Welcome to The Papale Eye Center

Thank you for scheduling your appointment with us. We look forward to meeting with you.

Please fill out the enclosed forms prior to your visit and either mail back to us or bring them with you on the day of your appointment. Kindly bring your insurance cards and a photo identification to your appointment so that we may make a photocopy of them.

We ask that you plan to arrive for your visit approximately 15 minutes prior to your appointment time to allow our staff to process your paperwork. We will make every effort to see you at your scheduled appointment time.

A complete eye examination will take between 1 ½ and 2 hours, so please allow ample time for this thorough exam.

It is important for the doctor to have a list of your current medications, so please list them on the enclosed health form.

Prior to your visit, please be sure to contact your insurance company to see if a referral is required. If one is needed, it is your responsibility to call your primary care physician to obtain the referral prior to your visit. It is also your responsibility to understand your insurance plan and associated copays and/or deductibles.

We ask that if you are new to our office and you currently wear contact lenses, please discontinue wearing your lenses for 4 days prior to your appointment. If you are scheduled for a routine eye exam or a contact lens fitting, you do not need to discontinue wearing your lenses.

Again, we look forward to including you in our growing family of happy patients.

The Staff at the Papale Eye Center

Directions to our 1515 Allen St., Springfield office:

From the South: Take 91 North to exit 2. Follow signs toward 83 to Sumner Ave. Continue on Sumner for 4-5 miles. After passing McDonalds on the right, bear right onto Allen St. Turn left into the first office building on the left.

From the North: Take 91 South to Exit 4. Take a left turn at the light, which brings you underneath I-91. Follow signs for 83 South. Turn right up the hill onto Longhill St. Turn left at the first light onto Sumner Ave/83 South. Continue on Sumner Ave for 4-5 miles. After passing McDonalds on the right, bear right onto Allen St. Turn left into the first office building on the left.

From East Longmeadow: From the rotary, take Elm St. northward and continue as it turns into Cooley St. Make a left onto Allen St. (at the intersection with 4 gas stations). The office is on the right side, across the street from Bicentennial Plaza.

PAPALE EYE CENTER

TODAY'S DATE _____

HOW DID YOUR HEAR ABOUT US?_____ DATE & LOCATION LAST EYE EXAM: _____

NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE DR NAME & ADDRESS: _____

MEDICAL HISTORY

	YES	NO		YES	NO
DIABETES	____	____	ARTHRITIS	____	____
HEART ATTACK	____	____	CANCER/TUMOR	____	____
HIGH BLOOD PRESSURE	____	____	THYROID DISEASE	____	____
STROKE/SHOCK	____	____	SEIZURES	____	____
PACEMAKER/DEFIBRILLATOR	____	____	BLOOD CLOTS	____	____
ASTHMA	____	____	BLEEDING DISORDER	____	____
EMPHYSEMA	____	____	TRANSFUSIONS	____	____
LIVER DISEASE/JAUNDICE	____	____	AIDS/HIV POSITIVE	____	____
STOMACH ULCER	____	____	KIDNEY STONES/DISEASE	____	____
PACEMAKER	____	____	**LATEX ALLERGY**	____	____

OTHER: _____

FAMILY HISTORY *AMONG BLOOD RELATIVES*

	YES	NO		YES	NO
GLAUCOMA	____	____	RETINAL DISEASE	____	____
CATARACTS	____	____	DIABETES	____	____
MACULAR DEGENERATION	____	____	HEART DISEASE	____	____
NIGHT BLINDNESS	____	____	BLEEDING DISORDER	____	____

SOCIAL HISTORY

	YES	NO		
DO YOU DRINK ALCOHOL?	____	____	HOW MUCH PER DAY?	_____
DO YOU SMOKE?	____	____	HOW MUCH PER DAY?	_____

LIST ALL ALLERGIES: _____

PLEASE LIST ALL ***EYE*** MEDICATIONS YOU ARE CURRENTLY USING: _____

_____

_____

PLEASE LIST ANY PREVIOUS EYE SURGERY:

1. _____
2. _____
3. _____

OTHER SURGICAL PROCEDURES:

1. _____
2. _____
3. _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND THE DOSE:

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

7)_____ 8)_____

PHARMACY NAME AND ADDRESS: _____

PATIENT SIGNATURE: _____ ***TODAY'S DATE*** _____

HOW DID YOU HEAR ABOUT US? _____ **TODAY'S DATE**: _____

PATIENT'S NAME: _____

ADDRESS: _____ EMAIL: _____
Street Address

_____ SOCIAL SECURITY #: __ __ __-__ __-__ __ __ __
City, State, Zip code

GENDER: MALE ☐ FEMALE ☐ DATE OF BIRTH: _____ AGE: _____

(If patient is a minor:) Father's name: _____

Mother's name: _____

TELEPHONE: Home: _____Work: _____ Cell:_____

MARITAL STATUS: SINGLE ☐ WIDOWED ☐

MARRIED ☐ DIVORCED ☐

OCCUPATION: _____

EMPLOYER (if applicable):

_____

_____
Employer's Street Address

_____
City, State Zip Code

Is today's visit related to an accident?: _____ Work Related? _____ Auto? _____

EMERGENCY CONTACT: _____ _____
Name *Relationship*

Phone:_____.

