

DR. ANDREA THAU & ASSOCIATES

DOCTORS OF OPTOMETRY
77 PARK AVENUE, NEW YORK, NY 10016
T: (212) 685-2457 F: (212) 685-5989

REFERRED BY: _____

PATIENT NAME: _____ SS#: _____

ADDRESS: _____ APT #: _____

CITY/STATE/ZIP: _____ DATE OF BIRTH: _____

CELL PHONE: _____ HOME PHONE: _____

WORK PHONE: _____ EMAIL: _____

PREFERRED CONTACT: CELL WORK HOME EMAIL MARITAL STATUS: S M SEP D W

EMPLOYER NAME: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ RELATION: _____

CELL PHONE: _____ WORK PHONE: _____

INSURED'S INFORMATION (IF NOT THE PATIENT)

NAME: _____ RELATION: _____

DATE OF BIRTH: _____ SS#: _____

HOME ADDRESS/CITY/STATE/ZIP: _____

WORK PHONE: _____ CELL PHONE: _____ EMAIL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ EFFECTIVE DATE: _____

ADDRESS: _____ PHONE: _____

ID#: _____ GROUP #: _____

SECONDARY INSURANCE NAME: _____ EFFECTIVE DATE: _____

ADDRESS: _____ PHONE: _____

ID#: _____ GROUP #: _____

FINANCIAL ARRANGEMENTS AND INSURANCE

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and amount exceeding your annual maximum are due at the time of service.
If your insurance requires you to have a referral at the time of the visit, it is your responsibility to obtain the referral. If you do not have one at the time of service, you are required to pay for the visit in full.
Returned checks are subject to a \$40.00 fee.
Routine eye examinations, refractions, contact lens fittings, contact lens evaluations and vision therapy are NOT COVERED by most insurance plans/companies.
There is a \$50.00 CANCELLATION FEE for failure to cancel within 24 hours prior to your appointment. Except for visual evaluations/perceptual appointments, there is a \$100.00 CANCELLATION FEE for failure to cancel these appointments within 48 HOURS prior to your appointment.
Visual Skills Evaluations and Visual Perceptual Evaluations are NOT COVERED by any insurance plans/companies.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRs. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DRs. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER, AND CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE BILL IF MY INSURANCE COMPANY DOES NOT COVER ANY SERVICES RENDERED.

PLEASE MAKE SURE YOU HAVE READ THIS DOCUMENT VERY CAREFULLY.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: _____ DATE: _____

DR. ANDREA THAU & ASSOCIATES
DOCTORS OF OPTOMETRY
FELLOW, AMERICAN ACADEMY OF OPTOMETRY
77 PARK AVENUE
NEW YORK, NY 10016
TELEPHONE: (212) 685-2457
FAX: (212) 685-5989

Pediatric Questionnaire

Please complete the following questionnaire concerning your child's medical and developmental history:

Child's Name: _____ Date of Birth: _____

Address: _____

Home Phone Number: _____ Alternate (cell): _____

Mother's Name: _____ Father's Name: _____

Occupation: _____ Occupation: _____

Work Number: _____ Work Number: _____

School: _____ Grade: _____

Whom can we thank for referring you? _____

Reason for examination (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Referred by school or doctor | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Broken or lost glasses | <input type="checkbox"/> Burning, itching tearing |
| <input type="checkbox"/> Academic difficulties | <input type="checkbox"/> Eyes turn in / up / down |
| <input type="checkbox"/> Trouble seeing the blackboard | <input type="checkbox"/> Rubs eyes |
| <input type="checkbox"/> Slow Reader | <input type="checkbox"/> Tilts head |
| <input type="checkbox"/> Poor reading comprehension | <input type="checkbox"/> Squints |
| <input type="checkbox"/> Doesn't enjoy reading | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Poor writing skills | <input type="checkbox"/> Fine or gross motor skills difficulty |
| <input type="checkbox"/> Inconsistent or poor sports performance | <input type="checkbox"/> Fatigue / frustration / stress |
| <input type="checkbox"/> Other _____ | |

History:

Date of last examination with pediatrician: _____ Name of doctor: _____

Date of last eye examination: _____ Name of doctor: _____

Does your child have or has s/he ever had:

Glasses / Eye Patch / Vision Therapy / Eye Injury / Eye Surgery?

General Health:

Height: _____ Weight: _____

Has your child ever taken an Influenza (Flu) Immunization: Y / N If yes when was it given: _____

Are immunizations up to date? Y / N If not when was last immunization date: _____

Medical Conditions: Y / N _____

Hospitalization: Y / N _____

Allergies (including medications): Y / N _____

Medication (current): _____

Has your child ever undergone any of the following testing? Or therapies?

If so, please include names of providers, the length, and the frequency of each therapy.

- Educational _____
- Psychological _____
- Neurological _____
- Developmental _____
- Other _____
- Physical _____
- Speech _____
- Occupational _____
- Language _____

Family History (identify family member next to condition):

- Lazy Eye _____
- Eye Disease _____
- Blindness _____
- Farsightedness _____
- Nearsightedness _____
- Astigmatism _____

Pregnancy History (did any of the following occur?):

- Routine care
- Infection
- Alcohol use
- Staining
- Drug use
- Toxemia
- Prescription Medication
- Other _____

Length of pregnancy: _____ months. Birth Weight: _____

Developmental History:

At what age did your child crawl? _____ Sit? _____ Walk? _____ Talk? _____.

Academic History

Current Grade: _____

Please check all that apply and complete all applicable sentences:

- Honors Curriculum
- Special Education
- Repeated Grade _____
- Other: _____
- Regular Classroom
- Resource Room
- Tutor for _____

Parent Signature: _____ Reviewed by: _____, OD

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

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- Returned checks are subject to a **\$40.00 FEE**.
- Routine eye examinations, refractions, contact lens fittings, contact lens evaluations and vision therapy are **NOT COVERED** by most insurance companies.
- There is a **\$50.00 CANCELLATION FEE** for failure to cancel within **24 hours** prior to your appointment. Except for visual evaluations and/or perceptual appointments, there is a **\$75.00 CANCELLATION FEE** for failure to cancel these appointments within **48 hours** prior to your appointment.
- Visual Skills Evaluations and Visual Perceptual Evaluations are **NOT** covered by any insurance plans/companies.

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SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF HIPPA RECEIPT

I acknowledge that I received and/or reviewed a copy of Dr. Andrea P. Thau and Associate's Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized by law under the circumstances described in the Notice of Privacy Practices.

Patient Name: _____

Signature: _____

If you are signing as a personal representative for the patient, describe your relationship to the patient and the source of your authority to sign the form:

Relationship to patient: _____ Print name: _____

Source of Authority: _____