LISA S. BUNIN, M.D.

WELCOME

PATIENT INFORMATION

DATE: _____

Thank you, for choosing our practice for your eye care and or cosmetic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name: _____ Date of Birth: _____ Age: _____
First MI Last
Address: _____ City: _____ State: _____ Zip: _____
Social Security # _____
Home Phone #: _____ Work Phone #: _____
Cell Phone #: _____ E-mail: _____
Do you prefer to receive calls at: Home Work Cell Text & E-Mail
Marital Status: Married Divorced Widowed Single Separated

Primary Language: _____ Preferred Pharmacy: _____ Phone: _____
Minor: Full time student: if so where? _____
Your or your parent's employer: _____ Occupation: _____
Employer's Address: _____ City: _____
State: _____ Zip: _____ Phone _____

SPOUSE INFORMATION
Spouse or parent's name: _____ Date of Birth: _____ Social Security # _____
Employer: _____ Work phone: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Emergency contact: _____ Relationship: _____
Phone #: _____

Family Physician: _____ M.D. , D.O. Phone #: _____
First name Last name
Address: _____ City: _____ State: _____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY (If not same as patient)
Name: _____ Address: _____
Date of Birth: _____ Social Security #: _____
Phone #: Home –Work - Cell _____
Relationship to patient: _____

Do you give consent to disclose health information to your spouse? yes no _____initial
May we leave a message on your answering machine or cell phone? yes no _____initial

Please indicate any individual(s) allowed access to your medical information. (Please note due to hippa regulations we may not discuss anything pertaining to your appointments without your signed consent. No-one _____ initial

Please be sure to initial
1) _____ relationship_____ initial _____
2) _____ relationship_____ initial _____

Referring Physician: _____

INSURANCE INFORMATION

Lisa S. Bunin, M.D.

Name of Insurance Company: _____
Insurance Company Address: _____
City: _____ State: _____
Policy Number: _____ Group Number: _____
Copay: □ Y □ N $ _____ Deductible: □ Y □ N $_____
Subscriber: _____ Date of Birth: _____ Relationship to patient: _____
Effective date of policy: _____ Type of plan: _____
Name of Employer: _____ Date Employed: _____
Address: _____ City: _____ State: _____ Zip: _____

DO YOU HAVE ADDITIONAL INSURANCE? □ Y □ N IF YES PLEASE COMPLETE THE FOLLOWING:

Name of Insurance Company: _____
Insurance Company Address: _____ City: _____
State: _____
Policy Number: _____ Group Number: _____
Copay: Y N $ _____ Deductible: Y N $_____
Subscriber: _____ Date of Birth: _____ Relationship to patient: _____
Effective date of policy: _____ Type of plan: _____

ASSIGNMENT OF BENEFITS

___ **X** I assign the benefits from my insurance carrier(s) to Lisa S. Bunin, M.D. for the medical/surgical benefits I am entitled to.

___**X** I understand that I am financially responsible for any charges not covered by this authorization.

___ **X** I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

Patient or Responsible Party
Signature_____**Date**_____

I HAVE RECEIVED AND READ A COPY OF THE FINANCIAL POLICY, ASSIGNMENT, AND RELEASE OF INFORMATION PARAGRAPHS THAT THAT APPLIES TO ME.

PLEASE INITIAL AND DATE RECEIPT OF FINANCIAL POLICY

_____ DATE: _____

Person Signing on Behalf of Patient _____
Please Print Name _____
Relationship to Patient _____
Reason Patient Cannot Sign _____

Lisa S. Bunin, M.D.

