RICHARD J. MANGANIELLO, MD
Connecticut Eye Physicians and Surgeons, LLC
479 Buckland Road, South Windsor, CT 06074

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

NAME: _____

May we leave messages/detailed medical information at either of these phone numbers?

Home:(_____)_____ □ Yes □ No Cell Phone:(____)_____ □ Yes □ No

May we contact you by email? □ Yes (email: _____) □ No

May we contact you at your place of employment? □ Yes □ No
If yes, Work Phone: _____ ext. _____

Do you have any particular person or family member that you authorize to receive and discuss information regarding your personal health information (general, medical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: (___)_____ Alternate phone number: (____)_____

Does this person have medical Power of Attorney for you? □ Yes □ No

If Power of Attorney for medical purposes is held by a different person, please provide:

Name: _____ Relationship: _____

Phone Number: (____)_____ Alternate phone number: (____)_____

I hereby authorize Connecticut Eye Physicians and Surgeons to obtain or release any and all pertinent information regarding my medical care, as needed, to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the CEPS Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

If signed by other: Name: _____ Relationship: _____

DRUG ALLERGIES: _____ [*or check here* □ *if NONE*]

Past ocular history and eye surgeries: _____

_____

CURRENT MEDICATIONS (all medications, not just eye-related): □ **check here if you are attaching a list**

MEDICATION NAME	STRENGTH/DOSAGE		MEDICATION NAME	STRENGTH/DOSAGE

DIABETIC PATIENTS: MOST RECENT A1C results _____ date: _____

Last 3 surgeries (non eye-related, name and year): _____

_____

FAMILY HISTORY: (please check all that apply and circle relationship)

□ Diabetes	Mother	Father	Sibling	Grandparent	□ Glaucoma	Mother	Father	Sibling	Grandparent
□ Cancer	Mother	Father	Sibling	Grandparent	□ Mac. Degeneration	Mother	Father	Sibling	Grandparent
□ Heart Disease	Mother	Father	Sibling	Grandparent	□ Retinal Disease	Mother	Father	Sibling	Grandparent
□ Stroke	Mother	Father	Sibling	Grandparent	□ High Blood Pressure	Mother	Father	Sibling	Grandparent
□ TB	Mother	Father	Sibling	Grandparent	□ Kidney Disease	Mother	Father	Sibling	Grandparent
□ Blindness	Mother	Father	Sibling	Grandparent	□ Lazy Eye	Mother	Father	Sibling	Grandparent
□ Cataracts	Mother	Father	Sibling	Grandparent	□ Other:				
□ Arthritis	Mother	Father	Sibling	Grandparent	_____	Mother	Father	Sibling	Grandparent

SOCIAL HISTORY

1) SMOKING: □ Every day □ Some days □ Former smoker □ Never

2) ALCOHOL: □ Yes □ No

3) DRUGS: □ Yes □ No

REVIEW OF SYSTEMS (symptoms that you are *currently experiencing, please check yes or no)*

EYES		**RESPIRATORY**		**BLOOD/LYMPH**	
Previous surgery	□ Yes □ No	Cough	□ Yes □ No	Easy Bruising	□ Yes □ No
Contact Lens	□ Yes □ No	Congestion	□ Yes □ No	Gums Bleed Easily	□ Yes □ No
Pain	□ Yes □ No	Wheezing	□ Yes □ No	Prolonged Bleeding	□ Yes □ No
Double Vision	□ Yes □ No	Asthma	□ Yes □ No	Heavy Aspirin Use	□ Yes □ No
Glaucoma	□ Yes □ No				
Cataracts	□ Yes □ No	**GASTROINTESTINAL**		**MUSCULOSKELETAL**	
Macular Degeneration	□ Yes □ No	Heartburn	□ Yes □ No	Stiffness	□ Yes □ No
Dry Eyes	□ Yes □ No	Nausea/Vomiting	□ Yes □ No	Arthritis	□ Yes □ No
Flashes	□ Yes □ No	Jaundice/Hepatitis	□ Yes □ No	Joint Pain/Swelling	□ Yes □ No
Floaters	□ Yes □ No				
		GENITO-URINARY			
EAR, NOSE, THROAT		Pain/Difficulty	□ Yes □ No	**SKIN**	
Hard of Hearing	□ Yes □ No	Blood in Urine	□ Yes □ No	Rashes/Sores	□ Yes □ No
Ringing in Ears	□ Yes □ No	History of Kidney Stone	□ Yes □ No	Lesions	□ Yes □ No
Vertigo	□ Yes □ No	History of STD's	□ Yes □ No	Hives/ Eczema	□ Yes □ No
CARDIOVASCULAR		**PSYCHIATRIC**			
Chest Pain	□ Yes □ No	Anxiety/Depression	□ Yes □ No	**NEUROLOGICAL**	
Dizziness	□ Yes □ No	Mood Swings	□ Yes □ No	Seizures	□ Yes □ No
Fainting Spells	□ Yes □ No	Difficulty Sleeping	□ Yes □ No	Weakness/Paralysis	□ Yes □ No
Shortness of Breath	□ Yes □ No			Numbness	□ Yes □ No
Irregular Heartbeat	□ Yes □ No			Tremors	□ Yes □ No
Difficulty Lying Flat	□ Yes □ No	**ENDOCRINE**			
		Increased Thirst	□ Yes □ No	**IMMUNOLOGIC**	
CONSTITUTIONAL		Increased Hunger	□ Yes □ No	Hives	□ Yes □ No
Fatigue/Weakness	□ Yes □ No	Increased Urination	□ Yes □ No	Itching	□ Yes □ No
Fever	□ Yes □ No	Increased Sweating	□ Yes □ No	Runny Nose	□ Yes □ No
Weight Gain/Loss	□ Yes □ No	Fingernail Changes	□ Yes □ No	Sinus Pressure	□ Yes □ No

