HARTZELLEYE
SPECIALISTS

Thank you for choosing Hartzell Eye Specialists for your eyecare!

We request you bring the following with you to your appointment:

- Photo ID
- Medical Insurance Cards
- Medication list
- Your current prescription glasses and/or contact lens prescription/boxes

Please complete the enclosed forms prior to your appointment. The completed forms can be emailed back to us at hes@hartzelleye.com or you can print them and bring them with you to your appointment.

If you have been to another eyecare provider in the past, please complete the record release consent form so we can obtain those records.

DAVID LEIGH HARTZELL MD
TYLER CROUSE OD
37 BROOKWOOD AVENUE | CARLISLE, PA 17015 | 717-243-8606 | HARTZELLEYE.COM

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** ____/____/_____

Referring Doctor: _____ **Primary Care Physician:** _____

Pharmacy Name and Location (street & city): _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language: □ English □ French □ Spanish □ Russian □ Italian □ Other _____

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems

□ Amblyopia (Lazy Eye)
□ Astigmatism
□ Cataracts
□ Corneal Disorder
□ Diabetic Retinopathy
□ Dry Eye Syndrome
□ Glaucoma
□ Hyperopia (Farsighted)
□ Iritis/Uveitis
□ Macular Degeneration
□ Myopia (Nearsighted)
□ Retinal Detachment

Other _____

Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	**R - L**	**R - L**
□ □ Blepharoplasty (Lid Surgery)	□ □ Glaucoma Surgery	□ □ Strabismus (eye muscle surgery)
□ □ Cataract Surgery	□ □ Laser Retinal Surgery	□ □ Vitrectomy
□ □ Corneal Transplant	□ □ LASIK	□ □ YAG Laser Capsulotomy

Other _____

Current Eye Medications: (Please list)

_____ _____ _____
_____ _____ _____

Other Medical History: □ No history of illnesses

□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Cancer
□ Congestive Heart Failure
□ COPD
□ Diabetes (circle: Type 1 or Type 2)
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Heart Attack
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ HIV/AIDS
□ Kidney Disease
□ Liver Disease
□ Lupus
□ Migraine
□ Multiple Sclerosis
□ Polymyalgia Rheumatica
□ Psychiatric Disorder
□ Rheumatoid Arthritis
□ Stroke
□ Thyroid Disease

Other _____

General Surgeries/Procedures: (Please list)

_____ _____ _____
_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please continue on the back side of this page →

Family History: (Please indicate relationship) □ No history of illnesses □ History unknown

□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes If yes, how much and how often?_____

Drug Use: □ No □ Yes If yes, which and how long?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genitourinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood/Lymph Nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Patient Signature:_____ **Date:**_____

Reviewed by:_____ **Date:**_____

HARTZELL EYE SPECIALISTS

PATIENT INFORMATION

Patient's Name (Last) _____(First)_____(Middle)_____

Patient's Address (Box#, Street or Rd#) _____

City, State & Zip_____

Patient's Phone Number_____ Sex: M F Date of Birth____/____/____

Email address_____

Patient's Marital Status (circle): Single Married Divorced Widowed Other_____

Person to whom we send bills: Name_____

Address_____

Patient's Social Security Number____-___-_____ Occupation_____

Patient's Employer_____ Work Phone #_____

Patient's Work Address_____

Patient's Nearest Relative's Name_____ Relationship_____

Patient's Nearest Relative's Phone Number_____

Patient's Medical Doctor_____

Patient's Medical Doctor Phone #_____

Patient's Medical Doctor Address_____

How did you hear about us?_____

If we could not reach you, we should contact_____ Phone #_____

Please indicate the type(s) of insurance you have in the space provided below. List your identification and/or policy numbers please. This information can be found on your insurance card(s).

