Please keep this page for your records and information.

Welcome to Harrisburg Eye Associates, we are excited that you have selected us to provide you with the highest quality medical and surgical care. We have outlined the key items that are required before and during your office visit.

For communication regarding private and medical information, please utilize our:

Patient Portal at www.harrisburgeyes.com

Prior to Your Appointment:

1. Please review and complete the new patient forms.
2. Please contact your insurance company to verify your medical coverage. Your appointment will be billed as a "medical" visit, along with any tests and/or procedures.
3. If your primary care Doctor is listed on your insurance card, you may be required to have a referral. Please contact your primary care Doctor to confirm whether a referral is required.

Day of Your Appointment:

1. **Medications** – please either bring a current list of all medications you are taking or provide your pharmacy information and permission to acquire this information electronically (see on forms below).
2. **Eyeglasses** – please bring your best or most recent eyeglasses and/or contact lens box, even if they no longer improve your vision. The glasses will provide important information about the past condition of your eyes.
3. **Insurance Cards** – please bring all current insurance cards with you to the appointment.
4. **Photo ID** – We are required to obtain a copy of your photo ID. This is to protect you from someone else using your medical insurance (a type of identity theft).

We are here for you at Harrisburg Eye Associates, please feel free to contact us and follow us through any of the following:

(717) 695-6326 info@harrisburgeyes.com Harrisburg Eye Associates

4700 Union Deposit Road, Suite 220, Harrisburg, PA 17111
(On the 2nd floor, entrance behind the building)

HARRISBURG EYE ASSOCIATES

Welcome! Thank you for choosing Harrisburg Eye Associates for your eye care needs. Please complete the following information and email them to info@harrisburgeyes.com, fax to 717-695-6908, or bring them in person to your appointment.

Patient Information

Full Name: _____
Last *First* *M.I*

DOB: _____ Email Address: _____
MM/DD/YYYY

Address 1: _____
Street Address *Apt #/Unit*

Address 2: _____
City *State* *Zip Code*

Cell Phone: _____ Home Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

May we discuss your medical information with this person? Y or N

How did you hear about HEA (check all that apply)?

☐ Referring Doctor ☐ Friends/Family ☐ TV/Radio ☐ Internet ☐ Mailing/Newspaper ☐ Event/Exhibit

☐ Insurance ☐ Other:

- By providing my contact information above, I authorize my health care provider to employ automated outreach and messaging systems to notify me regarding scheduled appointments, scheduling of appointments, and/or balances due. …….. (initials)
- Preferred contact: Email / Home / Cell / Other (circle one).
- HEA is committed to providing all our patients with exceptional care. When a patient cancels an appointment without prior notice, it may prevent another patient from being seen. Kindly provide 24 hour notice to cancel or change a scheduled appointment. We reserve the right to charge a $40 fee when prior notice has not been given. …….. (initials)

Insurance Information

At Harrisburg Eye Associates, we do our best to assist with insurance verification and eligibility in order to best serve our patients; however, this information is often complex and may require further assistance from you. For further questions, please contact our office at 717-695-6326 or email your questions to info@harrisburgeyes.com.

Primary Medical Insurance: _____ Group/#: _____

Subscriber Name and DOB: _____ Relationship: _____

Secondary Medical Insurance: _____ Group/#: _____

Subscriber Name and DOB: _____ Relationship: _____

- Office visits will be categorized as “medical” exams. We will bill your medical insurance cards. We do not participate with vision insurance. …….. (initials)
- HEA contracts with most major insurance plans; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. I understand that I am financially responsible and agree to pay any charges for care rendered to me not covered by my insurance plan. I agree that for services rendered to me by Harrisburg Eye Associates I will pay my account at the time of service or upon insurance claim processing. …….. (initials)
- If payment plan consideration is necessary, I understand that it is my responsibility to call and make financial agreements satisfactory to HEA for payment. …….. (initials)
- Any benefits under any policy of insurance or other party liable to the patient, is hereby assigned to Harrisburg Eye Associates. If copayments and/or deductibles are assigned by my insurance company or health plan, I agree to pay them to HEA. …….. (initials)
- If you do not have insurance, payment is required at the time of service and you will be seen as a Self Pay patient. …….. (initials). Self Pay rates will apply.
- Please be aware that when we call to verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plan’s benefits when your healthcare insurance company receives and processes the claim. …….. (initials)

Dilation Drops and Refraction Policy

- **Dilating Information:** Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.
- Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, so it is best if you make transportation arrangements
- Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. Please call us immediately if you have symptoms including severe pain, eye redness, light sensitivity, and halos following your dilated exam.
- I hereby authorize Harrisburg Eye Associates and/or such assistants as may be designated by him/her to administer dilating eye drops.
- **Refraction Policy:** Refraction is the test used to determine a glasses or contact lens prescription. Your doctor may also use a refraction to ensure blurry vision is correctable in order to further assess medical problems. Refractions are not always covered by insurance and you may be responsible for payment at time of service. Medicare *does not* cover refractions.