INSURANCE INFORMATION

COPY OF INSURANCE CARD ☐

PRIMARY INS CO: _____

POLICY HOLDER:_____

POLICY ID NUMBER: _____

SECONDARY INS CO:_____

POLICY HOLDER:_____

POLICY ID NUMBER: _____

1) MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Papale Eye Center for services furnished to me by The Papale Eye Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item p of the HCFA form or elsewhere on the approved claim forms, my signature authorizes releasing of the information to the insurer of the agency shown.

The Papale Eye Center accepts the charge determination of the Medicare carrier, Blue Cross/ Blue Shield of Mass., as the full charge and the patient is responsible only for the deductible ($155.00 per year as required my Medicare), the coinsurance, and non-covered services. Non-covered services include a refraction (the part of the examination to determine a possible change in glasses). I understand that I am responsible for this charge of $45.00 as it is a non-covered service per Medicare, and that it is unrelated to the exam by the doctor to assess the health of the eyes (checking for glaucoma, cataracts, etc.).

_____ _____ / _____/ _____

Signature Date

2) MEDICARE SUPPLEMENT INSURANCE (SECONDARY)

If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on the other approved forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to the Papale Eye Center. ***If my plan requires a referral from my primary care physician, I understand that I am responsible to obtain this referral and that if I do not, I am responsible for the charges in full.***

_____ _____ / _____/ _____

Signature Date

3) OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to The Papale Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance plan, I agree to pay them to The Papale Eye Center. ***If my plan requires a referral from my primary care physician, I understand that I am responsible to obtain this referral and that if I do not, I am responsible for the charges in full.*** I authorize The Papale Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____ / _____/ _____

Signature Date

John J. Papale, M.D Sarah A. Hanson, M.D. Mary Ann K. Rubis, O.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

I _____ acknowledge that I have received a copy of ***The Papale Eye Center's*** NOTICE OF PRIVACY PRACTICES. This notice describes how ***The Papale Eye Center*** may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Further, I _____ hereby authorize the doctors and/or staff of ***The Papale Eye Center*** to discuss my medical information with the following people:

Name:_____ Name : _____

Relationship:_____ Relationship: _____

Phone #: _____ Phone #: _____

_____ _____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Minor Patient)

FINANCIAL POLICY

_____ **1. Insurance Coverage**

init. It is the patients' responsibility to verify the following:

-Our physicians participate with your insurance plan and are In-network.
-Your plan covers routine eye care.
-If you have a separate insurance carrier for routine eye care.
-If a referral and/or pre-authorization is required for your visit

It is simply not possible for our staff to know the details of every individual insurance plan.

_____ **2. Coverage Changes**

init Please notify our office of any changes to your insurance coverage. If your coverage was not in effect at the time of your visit, you will be responsible for payment in full.

_____ **3. Co-payments and Deductibles**

init. All co-payments are due at the time of service. Contact your insurance company to obtain co-pay, coinsurance/deductible information. A $10.00 service charge will be added to your co-payment if we bill you.

_____ **4. Refraction**

init. A refraction (the required measurement for a glasses prescription by the doctor or technician) is typically not a covered benefit. You are responsible for the $45.00 fee. If you do not want this service, please alert the technician and/or doctor. Please note, you will not be able to get a new Rx without this service

_____ **5. Missed Appointments**

init. If you need to cancel an appointment, please contact our office at least 24 hours prior to the appointment time. **Any three missed appointments in a twelve-month period are grounds for patient termination from the practice**.

_____ **6. Returned Checks**

init. There is a $25.00 service charge for any returned check. This fee will be applied to your outstanding balance. The practice reserves the right to place you on a cash only basis following any returned checks.

I have read and understand the financial policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE PAPALE EYE CENTER MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Papale Eye Center is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by The Papale Eye Center or received by The Papale Eye Center from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. The Papale Eye Center will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

The Papale Eye Center reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

The Papale Eye Center may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment, and healthcare operations. There are certain restrictions on uses and disclosures or treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services fro mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, The Papale Eye Center may determine that you require services of a specialist. In referring you to another doctor, The Papale Eye Center may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by The Papale Eye Center to obtain reimbursement for services rendered to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with our insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, The Papale Eye Center will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluations and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, The Papale Eye Center may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

The Papale Eye Center may contact you by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when The Papale Eye Center is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.
- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency.

---

[1]This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient of community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test result, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, Including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or the community from imminent and substantial danger.

- For worker's compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

The Papale Eye Center will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that The Papale Eye Center has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of protected health information by The Papale Eye Center to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review/obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. The Papale Eye Center may deny an access under other circumstances, in which you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request the The Papale Eye Center send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that The Papale Eye Center not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that The Papale Eye Center amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by The Papale Eye Center for six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the notice electronically.

Any person or patient may file a complaint with The Papale Eye Center and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with The Papale Eye Center, please contact the Privacy Officer at the following:

Privacy Officer
The Papale Eye Center
1515 Allen St – Suite E
Springfield, MA 01118
(413) 782-0030

It is the policy of The Papale Eye Center that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.