MEDICAL OR ROUTINE?

DR. RICHARD MANGANIELLO is an ophthalmologist, a medical doctor who specializes in providing comprehensive medical eye care. Examinations are usually submitted to your insurance as a medical visit with a medical diagnosis code.

Some patients have "routine vision" coverage. As long as your routine coverage is submitted to and paid by your medical insurance carrier we may be able to submit your visit as a routine claim for you. However, we are not contracted with, do not participate with, and are unable to submit claims to a vision plan (i.e.,VSP, Davis Vision, etc.) **If your insurance coverage allows for routine exams, and you feel you are coming in for a routine exam *only*, you must notify us when scheduling your appointment.** We will review your choice with you when you arrive for your appointment.

ROUTINE EYE EXAMINATION: A routine eye exam is for general screening. It will provide an overall evaluation of the health of your eyes, and determine if your vision can be improved with a prescription for eyeglasses or contact lenses. A routine eye exam will NOT treat or monitor medical conditions that might require additional testing or imaging.

MEDICAL EYE EXAMINATION: A medical eye examination is for diagnosing and monitoring conditions and diseases that manifest with ocular symptoms, including but not limited to: Corneal disorders such as dry eyes, diabetes, cataracts, glaucoma or glaucoma suspect, double vision, retinal or macular problems, or any acute or sudden symptoms.

If you are being followed for a medical diagnosis, the doctor may not be able to address that issue during a routine eye exam. A separate appointment may need to be scheduled for a more in-depth examination to address any medical concerns.

REFRACTION: A refraction test determines the refractive power of your eyes and the best corrective lenses to be prescribed to correct your refractive error. It is the only way to determine your correct refractive power and provide you with an eyeglasses prescription. In addition, monitoring the changes in your refractive error is integral to the diagnosis and treatment of many eye disorders including those of the cornea, lens (i.e., cataracts) and the macula. It is a necessary, standard-of-care element of your exam. Many medical plans, including Medicare, do not cover refraction, regardless of the reason it is performed. Should your insurance plan not cover the cost of refraction, you will be responsible for a $35 refraction fee to cover a portion of the cost. The fee for an updated *contact lens prescription* is $30. You will not be given a copy of your prescription unless the fee is paid.

Please understand that each patient's insurance coverage varies and that Connecticut Eye Physicians & Surgeons cannot be held responsible for knowing each patient's insurance coverage or type of insurance. **It is your responsibility to know and understand your insurance benefits, and to provide us with your current coverage information BEFORE your examination.**

We will be happy to assist you in scheduling the correct appointment for your medical eye care needs.

OFFICE OF RICHARD J. MANGANIELLO, M.D.

