DOUGLAS J. LAVENBURG, M.D., P.A.

JOYCE VARKEY, D.O. | JULIANNE LIN, M.D. | KIMBERLY BRISTOW, O.D. | MEREDITH WEINBERGER, O.D.

DelMar Surgical Center, LLC
103 Chesapeake Blvd., Suite C, Elkton, MD 21921
One Centurian Drive, Suite 114, Newark, DE 19713
5305 Limestone Rd., Suite 201, Wilmington, DE 19808
410.392.6133 | 302.993.0722

Patient Form

*Please complete **ALL** blanks – Place "N/A" (Not Applicable) if information does not apply.* ***It is imperative that the information is thorough and accurate as the information is utilized for claims processing.***

Patient's Information:

Name:	Sex (circle one): M F Marital Status: Ethnicity:
SS#: --- -- DOB: / /	Patient's Primary Phone #: ( ) --
St. Address:	Patient's Work Phone #: ( ) --
City: State: Zip:	Patient's Best Contact Phone#: ( ) --
Emergency Contact:	Family Doctor **OR** Referring Doctor:
Emer. Contact Phone #: ( ) --	Ref. Dr. Phone #: ( ) --

E---Mail Address:_____

Pharmacy Name and Location:_____

Patient's Primary Insurance Information: (*The subscriber is the **person** who carries the insurance)*

Ins. Co. Name:	**ID #:**	**Grp./Acct. #:**
Subscriber (circle one): Self Other	***** ***ONLY*** **If "Other," need to complete info. below**	
Subscr. Name:	Subscr. SS#: --- ---	Subscr. DOB: / /
Subscr. St. Address:	Subscr. Sex: M F	Relationship to patient:
City: State: Zip:	Subscr. Home Phone #: ( ) ---	

Patient's Secondary Insurance Information: (*The subscriber is the **person** who carries the insurance)*

Ins. Co. Name:	**ID #:**	**Grp./Acct. #:**
Subscriber (circle one): Self Other	***** ***ONLY*** **If "Other," need to complete info. below**	
Subscr. Name:	Subscr. SS#: --- ---	Subscr. DOB: / /
Subscr. St. Address:	Subscr. Sex: M F	Relationship to patient:
City: State: Zip:	Subscr. Home Phone #: ( ) ---	

Patient's Additional and/or Routine Vision Insurance Information:

Ins. Co. Name:	**ID #:**	**Grp./Acct. #:**
Subscriber (circle one): Self Other	***** ***ONLY*** **If "Other," need to complete info. below**	
Subscr. Name:	Subscr. SS#: --- ---	Subscr. DOB: / /
Subscr. St. Address:	Subscr. Sex: M F	Relationship to patient:
City: State: Zip:	Subscr. Home Phone #: ( ) ---	

Patient's Employment Information:

Employer Name:	Employer Phone #: ( ) --
Employer St. Address:	City: State: Zip:

********** If this visit is work or auto---accident related, please advise the receptionist. **********

Guarantor Information: *(Only need to complete if the patient is under the age of 18)*

Guar. Name:	Guar. SS#: --- --- Guar. DOB: / /
Guar. St. Address:	Guar. Sex: M F Relationship to patient:
City: State: Zip:	Guar. Home Phone #: ( ) ---

My signature on this page signifies that all the above information is current and accurate. I understand that I will be called by my name at the time I am asked to proceed to the examination room.

_____ _____

Patient, Guarantor or Personal Representative Date

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Financial Agreement

Thank you for choosing Douglas J. Lavenburg, M.D., P.A., the Delmar Surgical Center, LLC, and Associates in Eye Care for your family eye and skin care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care for maintaining healthy vision.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our billing department or office manager to allow us to help you manage your account in the most effective manner. Please be advised that your insurance company is a contract with you and your employer, not our practice. We will be glad to submit your claims for payment, however, the final responsibility for payment due for services rendered is the sole liability of you, the patient or the guarantor.

Our financial policy is as follows. Please feel free to discuss this with our billing department at any time. Please complete all insurance information, read our financial policy, and sign below to verify the receipt of this information.