Health History Information Form **Date:** _____

Patient Name: _____ Date of Birth: _____ Age: _____
Preferred Pharmacy: _____ Pharmacy Location: _____ Phone: _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY, THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Person filling out this form: _____
Relationship to patient: _____ **Signature:** _____

1. **PAST MEDICAL HISTORY** – Have you ever had the following: ___**Patient denies any PMH**

___Alzheimer's	___ Depression	___ Hepatitis	___ Lupus	___ Sarcoidosis
___Anemia	___ Diabetes Type 1	___ Herpes Zoster	__ Meniere's	___Seizures
___Asthma	___Diabetes Type 2	____High Cholesterol	___ Mental Health Problems	___ Sickle Cell Anemia
___Arterial Fibrillation	___Fibromyalgia	____Hypertension (HBP)	___ Migraines	___Sinus
___Bell's Palsy	___Gallbladder	____ Kidney Problems	___ Parkinson's	___ Sleep Apnea
___Cancer	___Gastric Ulcer	____Liver Problems	____ Reflux	___ Stroke
___Crohn's	___Heart Disease	____ Lung Problems	___ Rheumatoid Arthritis	___ Thyroid problem
				___ Tuberculosis

Other: _____

2. **EYE CONDITIONS** – Have you ever had any of the following: ____**Patient denies any conditions**

____ Cataracts	____Eye Surgery	____Sensitivity to light	____ Eye infection or disease
____ Glaucoma	____Eye Injury	____ Floaters or spots	_____ Double vision
___ Mac Degen.	____ Medical Treatment	____ Poor distance vision	____ Eye strain
____ Retinal Prob.	____Severe Pain	____ Poor near vision	____ Eyes burn, itch or water

Other eye conditions: _____

3. **PAST SURGICAL HISTORY** – Have you ever had the following: ____ **Patient denies any past surgeries**

_____ Cancer Surgery	_____ Organ Transplant	_____ Eye Surgery/Lid Surgery
_____ Gastric Bypass	_____ Sinus Surgery	_____ Plastic Surgery
_____ Heart Surgery	_____Thyroid Surgery	_____ Lasik or Refractive Surgery
_____Hysterectomy	_____Vascular Surgery	_____ Laser Eye Surgery

Other: _____

Please check any of the following conditions that apply to you:
_____Frequent headaches _____Drug allergies _____Pregnant _____Sinus trouble
_____Have you given birth in the last 6 months?
Other: _____

CURRENT MEDICATIONS: (Please include dose and how many times per day taken.)
____Patient denies taking any medications

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Please list any vitamins that you are taking: _____
Are you allergic to any medication? ____Yes _____No If yes, what? _____
Allergic to: ____Latex Gloves _____ Contrast dye/Iodine _____ No Known Drug Allergies

Reason for today's exam: _____
Date of last exam: _____ Name of previous eye doctor: _____

4. **FAMILY HISTORY** – Does anyone in your family have a history of the following?

_____ Blindness
_____ Cataract
_____ Cornea Transplant
_____ Diabetes Type 1
_____ Diabetes Type 2
_____ Glaucoma
_____ Heart Condition
_____ Hypertension
_____ Keratoconus
_____ Macular Degeneration
_____ Allergies
_____ Cold sores
_____ Retinal Detachment
_____ Turned or Lazy Eye
_____ Asthma

5. **SOCIAL HISTORY**

Tobacco: ☐ **Yes** ☐ **Minimal** ☐ **(__- packs/day/wk. x ____ys)** ☐ **quit** ☐ **never**

Alcohol: ☐ **Daily** ☐ **Less than once per week** ☐ **More than once per week**

Do you wear glasses? ___Yes ___No Date of Prescription_____
When do you wear glasses?
___All the time ___Work/ Safety ___Reading ___Computer work ___Distance tasks only

Have you worn contacts? ___Yes ___No Date of Prescription_____
If yes, what type?
___Soft ___Extended wear ___Gas Permeable ___Bifocal ___Tinted
___Astigmatic ___Disposable ___Unsure

Do you work at a computer? __Yes __No If yes, How many hours per day?_____

What hobbies or sports do you participate in? _____

How did you hear about our practice?
___Physician ___Friend or Family Member ___A Seminar ___Insurance Company
___Internet ___Yellow Pages ___Advertisement/ Article

If you were referred by one of our patients, please share his or her name so we may thank them.
Patient's name: _____

Lisa S. Bunin, M.D.

Are you <u>currently</u> having trouble in any of the following areas? Explain your answers.

