

NEW PATIENT WELCOME PACKET

APPOINTMENT CHECKLIST

Please review, make corrections and complete the attached New Patient paperwork (front and back) and bring with you to your upcoming appointment. Please be sure that you also have the following:

- 👁️ Your current health insurance card is required and will be photo copied upon arrival.
- 👁️ If your health insurance requires a specialist co-payment or you have not met your deductible, this will be required at the time of your visit. We accept most credit cards, cash or check.
- 👁️ Please bring a list of all medications you are currently taking, including strengths/dosages. You must also have your pharmacy's contact information, including name, address and phone number.
- 👁️ If a Referral Authorization is needed, this is your responsibility. You will either need to bring this to your appointment or have it faxed to our office at the number listed below.
- 👁️ Please bring your glasses and/or contact lenses. If you currently wear contacts, please bring in your contact lens boxes containing lens information if available.
- 👁️ Be sure to arrive 15 minutes prior to your scheduled appointment time in order to turn in your paperwork and allow our staff to update your patient file; if you arrive late you may be asked to reschedule.
- 👁️ If you need to change or reschedule your appointment for any reason, please give our office at least 24 hours notice as a courtesy.

DIRECTIONS

If coming north on the Northway, take exit 15 to Route 50 and turn LEFT. You will head west towards the city of Saratoga Springs, but will take a right at your third traffic light (just after the reservoir), onto Route 9 (also referred to as Marion Avenue). You will head north on Route 9 for about 2 miles and will take a left into the Nemer Dealership (just after the Maple Avenue Fire Station).

If coming from the City of Saratoga Springs, stay on Route 50 heading East toward the Northway. You will take a left at the third light after you cross from Broadway onto Route 50. This left will take you onto Route 9 (also referred to as Marion Avenue). You will head north on Route 9 for about 2 miles and will take a left into the Nemer Dealership (just after the Maple Avenue Fire Station).

If coming from Wilton or Gansevoort, get on Route 9 heading South. You should pass Northern Pines road as you head South. There is an Adirondack Trust Bank and a Dunkin Donuts at that intersection. Proceed South on Route 9 about 1/10th of a mile and take a right into the Nemer Dealership (just after Hewett's Garden Center).

PLEASE NOTE: As you pull into the dealership, take an IMMEDIATE LEFT toward the small plaza on the left side of the dealership parking lot. We are the office located in the middle of the plaza.

Your Vision Resource

Edwin A. Davison, Jr., M.D.
615 Maple Avenue, Suite #3
Saratoga Springs, NY 12866
Ph: (518) 584-5821 • Fax: (518) 583-9404

MEDICAL QUESTIONNAIRE / EYE HISTORY

Name: _____ Reason for visit: _____

Primary MD: _____ Cardiologist: _____

VISION HISTORY

Are you having difficulties with your vision? Yes No If yes, please explain: _____

Do you wear glasses for vision? Yes No If yes, how old is your current pair? _____

Do you wear contact lenses? Yes No If yes, what kind? _____

Would you like a new prescription for glasses or contact lenses? Yes No If yes, which? _____

Have you had cataract surgery? Yes No If yes, when? _____

Any other eye surgeries/eye diseases? Yes No If yes, please explain: _____

Any problems with night driving? Yes No If yes, please explain: _____

If you have an additional problem or complaint, please explain: _____

How long have you had this problem? _____

Does the problem come and go or is it constant? _____

If there is any discomfort, what is it like (i.e. pressure, stabbing, burning, aching, scratching)? _____

Do you have any other symptoms that began with this current complaint (such as fever, headache, flashing lights, etc.)? _____

FAMILY HISTORY

Is there a family history of any of the following? _____

**Family history includes patient's parents, grandparents, siblings and children (living or deceased).*

- | | | | |
|---------------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Migraine | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Other: _____ | | | |

SOCIAL HISTORY

Do you use tobacco products? Yes No If yes, amount/frequency: _____

Do you drink alcohol? Yes No If yes, amount/frequency: _____

Do you use illegal drugs? Yes No If yes, type/amount/frequency: _____

What is your current marital status? Married Single Divorced Widow(er)

Are you currently employed? Yes No If yes, current occupation: _____

Are you allergic to any of the following? _____

- | | | | | | |
|--|---------------------------------------|-------------------------------------|---------------------------------|--|--------------------------------|
| <input type="checkbox"/> Ciprofloxacin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfas | <input type="checkbox"/> Environmental/Seasonal | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> No Known Drug Allergies | |

PERSONAL MEDICAL HISTORY

Review of Systems—Do you currently have any problems in the following areas?

