsibility to be aware of the limitations of your plan and your co-pay, co-insurance, deductible, and out-of-pocket expense amounts.
- If we are a participating provider with your insurance, all charges for covered services rendered will be submitted to your insurance company for you.

Payments for Services and Materials:

- All co-pay, co-insurance, and deductible payments for insurance-covered services and materials are expected at the time of service.
- All out-of-pocket payments for non-covered services and materials are expected at the time of service.
- Any balance not paid at the time of service will be subject to an additional billing charge of $20.00.

Statements and Outstanding Balances:

- All balances are due upon receipt of the first statement and must be paid in full prior to receiving additional services or materials.
- Any unpaid balance over 30 days past due from the date of the first statement will be subject to additional interest fees of up to 10% per month.
- If balances remain unpaid, we may turn the account over to a collection agency. The collection agency may add collection and processing fees of up to 33% of the original unpaid balance.

Other Fees:

- There may be a fee of up to $40.00 for checks returned by your bank.

I have read the Financial Policy of Tri-Century Care, PC and agree to the terms set forth herein.

_____ _____ _____

Print Name Signature Date

(Revised January 21, 2021)

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TRI-CENTURY EYE CARE

Patient Name: _____
Date of Birth: _____

Vision Insurance or Medical Insurance Election

Vision Insurance COVERS and Medical Insurance USUALLY DOES NOT COVER:

- Routine well-eye exams only
- Refraction (to determine eyeglass prescription)

Medical Insurance USUALLY COVERS and Vision Insurance DOES NOT COVER

- Specific eye complaints or conditions
- Follow-up of pre-existing conditions
- Testing

Once the charges for services rendered have been submitted to your insurance at the conclusion of your visit, we CANNOT ALTER OR CHANGE the visit type to bill a different insurance.

I elect to use the following insurance type for today's visit:

☐ Vision Insurance ☐ Medical Insurance

_____ _____ _____
Print Name Signature Date

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TRI-CENTURY EYE CARE

Patient History Form

Title: _____ First Name: _____ Last Name: _____

Date of Birth (DOB): ____/____/_____ Email address: _____

Address: _____/_____/_____
(Street) (City, State) (Zip Code)

Social Security Number: _____ Cell phone: _____ Home phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____ Referred by (if other than PCP): _____

Pharmacy name/address: _____ Phone number: _____

Reason for today's visit (symptoms): _____ Date of last eye exam: ____/____/_____

List any significant eye conditions and surgeries with dates (cataracts, macular degeneration, diabetic retinopathy, glaucoma, injuries to the eye, lasers, injections, lazy eye, crossed eyes, etc.):

_____

_____

MEDICAL HISTORY – Have you ever had any problems in the following areas?

☐ Yes ☐ No Diabetes	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Anemia
☐ Yes ☐ No Degenerative arthritis	☐ Yes ☐ No Hiatal hernia	☐ Yes ☐ No Leukemia
☐ Yes ☐ No Rheumatoid arthritis	☐ Yes ☐ No Ulcers	☐ Yes ☐ No Sickle cell disease
☐ Yes ☐ No Alzheimer's Disease	☐ Yes ☐ No Skin disease	☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Migraines	☐ Yes ☐ No Kidney disease	☐ Yes ☐ No Emphysema
☐ Yes ☐ No Convulsions/seizures	☐ Yes ☐ No Pregnant	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Stroke/paralysis	☐ Yes ☐ No Congestive heart failure	☐ Yes ☐ No Sarcoidosis
☐ Yes ☐ No Parkinson's Disease	☐ Yes ☐ No Heart murmur	☐ Yes ☐ No Immune problems
☐ Yes ☐ No Multiple sclerosis	☐ Yes ☐ No Heart attack	☐ Yes ☐ No High cholesterol
☐ Yes ☐ No Schizophrenia	☐ Yes ☐ No Irregular/fast heartbeat	☐ Yes ☐ No Cancer - please specify
☐ Yes ☐ No Lupus	☐ Yes ☐ No High blood pressure	_____

