WELCOME TO OUR OFFICE

DR. ANDREA THAU & ASSOCIATES

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

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 a referral is required, the patient must obtain the referral prior to the visit, if not the visit must be paid 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 **$100.00 CANCELLATION FEE** for failure to cancel within **24 hours prior to your appointment.** For visual evaluations/perceptual appointments, there is a **$200.00 CANCELLATION FEE** (per evaluation) 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.
- Contact lens and frame orders must be paid in full before ordering.

AUTHORIZATION FOR ASSIGMNENT OF BENEFIT

I HEREBY AUTHORIZE DR. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA AND/OR LAUREN STRAWN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SREVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. ANDREA THAU. FRAN REINSTEIN, MARILYN VRICELLA AND/OR LAUREN STRAWN 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:** _____

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and amount exceeding your annual maximum are due at the time of service.
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- Visual Skills Evaluations and Visual Perceptual Evaluations are NOT COVERED by any insurance plans/companies.
- Contact lens and frame orders must be paid in full before ordering.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR LAUREN STRAWN 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 LAUREN STRAWN, 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.

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

SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT 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: _____

Dr. Andrea Thau and Associates
Doctors of Optometry
77 Park Avenue, New York, NY 10016
212.685.2457

Pediatric Questionnaire

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

Child's Name: _____ Date of Birth: _____

Address: _____ Home phone: _____

Parent's Name (1): _____ | Parent's Name (2): _____

Cell phone: _____ | Cell phone: _____

Occupation: _____ | Occupation: _____

Work number: _____ | Work number: _____

Child's 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
- ☐ 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

☐ 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 she/he ever had: Glasses / Eye patch / Vision therapy / Eye injury / Eye surgery?

General Health:

Height: _____ Weight: _____

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

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

Medical conditions: Y / N If yes: _____

Hospitalizations: Y / N If yes: _____

Allergies (including medications): Y / N If yes: _____

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 _____
- ☐ Nearsightedness _____
- ☐ Eye disease (i.e. Glaucoma/ Macular degeneration/ Other) _____
- ☐ Blindness _____
- ☐ Medical conditions (circle which apply): High blood pressure Diabetes Heart disease Cancer
- ☐ Farsightedness _____
- ☐ 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: _____ Date: _____

Reviewed by: _____, OD

Dr. Thau and Associates • 77 Park Avenue • New York, NY 10016 • T 1-212-685-2457 • F 1-212-685-5989
Dr. Andrea Thau • Dr. Fran Reinstein • Dr. Marilyn Vricella • Dr. Lauren Strawn

Medications and Allergies Form

Medication Name Example: *"Aspirin"*	**Dosage** **(# of mg etc)** Ex: *"81 mg"*	**Form** **(capsule, tablet, drop)** Ex:*"Tablet"*	**Frequency** Ex:*"1x/ day"*	**Indication** **(What is it a treatment for?)** Ex: *"Heart condition"*

Drug/Medication Allergic to Example: *"Penicillin"*	**Allergic Reaction** Ex: *"Hives"*	**Severity** Ex: *"Moderate"*	**Start Date** Ex: *3/1990*