SYSTEM	NO	YES	If yes, please describe in space below.
EYES (dryness, mucus discharge, redness, sandy or gritty feeling, itching, burning, eye pain or soreness)			
EYES (loss of vision, blurred vision, distorted vision/ halos, loss of side vision, double vision)			
EYES (foreign body sensation, excessive tearing/ watering, glare/light sensitivity)			
EYES (sties or chalazion, flashes/floaters in vision)			
EARS, NOSE, MOUTH, THROAT (allergies/hay fever)			
CONSTITUTIONAL (fever, weight loss/gain)			
ENDOCRINE (diabetes, thyroid/other glands)			
INTEGUMENTARY (skin)			
GASTROINTESTINAL (diarrhea/constipation)			
PSYCHIATRIC			
ALLERGIC/IMMUNOLOGIC (sneezing, hives, redness, swelling, itching)			
NEUROLOGICAL (headaches, migraines, seizures)			
GENITOURINARY (genitals, kidney, bladder)			
LYMPHATIC/HEMATOLOGIC (anemia, bleeding problems)			
VASCULAR/CARDIOVASCULAR (heart pain, high blood pressure, high cholesterol, vascular disease)			
RESPIRATION (asthma, chronic bronchitis, emphysema)			
BONES, JOINTS, MUSCLES (rheumatoid arthritis, muscle pain, joint pain)			

Other illness, major injuries, or medical conditions not noted above (i.e. diabetes, thyroid disease, heart disease, eye disease, high blood pressure, etc.)? _____

Other surgery or hospitalization not noted above (i.e. cataract surgery, appendectomy, coronary bypass, etc.)? _____

List any medications you take (including aspirin, over the counter medications, home remedies and eye drops):

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Your Vision Resource of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ **DATE:** _____

CONTACT LENS SERVICES AND FEES

I. FITTING FEES

We require that **ALL** contact lens patients be evaluated annually, prior to authorizing a renewal of their contact prescription. As a result, a prescription for contacts **will not** be given unless a contact lens evaluation is completed. The fees listed below are **in addition** to the regular examination fee as contact lenses evaluations are not covered by medical insurance. This fee must be paid on the day of the fitting.

I have read the above information regarding contact lenses and I certify that: (check one please)

- I currently do not wear contacts and have no interest in trying them.*
NO CHARGES
- I currently wear contacts and am happy with the brand and fit of my current lenses.*
CHARGES: Annual contact lens evaluation fee of \$30. Includes a thorough evaluation of the anterior surface of the eye and under the eyelids, corneal thickness measurements, corneal specular microscopy with cell counts and an evaluation of the corneal cellular morphology.
- I currently wear contacts, but would like to try a different brand and/or style of lens.*
CHARGES: A contact lens fitting for an established wearer will be required with fees ranging from \$70 to \$160, depending on the type of lens desired. The fee includes follow-up care and lens adjustments for a 90 day period.
- I currently do not wear contacts, but would like to try them.*
CHARGES: A contact lens fitting for a new wearer will be required with fees ranging from \$90 to \$180, depending on the type of lens desired. The fee includes follow-up care and lens adjustments for a 90 day period.

II. CONTACT LENS PRESCRIPTIONS

Contact lenses are a **medical device** and can only be dispensed by **prescription**. There is a great potential for damage to the eye and even blindness if contact lenses are not properly cared for.

A written copy of your prescription will be provided once the fitting process is complete and your doctor is confident of your continued eye health while wearing lenses. **Contact lens prescriptions are valid for one year in the State of New York.**

If contact lenses are ordered through our office using your new prescription, **they must be paid for in full at time of ordering.**

I hereby agree to and acknowledge that I have read and understood the above terms and conditions concerning contact lens services and fees.

Patient (or Responsible Party) Signature

Date



PATIENT FINANCIAL POLICY

I. OFFICE AND FINANCIAL POLICIES

On an annual basis, we will request that you update your medical history information by filling out a new questionnaire form. At each visit, we will ask about your insurance and ask to see your insurance cards. Please note that we cannot file insurance for your services unless we have a card that is current and correct.

Many insurance companies also require a referral/authorization for office visits. It is the patient's responsibility to make sure this is in place prior to being seen in our office.