Patient or Authorized Signatory: _____ Date: _____

Patient Agreement

- **Consent for Treatment:** I authorize HEA to assess and treat me, complete tests and administer medications considered necessary or advisable. I understand that my healthcare provider is available to explain the purpose of any procedure and that I have the right to refuse, even if against medical advice.
- **Release of Medical Information:** If I would like a copy of my health information released to me or any individual(s), I will request and submit an Authorization for Release of Medical Information. A release may be revoked by me in writing at any time. I understand that a copy of my records is subject to fee for labor/supplies/postage.
- **Notice of Privacy Practices**: I acknowledge that I have been made aware of Harrisburg Eye Associates' privacy practice. I understand a copy of the Notice of Privacy Practices is available at my request.
- **Medicare Signature:** For patients with Medicare, HEA will submit a completed insurance form to Medicare, and their guidelines permit a one-time signature that is valid for all current and future visits. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare Forms submitted by our office.

Patient or Authorized Signatory: _____ Date: _____

Billing Agreement

- I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at HEA. I am responsible for any applicable deductible or copayment prior to the provision of services. HEA will provide me with an ***estimate*** of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. HEA may file a claim for payment with my insurance company as a courtesy to me. If the primary insurance company fails to pay HEA in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to HEA. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee. Outstanding balances will be referred to a collection agency after 90 days billed, which will then initiate termination of patient from HEA.

Patient or Authorized Signatory: _____ **Date:** _____

Media Agreement

- Dr. Szeles values education and endeavors to teach through lectures, publications, teaching conferences, and media. By signing here, you provide permission for Dr. Szeles to use de-identified testing or unidentifiable photographs in any medium for educational purposes.

Patient or Authorized Signatory: _____ Date: _____

Medical History Questionnaire

- **Release of Protected Health Information:** I hereby authorize HEA to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from third party health care providers, laboratories, radiology facilities or other institutions and providers. I also understand that I have the right to revoke this authorization at any time by sending a written notification to HEA. ..... *(initials)*

Referring Doctor:		**Primary Care Doctor:**	

List any medical problems that other doctors have diagnosed:

☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Autoimmune Disease

Surgeries, including prior Eye Surgeries

Year:	Reason:	Hospital:

Pharmacy Information

Pharmacy Name:	Address/Phone:

- HEA has my permission to obtain a list of my prescriptions directly from my pharmacy. ..... *(initials)*

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:
You may also provide a copy of your medications with this form or we will review medications linked from your pharmacy during your appointment.

Name the Drug	Strength	Frequency Taken

Have you ever taken prostate medicines / alpha blockers?
Please circle: Flomax, Tamsulosin, Hytrin, Cardura, Saw Palmetto, Doxazosin, Terazosin, Uroxatral, Rapaflo

Allergies to medications:	
Name the Drug:	Reaction You Had:

HEALTH HABITS AND PERSONAL SAFETY

Vaccines	Yearly Flu			☐ Yes	☐ No
	Shingles			☐ Yes	☐ No
	Pneumococcal			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			

FAMILY HEALTH HISTORY

Does anyone related to you have/had any of the following:						
Heart Disease or Heart Attack:	☐	Yes	☐	No	**Relationship:**	
Diabetes Mellitus:	☐	Yes	☐	No	**Relationship:**	
Blindness:	☐	Yes	☐	No	**Relationship:**	
Glaucoma:	☐	Yes	☐	No	**Relationship:**	
Macular Degeneration:	☐	Yes	☐	No	**Relationship:**	

WOMEN ONLY

Are you pregnant or breastfeeding?	☐ Yes	☐ No

OTHER PROBLEMS

Please tell us if you currently have any medical or health symptoms that are being evaluated or are presently causing you discomfort.