1. We accept cash, check, American Express, MasterCard, Visa, Discover, Wells Fargo and Care Credit.
2. **Medicare and some other insurance carriers do not pay for your refraction (checking your vision for glasses and/or contact lenses). A fee of $40.00 is due at the time of your visit.**
3. If Medicare is your primary insurance, and your visit is for a medical condition, we will gladly submit your insurance claim to Medicare for you. You will be responsible for any co-insurance and/or deductible.
4. Your co-payment and self payment amounts are due at the time of service.
5. You are financially responsible for all payments not paid by your insurance company.
6. If we do not participate with your insurance carrier, payment is due at the time of service.
7. If your insurance carrier requires a referral from your primary care provider for treatment, it is your responsibility to obtain the referral prior to your appointment. If you do not obtain and provide the referral within the time allowed by your insurance carrier, you will be financially responsible for services rendered.
8. **Returned checks are subject to a $25.00 service charge.**
9. **Any cancellation of product will incur a 20% fee.**
10. It is your responsibility to advise our office if you are being seen as part of a Vision Benefit Package provided by your employer prior to your appointment.
11. We are happy to provide any counseling on our billing practices, however, if your account is not paid within 60 days you will be responsible for payment plus a monthly finance charge of 1.5% per month.
12. If we are participating with your insurance company, we are contracted to adjust your account by a certain amount which is known as a "contractual write-off". This does not mean you will not have a balance. We will bill you for monies as directed by your insurance company.
13. If your account goes into "collections," in addition to your outstanding balance, you will be responsible to pay a 25% fee charged by the collection agency as well as any legal or court costs as specified by our collection agency.
14. Any Medical Necessity forms/letters required by your insurance company, or any communication outside the usual and customary forms required for billiing or communication with other physician providers, will be subject to a $25.00 administrative fee (including MVA forms).
15. We will be happy to complete your disability forms which are subject to a $25.00 administrative fee.
16. As a courtesy to our patients relocating out of the area, we will be happy to supply your new eye care provider a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to a $25.00 administrative fee.
17. You will have 90 days from date of exam to return for a recheck of your glasses prescription for a fee of $35.00. There will be a courtesy waiver of this fee for glasses purchased at our optical locations. After 90 days, a $55.00 refraction fee will be charged.
18. *We require a 24 hour notice of cancellation of your appointment. Anything other will be subject to a $35.00 missed appointment fee.*

X _____

PATIENT, GUARANTOR OR PERSONAL REPRESENTATIVE'S SIGNATURE ***DATE***

Your signature on this page signifies that you acknowledge and accept the above information. This also serves as an assignment of insurance benefits to be paid directly to Douglas J. Lavenburg, M.D., P.A. and/or Delmar Surgical Center, LLC and/or Associates in Eye Care.

Revised 01/17/19

DOUGLAS J.
LAVENBURG, M.D., P.A.
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Contact Lenses

The major use of contact lenses is for the correction of refractive errors. A small number of patients who meet pre-fitting criteria are unable to tolerate contact lenses regardless of fitting technique or lens type. It is important to remember that contact lenses are medical devices used to correct vision, and when used improperly, can cause permanent visual loss, especially when sleeping in them. Complications may arise with the use of contact lenses; the changes usually occur to the cornea and eyelids. Even a patient that has tolerated contacts for years may develop problems. For these reasons, yearly eye examinations are essential.

We also require all new contact lens patients, or patients new to our practice, to have a contact lens fit and evaluation, which includes a one week follow-up visit. If follow-up visits are not kept, we will not be able to order lenses or release the contact lens prescription.

Additionally, contact lens fitting and/or evaluations may not be covered by your insurance and payment in full is due at the time of service and is non-refundable.

Financial Responsibility for Contact Lens Services

New Contact Lens Wearers:

The glasses prescription is **not** the same as the contact lens prescription. All new contact lens wearers need to schedule a contact lens fit. The price typically ranges from $90 (single vision) to $140 for more complicated fits (soft bifocal / multivision). This fitting fee is non-refundable. The fit includes an initial evaluation, a contact lens training session, and a one week contact lens evaluation (follow-up). We provide a 30 day warranty on our services pertaining to the proper fitting of contact lenses. If the contact lens evaluation (follow-up) is not completed within 30 days, an additional charge of $25.00 will be incurred on each visit thereafter.

Established Contact Lens Wearers:

If a change in fit or lens type is required, a contact lens refit evaluation will be performed. The price typically ranges from $80 for single vision and up to $130 for bifocal refits. This refit service includes the contact lens refit evaluation and a one week contact lens evaluation (follow-up) with the newer lenses.

However, if the current lenses are satisfactory with the patient and the doctor, only a contact lens evaluation fee of $65 will be charged to existing patients wearing standard lenses and $75.00 will be charged to patients new to our practice. A multifocal contact lens evaluation will be $75.

Contact Lens Ordering and Reordering Policy:

It is recommended that all patients being fit/refit for contacts purchase their first order from the practice.
Payment in full is required for all contact lens orders.
A fee of $20 is applied to all canceled and returned orders, as well as a 20% restocking fee.
In the event that it is necessary to return or exchange contact lenses, unopened and boxes not written on may be returned within 30 days.

I have read, understand, and agree with the Informed Consent and Financial Responsibilities for contact lens services.

Please sign below, OR indicate "N/A" (Not Applicable) on the signature line if contact lens services are not being received.

✔

Patient, Guarantor or Personal Representative's Signature Date

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the practices Notice of Privacy Practices effective September 20, 2013.

Name (please print): _____
Signature: _____
Date: _____

I choose to ☐ Opt-In ☐ Opt-Out of receiving electronic text messages and/or emails from the practice regarding appointments and/or practice promotions.

I am a parent or legal guardian of _____ (patient name). I have received a copy of the practices Notice of Privacy Practices effective September 20, 2013.