II. FINANCIAL ASSIGNMENT AND AGREEMENTS

Our practice participates in many Medical insurance plans, but as a medical office **we do not accept vision care plans.** Medical insurance plans, including Medicare, will not pay for routine eye examinations. **Patients must have a medical complaint in order for the examination to be covered by medical insurance.** Exceptions to this are patients who have been asked to come back for a follow-up visit due to specific ocular issues that are being monitored by the doctor. Ultimately, it is the patient's responsibility to understand their insurance coverage. **If the patient's insurance plan, including Medicare, does not cover the examination, the patient is responsible for the examination fee.**

Eye examinations have two portions: the eye exam itself and the refraction. The refraction is when the doctor determines whether you can be helped in any way by a new eyeglasses prescription. It is also how we determine the best possible visual acuity and function of the eye. Most insurance plans, do not pay for refractions as they consider refraction a "vision" service, not a "medical" service. **Medicare does not pay for refractions under any circumstances.** Our **office fee for a refraction is \$30** and you will be asked to pay for this fee at the time of service. Should the insurance company pay for the refraction, the \$30 fee will be refunded to the patient. Please note that if a refraction is performed, the patient is responsible for the refraction fee, even if there is no significant change in the eyeglass prescription and they decide not to get new eyeglasses.

The patient's co-pay is also due at the time of service. We will collect the appropriate co-pay and bill the insurance appropriately. If there is a difference in the amount of co-pay as determined by your insurance coverage, you will either be refunded or billed the difference. If the patient requests to be billed for their co-pay, there will be an additional **\$5 service charge added to the billed amount.** There will also be a \$20.00 fee assessed for all checks returned by the bank. Balances over 30 days may be subject to additional collection activities and fees, including paying all collection costs incurred for the services.

Edwin A. Davison, Jr., M.D. DBA Your Vision Resource

I certify that the information given by me in applying for payment under my insurance contract is correct. I **authorize Edwin A. Davison, Jr., M.D. to release to any third party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits.** I request that payment of authorized health care benefits be paid and I assign the benefits payable for physician services to Edwin A. Davison, Jr., M.D. I authorize Edwin A. Davison, Jr., M.D. to submit a claim to my health insurance carrier or any other third party payer including Medicare and Medicaid on my behalf. I request payment of benefits under Title IVIII (Medicare) and XIX (Medicaid) of the Social Security Act, to **Edwin A. Davison, Jr., M.D.** I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges.

Patient Name (printed)
Patient (or Responsible Party) Signature
Date



NOTICE OF PRIVACY PRACTICES

Your Vision Resource

Edwin A. Davison, Jr., M.D.
615 Maple Avenue, Suite #3
Saratoga Springs, NY 12866
Ph: (518) 584-5821 • Fax: (518) 583-9404

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

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 personal health information (“PHI”) is used. HIPAA provides penalties for covered entities 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- ⇒ Treatment means providing, coordinating, or managing health care and related services by one of more healthcare providers. An example of this would include referring you to a retina specialist.
- ⇒ Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would including sending your insurance company a bill for your visit and/or verifying coverage prior to surgery.
- ⇒ Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be the review cards that are given after cataract surgery.
- ⇒ 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.

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

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

NOTICE OF PRIVACY PRACTICES

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 take actions relying on your authorization.

You may have the following rights 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 reasonable requests to receive confidential communications of Protect Health Information 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 have paid 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.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of July 30, 2014 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 your office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact Your Vision Resource for more information, in person or in writing.



PRIVACY PRACTICES ACKNOWLEDGEMENT

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I have been provided the opportunity to read, or it has been read to me, the Notice of Privacy Practices at Your Vision Resource.

I understand that Your Vision Resource is committed to treating and using protected health information about me responsibly.

I understand my right as it relates to my records at Your Vision Resource and understand how information about me may be used or disclosed.

I understand that my health record is the physical and legal property of Your Vision Resource, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs may be incurred for copies of my records and appointments must be made with Your Vision Resource to inspect, access or amend my health information.

I understand that Your Vision Resource is required to maintain the privacy of my health information. Your Vision Resource will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by Your Vision Resource staff and physicians; billing to myself or a third-party payer; in addition, business associates of Your Vision Resource may, from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physician's best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.

Your Vision Resource may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Notice of Privacy Practices of Your Vision Resource.

Patient Signature: _____ Date: _____

AUTHORIZATION OF DISCLOSURE: I authorize the release of my medical records, test results and any pertinent information related to me to the following person(s):

Name of Person(s): _____

Relationship to Patient: _____