



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](http://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 condition(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**

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



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)

#### 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



**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

#### **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

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_/\_\_\_\_/\_\_\_\_ Email address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Pharmacy name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Pharmacy Address/Location: \_\_\_\_\_

If you are a new patient, date of last eye exam: \_\_\_\_\_

Reason for today's visit (symptoms): \_\_\_\_\_

**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?**

<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No Anemia
<input type="checkbox"/> Yes <input type="checkbox"/> No Degenerative arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No Hiatal hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia
<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No Sick cell disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Skin disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema
<input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions/seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Stroke/paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No Congestive heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No Sarcoidosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Immune problems
<input type="checkbox"/> Yes <input type="checkbox"/> No Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No High cholesterol
<input type="checkbox"/> Yes <input type="checkbox"/> No Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No Irregular/fast heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer - please specify
<input type="checkbox"/> Yes <input type="checkbox"/> No Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> Amblyopia (lazy eye)		<input type="checkbox"/> Arthritis		<input type="checkbox"/> Respiratory disease	
<input type="checkbox"/> Blindness		<input type="checkbox"/> Asthma		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Cancer		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Corneal disease		<input type="checkbox"/> Circulatory disorders		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Other	
<input type="checkbox"/> Macular Degeneration		<input type="checkbox"/> Heart attack			
<input type="checkbox"/> Retinal detachment		<input type="checkbox"/> Heart disease			
<input type="checkbox"/> Retinal disorders		<input type="checkbox"/> High blood pressure			
<input type="checkbox"/> Strabismus		<input type="checkbox"/> Kidney disease			

**OVER**





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)

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



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