Marguerite R. Billbrough, MD – Medical Director, Eye Physician & Surgeon
The Ridley Professional Building, 1553 Chester Pike, Suite 101, Crum Lynne, PA 19022
Tel: 610-522-2822 Fax: 610-522-2880

Welcome to the Center for Sight of Delaware County! The information included in this packet will assist all of us here with providing you comprehensive and quality eye care. Since we have not had an opportunity to meet you in person, the enclosed materials will introduce our office policies so that your experience at our practice is a positive one!

You will find a vast array of information enclosed. By familiarizing yourself with this information and completing the personal medical history forms and bringing them with you, we can focus on the quality of eye care that we strive to provide to each of our patients. Included in this packet is:

- Information about referrals, fees, co-pays, ID's and insurance cards
- Our privacy notice as required by HIPAA regulations, and
- Three patient information forms to be filled out and brought to your appointment

Payments for co-pays and other fees are expected at the time of visit and will be collected upon checking out with the receptionist.

If you have any questions or concerns relating to our ophthalmology practice, please do not hesitate to contact the office at (610)522-2822.

Thank you for selecting The Center for Sight of Delaware County. We look forward to meeting you in the near future.

Sincerely,

Marguerite R. Billbrough, MD
Medical Director

***YOU CAN PRINT OUT THE (**PATIENT INFORMATION FORM, MEDICAL HISTORY, INSURANCE INFORMATION FORM & HIPPA PATIENT CONSENT FORMS**) AND BRING WITH YOU AT YOUR SCHEDULED APPOINTMENT OR YOU CAN EMAIL THESE FORMS TO US AT:
EMAIL: cfs@centerforsightpa.com

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SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. You may request a copy of our full-length Notice or you may review the Notice located in a three ring binder in the waiting area.

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

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the full-length Notice of Privacy Practices):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential Communications

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the

Practice, contact our Privacy Officer at #610-522-2822. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

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REFERRALS

If you are seeing the physician for a specific eye condition, you may be required to obtain a referral prior to the visit. If you are unsure if your insurance requires a referral for eye doctor visits, please contact your insurance company and they will provide you with your requirements for visit coverage. You can contact the insurance company by dialing the customer service number listed on your insurance card.

FEES AND CO-PAYMENTS

Most insurance companies require that the patient pay a co-payment for their visit. You are expected to pay this co-payment the day of your visit. We are required by law to collect this from you. We accept cash, personal checks and credit cards (VISA, MASTERCARD, & DISCOVER). If you do not have your co-payment at the time of your visit, you will be asked to reschedule.

"Refraction" is a necessary part of an eye exam that allows the physician to determine the best possible corrective prescription. It also assists in determining if any medical, optical or surgical treatment is needed. Please be aware that Medicare does not cover the refraction fee. There will be a charge of **$50.00** collected from you the day of your visit. If you wear glasses, please bring them with you also!

IDENTIFICATION & INSURANCE CARDS

We ask that you bring your state issued identification card (driver's license or state ID) AND your insurance cards. The policy is in place to ask for identification to help protect you from fraud. If you do not have your insurance cards with you, you will be held financially responsible for payment at the time of service or you will have to reschedule your appointment.

Thank You!

PATIENT INFORMATION

Today's Date_____

Name _____

Address _____

_____

Home Phone _____ Work Phone _____

Cell Phone: _____

Email Address_____

Race _____

SS # _____ DOB _____

Marital Status_____ Sex _____

Emergency Contact _____

Emergency Phone # _____

Primary Care Doctor _____

Address & Phone # _____

_____

Pharmacy Name: _____

Address & Phone# _____

_____

_____

Referred by _____

Patient Name: _____ Birth date: _____

MEDICAL HISTORY

Illness/Disease	YES	Please explain problem
Cardiovascular (heart, vessels, etc.)		
Respiratory (asthma, emphysema, etc)		
Gastrointestinal (stomach, intestines, etc)		
Genital, Kidney, Bladder		
Muscles, Bones, Joints		
Skin		
Neurological		
Psychiatric (anxiety, depression, insomnia)		
Endocrine (diabetes, thyroid)		
Blood/Lymph (cholesterol)		
Allergic/Immunologic (seasonal, lupus)		
Ear, Nose, Throat (sinuses)		