APPOINTMENT DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL ____

STREET ADDRESS _____ TOWN _____

STATE _____ ZIP CODE _____ AGE _____

☐ MALE ☐ FEMALE SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH ____/____/____

HOME PHONE (_____)_____ WORK PHONE(_____)_____ EXT. _____ CELL (_____)_____

MARITAL STATUS: ☐MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED EMAIL: _____

1) LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

2) ETHNICITY: ☐ **HISPANIC OR LATINO** ☐ **NOT HISPANIC OR LATINO** ☐ **REFUSED TO ANSWER**

3) RACE: ☐ AMER. INDIAN ☐ BLACK OR AFRICAN AMER. ☐ HAWAIIAN OR PACIFIC ISLAND ☐ REFUSED TO ANSWER ☐ ASIAN ☐ UNKNOWN ☐ WHITE

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS _____

PERSON TO CONTACT OTHER THAN PATIENT:

NAME_____ PHONE _____ RELATIONSHIP _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN:_____

PHARMACY: RETAIL: _____ MAIL ORDER: _____
(NAME) (TOWN)

INSURANCE INFORMATION

1) PRIMARY INSURANCE**:** _____ ID# _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DATE OF BIRTH ____ / ___ / ___

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER: _____

2) SECONDARY INSURANCE**:** _____ ID# _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DATE OF BIRTH ____ / ___ / ___

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER: _

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

___ DECREASED DISTANCE VISION ___ CHANGE IN FLOATERS ___ DIMMING OF VISION

___ DECREASED NEAR VISION ___ FLASHES OF LIGHT ___ WORSENING NIGHT VISION

___ ITCHING, REDNESS, OR TEARING ___ DOUBLE VISION

___ **OTHER (please explain)**: _____

HOW DID YOU HEAR ABOUT US? ☐ FAMILY ☐ FRIEND ☐ HOSPITAL ☐ WEBSITE
☐ YELLOW PAGES ☐ INTERNET ☐ INSURANCE DIRECTORY ☐ PHYSICIAN ☐ OTHER: _____

SIGNATURE AND FINANCIAL AUTHORIZATION: I certify that insurance information I have provided is accurate. Insurance submission is provided as a courtesy to me and I am responsible for correct insurance information and any required referrals. I am responsible for all co-payments, deductibles, refraction fees and balances not covered by my health insurance. **I agree to pay any co-payments, refraction fees and deductibles at time of service.** In the event of default I understand a finance charge may be added to my outstanding account after 30 days. The minimum monthly finance charge is $15.00 or 18% per annum (whichever is greater). Unless I have made previous arrangements my outstanding balance will be processed for collections after 2 statements. I agree to pay all collections costs and legal fees associated with collecting the debt. I agree to pay a $35.00 fee for each returned or NSF check.

SIGNATURE _____ NAME (PRINT) _____

PLEASE COMPLETE BOTH SIDES!!!►►►►►►►►►►►►

RICHARD J. MANGANIELLO, MD

REFRACTION BILLING POLICY FOR ALL PATIENTS

PLEASE SIGN AND RETURN TO OFFICE

To my patients:

REFRACTION is the process of determining refractive error, and is done for diagnostic purposes as well as for establishing any need for corrective lenses (eyeglasses). This is an essential part of an eye examination, and is done during a complete medical eye exam as a standard of responsible care. Unfortunately, Medicare and some commercial insurance carriers choose not to cover this service, even while recognizing the need for it.

The patient fee for refraction is $35.00 if your insurance plan does not cover this service. This fee is *in addition to* any co-pay, co-insurance, or deductible required by your insurance. In order to keep billing costs down, we will ask for refraction payments at the time of your appointment if it is not a covered service on your insurance plan.

The fee for a complete, updated contact lens prescription is $30.00. This service is provided for those patients who are happy with their current brand of contact lenses and wish to have the fit, prescription strength, and suitability checked so that refill lenses can be ordered locally or online. You will need to wear your current contact lenses in for the exam and bring the boxes that have the measurements printed on them. This fee is not covered by medical insurance plans and will be collected at the time of service.

My office staff and I will be happy to answer questions regarding this policy.

Thank you,

Richard J. Manganiello, MD

CEPS 02-04-14

☐ ALL PATIENTS: I have read the above information and accept full financial responsibility for the $35.00 patient refraction fee should my insurance plan not cover the service.

☐ CONTACT LENS PATIENTS: I understand that there is an additional $30.00 fee payable at the time of service if I wish to obtain a complete, updated contact lens prescription.

I understand that these fees are in addition to any and all co-pays, co-insurances and deductibles.

Patient Signature: _____ DATE: _____

Patient Name (printed): _____

If signed by someone other than the patient, please print name and relationship to patient:

_____