List any surgeries with dates: _____

_____

FAMILY AND SOCIAL HISTORY:

Eye Diseases	Relationship to patient	**Medical Diseases**	Relationship to patient	**Medical Diseases**	Relationship to patient
□ Amblyopia (lazy eye)		□ Arthritis		□ Respiratory disease	
□ Blindness		□ Asthma		□ Stroke	
□ Cataracts		□ Cancer		□ Thyroid disease	
□ Corneal disease		□ Circulatory disorders		□ Tuberculosis	
□ Glaucoma		□ Diabetes		□ Other	
□ Macular Degeneration		□ Heart attack			
□ Retinal detachment		□ Heart disease			
□ Retinal disorders		□ High blood pressure			
□ Strabismus		□ Kidney disease			

OVER

TRI-CENTURY EYE CARE

Patient History Form

Patient Name: _____ DOB: ____/____/_____

Do you smoke or use tobacco? □ Never smoked/used tobacco □ Former smoker □ Unknown
□ Current some day smoker □ Current every day smoker □ Current heavy smoker

Have you fallen in the last year? □ Yes □ No
If yes, how many falls in the last year? _____ Did any fall result in an injury? □ Yes □ No

REVIEW OF SYSTEMS - Do you presently have any problems in the following areas? (Please check Yes or No)

CONSTITUTIONAL SYMPTOMS			**GASTROINTESTINAL (Stomach/Intestines)**		
☐ Yes	☐ No	Fatigue	☐ Yes	☐ No	Constipation
☐ Yes	☐ No	Fever	☐ Yes	☐ No	Diarrhea
☐ Yes	☐ No	Night sweats	☐ Yes	☐ No	Vomiting
Other			Other		
HEENT (Head, Ears, Nose and Throat)			**PSYCHIATRIC**		
☐ Yes	☐ No	Hearing loss	☐ Yes	☐ No	Emotional changes
Other			Other		
RESPIRATORY (Lungs/Breathing)			**NEUROLOGICAL**		
☐ Yes	☐ No	Cough	☐ Yes	☐ No	Dizziness
☐ Yes	☐ No	Wheezing	☐ Yes	☐ No	Headaches
Other			Other		
CARDIOVASCULAR			**HEMATOLOGIC/LYMPHATIC**		
☐ Yes	☐ No	Chest pressure or discomfort	☐ Yes	☐ No	Bleeding
☐ Yes	☐ No	Irregular heartbeat/palpitations	☐ Yes	☐ No	Bruising
Other			Other		
GENITOURINARY (Genitals/Kidney/Bladder)			**ALLERGIC/IMMUNOLOGIC**		
☐ Yes	☐ No	Dysuria (painful urination)	☐ Yes	☐ No	Environmental allergies
☐ Yes	☐ No	Hematuria (blood in urine)	☐ Yes	☐ No	Food allergies
Other			Other		
METABOLIC/ENDROCRINE			**MUSCULOSKELETAL**		
☐ Yes	☐ No	Cold intolerance	☐ Yes	☐ No	Arthralgia (joint pain)
☐ Yes	☐ No	Heat intolerance	☐ Yes	☐ No	Gait disturbance
☐ Yes	☐ No	Polydipsia (excessive thirst)	☐ Yes	☐ No	Joint swelling
☐ Yes	☐ No	Polyphagia (excessive hunger)	☐ Yes	☐ No	Muscle weakness
☐ Yes	☐ No	Polyuria (frequent urination)			
Other			Other		
INTEGUMENTARY (Skin)					
☐ Yes	☐ No	Rash			
Other					

TRI-CENTURY EYE CARE

Patient History Form

Patient Name: _____ DOB: ____/____/_____

MEDICATIONS AND ALLERGIES:

List all EYE medications you take (prescription and over-the-counter). Attach a list if necessary.

Name of Eye Medication	Dosage	Start Date

List all OTHER (non-eye) medications you take (prescription and over-the-counter). Attach a list if necessary.

Name of Medication	Dosage	Start Date

List all known allergies.

□ Check here if you have no known allergies

Allergen	Reaction	Severity