I choose to ☐ Opt-In ☐ Opt-Out of receiving electronic text messages and/or emails from the practice regarding appointments and/or practice promotions.

Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective September 20, 2013 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation: _____ ☐ Telephone contact: _____
☐ Mailing: _____ ☐ Email: _____
☐ Other:_____ Outcome:_____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

Revised 01/18/19

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Dry Eye Questionnaire

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease? ☐ Y ☐ N

Do you have any of the following symptoms?

- ☐Blurry vision
- ☐Burning
- ☐Light sensitivity
- ☐Tired eyes, eye fatigue
- ☐Foreign body sensation
- ☐Scratchy feeling of sand or grit in the eye
- ☐Redness
- ☐Itching
- ☐Excess tearing/ watering eyes
- ☐Stringy mucus in or around the eyes
- ☐Contact lens discomfort

Have you had any of the following surgeries?

- Cataract: ☐ Y ☐ N
- Glaucoma: ☐ Y ☐ N
- Refractive surgery: ☐ Y ☐ N

Do you use?

- ☐ Contact lenses
- ☐ OTC eye drops such as artificial tears
- ☐ Rx eye drops for Dry Eye Syndrome (*e.g.,* Restasis)
- ☐ Rx eye drops for Glaucoma (*e.g.,* Xalatan, Timolol)
- ☐ Rx eye drops for Allergy (*e.g.,* anti-inflammatory, antihistamine)
- ☐ Nutritional supplements (*e.g.,* flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

- ☐ Windy conditions
- ☐ Places with low humidity (*e.g.,* airplanes/hospital)
- ☐ Areas that are air conditioned/heated

Are you taking any of the following medications?

- ☐ Antihistamines/decongestants
- ☐ Oral corticosteroids
- ☐ Antihypertensives (e.g. diruetic, beta-blocker)
- ☐ Antidepressant or anti-anxiety
- ☐ Hormone replacement therapy or estrogen
- ☐ Accutane or other oral treatment for acne

Have you ever had punctal occlusion? ☐ Y ☐ N

I understand and agree that dry eye testing may be necessary depending upon the findings of my examination. I understand this lab test will be billed to my medical insurance and I may be responsible for deductibles and co-insurance, according to my insurance plan.

Patient name: _____ Date:_____

Because my eye doctor may recommend that I use nutritional supplements from Physician Recommend Nutraceuticals PRN or Doctors Advantage, I consent to the above named practice providing my contact information, as well as information about my eye health diagnosis and treatment, to PRN or Doctors Advantage so that they can contact me directly to follow-up on the recommendation, answer any questions about the supplements my doctor has recommended, and explain the benefits of the program for my eye health

Patient name: _____ Date:_____

I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has dry eye disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Doctor: _____ Date:_____

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About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both, and our practice accepts both:

Vision care plans (such as Spectera, EyeMed and Medical Insurance Well Vision Benefits)
Medical insurance (such as Blue Cross/Blue Shield and Medicare).

Vision care plans only cover Routine Vision Examinations and/or Contact Lens Examinations. Additionally, a vision care plan may include coverage or special discounts for the purchase of eyeglasses and contact lenses.

Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye diseases.

Medical insurance must be used if you have any eye health problem or systemic health problem that may lead to ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

We will bill your insurance plan for services if we are a participating provider for that plan. If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this legally and properly to minimize your out-of-pocket expense. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered.

Please tell us why you are here today. (Initial the reason for your visit today):

- ○_ Vision Examination
  - ➢ Vision Check
  - ➢ Pressure Check
  - ➢ Limited Slit Lamp Examination
  - ➢ Eyeglasses Prescription
- ○_ Contact Lens Examination
  - ➢ Vision Examination (includes “Vision Examination” above)
  - ➢ Contact Lens Prescription
- ○_ Comprehensive Medical Examination
  - ➢ Vision Examination (includes “Vision Examination” above)
  - ➢ History of Present Illness
  - ➢ Patient Ocular Medical Health Assessment (review and update ocular medications)
  - ➢ Patient Medical Assessment, (review and update medication list, medical conditions, surgical history)
  - ➢ Review of Overall Health
  - ➢ Social History & Family History
  - ➢ Comprehensive Dilated Medical Examination if Necessary
  - ➢ Drug Prescription Assessment
- ○_ Ancillary Testing (i.e. Visual Field, OCT, Pachymetry Corneal Topography Endo Cell Count, ASCAN, Photos, etc.)

If the purpose of your office visit today is for a Routine Vision Examination and/or Contact Lens Examination and a medical condition is discovered you will have the option to schedule a Medical Examination for a later date or convert today’s visit to a Comprehensive Medical Examination. If your visit is deemed as a “Comprehensive Medical Examination” any **deductibles, co-pays and coinsurance fees not paid by your plan will be your responsibility and due at time of service**.

✔ _____
Patient, Guarantor or Personal Representative's Signature Date