	YES	NO	Explanation of Problem
<u>Constitutional Symptoms</u>			
Fever	[ ]	[ ]	_____
Weight Loss	[ ]	[ ]	_____
Other	[ ]	[ ]	_____
<u>Eye</u>			
Loss of vision/Blurred vision	[ ]	[ ]	_____
Distorted vision (halos)	[ ]	[ ]	_____
Loss of side vision	[ ]	[ ]	_____
Double vision	[ ]	[ ]	_____
Dryness	[ ]	[ ]	_____
Mucous discharge	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Sandy or gritty feeling	[ ]	[ ]	_____
Itching	[ ]	[ ]	_____
Burning	[ ]	[ ]	_____
Foreign body sensation	[ ]	[ ]	_____
Excess tearing/watering	[ ]	[ ]	_____
Occasional tearing	[ ]	[ ]	_____
Glare/Light sensitivity	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Chronic infection of eye or lids	[ ]	[ ]	_____
Sties, chalazia	[ ]	[ ]	_____
Fluctuating visual acuity	[ ]	[ ]	_____
Flashes of light	[ ]	[ ]	_____
Floaters in vision	[ ]	[ ]	_____
Glasses: type, how used, age of Rx	[ ]	[ ]	_____
Contact Lens use, type, age of Rx	[ ]	[ ]	_____
Video display terminal use	[ ]	[ ]	_____
<u>Ears, Nose, Mouth, Throat, Body</u>			
Sinus congestion	[ ]	[ ]	_____
Cold symptoms	[ ]	[ ]	_____
Dry mouth/throat	[ ]	[ ]	_____
Respiratory (breathing)	[ ]	[ ]	_____

<u>This information is completely confidential but will help us to serve you better.</u>

What are your primary areas of concern? _____

Would you be interested in?
____Laser or Surgical Vision Correction
____Multifocal Intraocular Lenses
____Custom Cataract Surgery

Would you be interested in any of the following cosmetic services?

____Restylane	____Chemical Peels	____Sunscreen Advice
____AHA and Glycolic Peels	____Laser Resurfacing	____Removing Leg Veins
____Collagen Therapy	____Laser Treatment s	____Facial and Hair Treatments
____Skin Rejuvenation	____Avage (tazarotene)	____Hair Removal
____Retin-A or Renova	____Skin Care Advice	____Spider Vein Treatments
____Microdermabrasion	____Skin Care Products	____Removing Facial Veins
____Botox Cosmetic	____Birthmarks	____Liver or Age Spot Treatments
____Acne Treatment	____Other, please specify_____	

Have you ever had fillers? (___Restalyne, ___Radiesse, ___Juvederm, ___Other_____)
Have you ever had Botox? ____yes ____no
Have you ever had Lasers? ____yes ____no if yes for what? _____
Have you ever had cosmetic surgery? ____yes ____no if yes for what? _____
Were you pleased with the outcome? ____yes ____no if not, Why? _____

If our office held a seminar for patients to learn more about certain cosmetic procedures, would you be interested in attending? _____

Lisa S. Bunin, M.D.
1611 Pond Rd
Suite 403
Allentown, Pa 18104
(610) 435-5333

Financial Policy

It is our office policy to inform you of our patient payment procedure, if a balance remains unpaid, we may refer your account to a collection agency. Please review the section below and check off the category, which is applicable to you:

_____ **Patients Without Insurance (Self Pay):**
Please make payment for your care at each patient visit. Payment is required at time of service.

_____ **If We Do Not Participate With Your Insurance:**
Please make payment for your care at each patient visit. If payment is made at the time of service, we will assist you by submitting a claim to your insurance carrier. Benefits will be assigned to you. It is your responsibility to follow up with your insurance carrier regarding your claim.

_____ **If We Do Participate With Your Insurance (Non Medicare):**
You are responsible for deductibles, co-pays, non-covered services, coinsurances and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. We will submit your claim and assist you in any way reasonable to resolve claim payment. Your insurance company may need you to supply certain information. It is your responsibility to comply with their request. Insurance information must be supplied to us at the time of service. As insurance carriers have time limits on filing claims. You may be responsible for any claim where insurance information was not provided to us.

