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

WELCOME TO OUR OFFICE

REFERRED BY: _____

PATIENT NAME: _____ SS#: _____
ADDRESS: _____ APT#: _____
CITY/STATE/ZIP: _____ HOME PHONE#: (____) _____
CELL PHONE#: (____) _____ EMAIL: _____
WORK PHONE#: (____) _____ WORK FAX#: _____
DATE OF BIRTH: _____ MARITAL STATUS: S M SEP D W
EMPLOYER NAME: _____ OCCUPATION: _____
WORK ADDRESS/CITY/STATE/ZIP: _____
EMERGENCY CONTACT: _____ RELATION: _____
HOME PHONE#: (____) _____ WORK PHONE#: (____) _____

INSURED'S INFORMATION (IF NOT THE PATIENT)

NAME: _____ RELATION: _____
ADDRESS/CITY/STATE/ZIP: _____
HOME PHONE#: (____) _____ DATE OF BIRTH: _____ SS#: _____
EMPLOYER: _____ WORK PHONE#: (____) _____

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 **$30.00 CANCELLATION FEE** for failure to cancel within **24 hours** prior to your appointment. Except for visual evaluations/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.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ERICA SCHULMAN AND/OR 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 ERICA SCHULMAN. I 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 BE 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):

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

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 _____ ☐ Physical _____

☐ Psychological _____ ☐ Speech _____

☐ Neurological _____ ☐ Occupational _____

☐ Developmental _____ ☐ Language _____

☐ Other _____

Family History (identify family member next to condition):

☐ Lazy Eye _____ ☐ Farsightedness _____

☐ Eye Disease _____ ☐ Nearsightedness _____

☐ Blindness _____ ☐ 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 ☐ Regular Classroom

☐ Special Education ☐ Resource Room

☐ Repeated Grade _____ ☐ Tutor for _____

☐ Other: _____

Parent Signature: _____ Reviewed by: _____, OD

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

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SIGNATURE_____ DATE_____

ACKNOWLEDGMENT OF HIPAA 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: _____