YOU & YOUR FAMILY'S EYE HISTORY

Disease	Yes – Your History/ Explain	Yes - Family Member/ Explain	Surgery Date
Macular Degeneration			
Glaucoma			
Cataracts			
Retinal Detachment			
Cancer			
Diabetes			
Cornea			
Eye Injury			
LASIK			
Other			

Patient Name: _____ Birth date: _____

SOCIAL/MEDICAL HISTORY

Current occupation: _____

Are you pregnant? YES NO UNSURE
Do you drink alcohol? YES NO If yes, how often? _____
Do you smoke? YES NO If yes, how often? _____
Do you wear glasses? YES NO How long have you had your prescription? _____
Do you wear contact lenses? YES NO If yes, for how long? _____
Have you ever tried to wear contacts? YES NO
List any medications you take, the reason why you take them and the dosage – prescription or non prescription. If you have a list of medications available, please allow our staff to make copies:

_____
_____
_____

List any medications you are allergic to:

_____
_____

List all medical conditions (Diabetes, HBP, heart attack, depression, anxiety, etc.):

_____
_____

List any major surgeries you have had:

_____

What is the reason for your visit today?

_____

Are you experiencing ANY of the following (circle all that apply): loss of vision, halos, blurred vision, reading/computer problems, fluctuating vision, distorted vision, redness, loss of side vision, double vision, dryness, mucous discharge, sandy or gritty feeling, itching, burning, floaters, flashes, tearing/watering, glare/light sensitivity, pain/soreness, diagnosed infection, tired eyes, crossed/lazy eyes, drooping, and/or puffiness

Patient Name: _____ Birth date: _____

PATIENT CONSENT/HIPAA FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our Practice.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment or health care operations
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
* The Practice reserves the right to change the Notice of Privacy Policies
* The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
* **You grant permission to allow your medical information to be shared with the following individual(s)**:

_____ _____
Name Relationship

_____ _____
Name Relationship

* The patient may revoke this Consent in writing at any time and all future disclosures will then cease
* The Practice may condition treatment upon the execution of this Consent.

Signed by: _____ Date: ___/___/_____
Signature – Patient or Representative

In front of: _____
Signature – Facility representative

IMPORTANT INSURANCE INFORMATION

- If you are unsure about your insurance coverage, please call the toll-free number on your insurance card to request information from your insurance company and **become familiar with your insurance coverage.**
- You are responsible for your copayment at the time of your scheduled visit; unfortunately we cannot make **ANY** exceptions.
- You are expected to bring your insurance cards at the time of your visit. If you do not have your cards with you, you will be financially responsible for your scheduled visit or you will be asked to reschedule your appointment; unfortunately we cannot make **ANY** exceptions.
- If your insurance requires you to obtain referrals for specialists, obtain a referral from your primary care physician before your scheduled appointment time.

INSURANCE COMPANIES WE *DO* PARTICIPATE WITH:

MEDICAL	VISION
Keystone Health Plan East	Davis Vision
Blue Cross/Blue Shield (including Personal Choice and out of state carriers)	Vision Benefits of America (VBA)
AmeriHealth	National Vision Administrators (NVA)
United Healthcare	Carpenter Vision Plans
Aetna	AmeriHealth Vision plans (Delaware Co. Employees)
Cigna Commercial plans	

INSURANCE COMPANIES WE *DO NOT* PARTICIPATE WITH:

MEDICAL	VISION
Bravo	EyeMed
Humana and Humana Medicare	Cole Managed Vision
Advantra	VSP
Keystone Mercy	Spectera
Cigna Medicare	
ANY Medicare private fee for service plan (PFFS)	

Primary Insurance Co	
Policy holder's name/DOB/SSN	
Policy #/Group #	
Copay amt	

Secondary Insurance Co	
Policy holder's name/DOB/SSN	
Policy #/Group #	
Copay amt	

Vision Insurance Co	
Policy holder's name/DOB/SSN	
Policy #/Group #	
Copay amt	