_____ **Medicare**
Our office will submit your Medicare charges to your Medicare carrier and your secondary insurance. You are responsible for deductibles, co-pays and any non-covered services. **Refraction fees are a non-covered service under your Medicare plan however; they are a mandatory service under Medicare regulations.**

__X___ **Photo Fees**
External photos are always a non-covered service. You will be responsible for those fees.

__X___ **Additional Fees**
We reserve the right to charge a $25.00 no show appointment fee for any appointment not cancelled within
24 business hours from the time/date of the appointment. (Example Friday a.m. for a Monday appointment).

If Refraction fees are a non-covered service under your insurance plan you will be responsible for those fees.
We may submit refractions fees to your insurance on your behalf however this is not a guarantee of coverage.

Lisa S. Bunin MD

Refraction Policy

1. **What is a refraction**?

Refraction is the process of determining the eye's refractive error, or need for corrective glasses and or contact lenses.

2. **Why is it necessary**?

Refraction is necessary depending on the patient's diagnosis and /or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction is needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also needed to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription. As you can see, a refraction is an essential part of an eye exam, however Medicare and most insurance plans DO NOT COVER IT.

IMPORTANT: If you decline to have the refraction done we may not be able to determine the cause for your decrease in vision. I also understand that if I break, lose or change my mind and need a glasses prescription we will not have one one file. You will be scheduled a return appointment and charged another office visit and $40.00 refraction

3. **How much** is it?

Our office policy is to charge **$40.00** for this procedure in addition to the office visit copay and/or deductible. **This is due at the time services are rendered**. We will bill your insurance according to the individual contracted fee schedules. However, *if your insurance pays the fee we will gladly refund you this prepaid* **$40.00** amount once we receive notice from your insurance.

NOTE: This fee is due and payable **whether or not** you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and new prescription will not be given. However, the fee covers the technician's time and effort in achieving this process.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductable are separate from, and not included in, the refraction fee.

_____ _____

Patient signature (Parent for minor) Date

LISA S. BUNIN'S PRIVACY NOTICE

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED (SHARED) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Lisa S. Bunin and staff are legally required to Follow the policies in this notice. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). PHI includes information that can be used to identify you. We collect or receive this information about your past, present or future health or condition, to provide health care to you, or to receive payment for this health care. We must provide you with this notice that explains how, when and why we use and share your PHI.

WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION for many different reasons. Below we describe the different categories of when we use and share your PHI. We give you some examples of each category. All of the ways we are permitted to use and share this information will fall within one of the categories.

- **For Treatment**. We may share your PHI with physicians, nurses, nursing home personnel, pharmacists and other health care personnel and agencies that provide or are involved in your health care. If you are being treated for an injury, we may share your PHI with a physician in order to coordinate your care.
- **To Obtain Payment for Treatment**. We may use and share your PHI in order to bill and collect payment for the services provided, to determine insurance eligibility or to obtain pre-authorization prior to treatment. It is important that you provide us with correct and up-to-date PHI. We may share portions of your PHI with our billing department and your health plan to get paid for the health care services we provided to you.
- **To Run our Health Care Business**. We may share your PHI in order to operate our medical practice according to healthcare regulations. They many include cost-management reviews, quality of care audits, compliance reviews and other administrative functions.
- **To Business Associates**. There are some services such as collection agencies that we contract with as business associate. We may share your information with them. However, we require our business associates to protect your PHI through contracted agreement.
- **When Government or Law Enforcement Agencies Request Your PHI**. We share your PHI that we report information about victims of abuse, domestic violence or in response to a court order, subpoena, warrant, summons or similar request.
- **For Public Health Activities.** We report information about deaths, and various diseases to government officials and agencies such as the CDC and FDA. We will use or disclose your health information in order to prevent a serious threat to your health or safety, or the health or safety of the public or another person.
- **For Health Oversight Activities**. We share your PHI with health oversight agencies as authorized by the law. Activities such as audits, investigations, inspections and licensure are necessary for the government to monitor the health care system, government benefit programs and our compliance with your civil rights.
- **For Military and Veterans.** We may share your information as required by military command authorities. We may also share PHI about foreign military personnel with the appropriate foreign military authority.
- **For National and Intelligence Activities.** We may share your PHI with authorized federal officials for lawful intelligence, counterintelligence and other national security activities authorized by law.
- **For Protective Services for the President and Others. We may share your PHI with authorized** federal officials so they may provide protections to the President, other authorized persons or foreign heads of state or for the conduct of special investigations.
- **For Worker's Compensation Purposes.** When we share your PHI to comply with worker's compensation laws or similar programs
- **For Appointment Reminders and Health - Related Benefits Services.** We may use your name, address, e-mail and phone number to contact you to cancel or reschedule an appointment
- **For Health Related Benefits and Services** .We may use or disclose your health information in order to inform you about health related benefits or services that may be of interest to you.

A. **You have the Opportunity to Object to Information Shared with Family, Friends or Others**. Unless you object , we may share your PHI to a family member, friend or other person that you choose in writing to involve in your care. Your choice to object may be made any time.

B. **Your Prior Written Consent is Required in Other Situations.** In situations not described above, we will ask for your specific written consent before using or sharing any of your PHI. If you choose to sign a specific consent to share your PHI, you can later cancel that consent in writing. This will stop any future sharing of your PHI

YOUR RIGHTS REGARDING YOUR PHI

A. **You Have the Right to Request Limits on How we Use and Share Your PHI.** If we accept your request, we will put your limits in writing and follow them except in emergency situations. You may not limit PHI that we are legally required or allowed to share.
B. **You Have the Right to Choose How We Communicate PHI to You.** All of our communication to you are considered confidential. You have the right to ask and we Will send information to you at another address (for example work instead of home). You will be billed for any additional cost.
C. **You Have the Right to See and Get Copies of Your PHI**. But you must make this request in Writing. We will respond to you within 30 days after receiving your written request. If you request copies of your PHI, we will quote and charge you the current rate for each page.
D. **You Have the Right to Get a List of When and To Whom We Have Shared Your PHI**. This list Will not include uses to which you have already consented. We will respond within 60 days of receiving your request. This list will include the last six years of activity. You may request a shorter time. The list will include dates when your PHI was shared and why, to whom your PHI was shared (including their address if known), and description of the information shared. The first list you request within a 12 month period will be free. You will be charged our cost for additional lists.
E. **You Have the Right to Correct, Update or Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct it. We can do this for as long as the information is kept by our facility. You must provide the request and your reason For the request in writing. We will respond Within 60 days of receiving your request. If we deny your request, our written denial will tell our reasons and explain how to tell us why you disagree You have the right to request that the Above information be attached to all future uses or sharing of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change.
F. **You Have the Right to Get a Copy of This Privacy Notice.**
G. **Please forward all request for information in writing to: Office Manager**
Lisa S. Bunin, M.D.
1611 Pond Road
Allentown, PA 18104

CHANGES TO THIS NOTICE

We may change the terms of this notice and our Privacy policies at any time. Any changes to this Notice will apply to the PHI that we already have. **Before we make any change to our policies, we will promptly change this notice and post a new notice in** our waiting room. You may request a copy of this notice from the office manager at any time.

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES. I you think that **we may have violated your privacy rights, or you** disagree with a decision we made about access to your PHI, you may send a written complaint to the person listed at the end of this notice. You may also send a written complaint to the Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

HIPAA PRIVACY OFFICER
C/O Lisa S. Bunin, M.D.
161 Pond Road, Suite 403
Allentown, PA 18104

_____
PRINT PATIENT NAME

_____
SIGNATURE OF PATIENT

_____
DATE

_____
SIGNATURE OF AUTHORIZED REPRESENTATIVE

_____
SIGNATURE OF AUTHORIZED REPRESENTATIVE

_____
RELATIONSHIP