Medicare # (include letters)_____

Effective Date on Medicare Card_____/_____/_____

Is Medicare your Primary Insurance? Yes No

Other Insurance Name_____

Identification # on Card _____Group #_____

Phone Number on Insurance Card_____

Claims Address_____

Whose Name is Insurance In? _____Date of Birth____/____/____

Relationship to patient_____

DAVID LEIGH HARTZELL MD

37 BROOKWOOD AVENUE CARLISLE, PA 17015 717-243-8606 HARTZELLEYE.COM

Hartzell Eye Specialists, LLC *featuring Optical Allusions*

37 Brookwood Avenue, Carlisle, PA 17015
(717) 243-8606 Fax: (717) 243-7221

David Leigh Hartzell, MD
Ophthalmologist

INSURANCE
Financial Responsibility
Assignment of Benefits
Authorization to Release Information

Financial Responsibility
I have requested ophthalmology/optician services from Hartzell Eye Specialists on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that all professional services rendered are charged to the patient and are due at the time of service, UNLESS other arrangements have been made in advance with our business office which includes the completion of necessary forms in order to file with insurance and full disclosure of deductible information.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits
I hereby assign all ophthalmology/optician benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Hartzell Eye Specialists for ophthalmology/optician services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information to Insurance Company
I hereby authorize Hartzell Eye Specialists to: (1) release any information necessary to insurance carriers regarding my treatment; (2) process insurance claims generated in the course of evaluation and/or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of covered care. This authorization will remain in effect until revoked by me in writing.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

c: patient
forms/fin respons-assign of bene-roi

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Acknowledgment of Receipt of Notice and Consent
To Use and Disclose Health Information (HIPAA)

READ BEFORE SIGNING THE ACKNOWLEDGMENT AND CONSENT

This acknowledgment of notice and consent authorizes Hartzell Eye Specialists to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Hartzell Eye Specialists has a Notice of Privacy Practices which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request.

Acknowledgment and Consent

I have received the Notice of Privacy Practices for Hartzell Eye Specialists. Hartzell Eye Specialists is authorized to use and disclose health information about _____(patient name) for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

Personal Representative Information:

_____
Name of Personal Representative

_____
Relationship to Patient

HARTZELL EYE SPECIALISTS

Patient_____DOB:_____Acct #:_____

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$40.00** cancellation fee. Procedure cancellations require 5-7 business days advance notice, without notification they may be subject to a **$100.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel their office appointment or procedure appointment will be considered a **NO SHOW**. Patients who No Show and/or Cancel three (3) times in a 12-month period may be dismissed from the practice. Thus they will be denied any future appointments. Patients may also be subject to **a $40.00 fee for office appointments and $100.00 office procedure No Show fee.**

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based on understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department (717-243-8606).

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

_____ _____

Date Patient/Responsible Party's Signature

DAVID LEIGH HARTZELL MD
RADHIKA PATEL OD

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CONSENT FORM

ONLY ONE PATIENT PER FORM | **YOU MUST COMPLETE *required* INFORMATION**

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ SSN: _____
PHONE (H): _____ (W): _____

I hereby authorize HARTZELL EYE SPECIALISTS to release information ☐ to
receive information ☐ from
Name of Individual (***required***): _____
Name of Agency: _____
Complete Address (***required***): _____ State ___ Zip Code _____

Such information may be transmitted under the conditions stated below, and/or as required by Federal or State Statute or Order of Court.

The information which may be released is limited to (check one or more (***required***)):

_____ summary of contacts
_____ history and physical summary
_____ medical and/or vision tests
_____ school records
_____ hospital discharge summar(ies) of my hospitalizations of: _____
_____
_____ other (please specify) _____
_____

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by Pennsylvania Law, Act #63 and/or Pennsylvania P.L. #817, and/or the Health Insurance Portability & Accountability Act (HIPAA), and/or Federal Law #93/282. The regulations prohibit the above person, organization or agency from making any further disclosures of this information without my prior consent.

I understand that I have no obligation whatsoever to disclose any information from my record and I understand that I may revoke this consent at any time by notifying HARTZELL EYE SPECIALISTS in writing. I have had this form read and explained to me and I understand its contents.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

This consent is good for one year from the date of patient/guardian signature unless revoked by patient/guardian in writing.

ADULT PATIENT	CHILD PATIENT
_____	_____
Patient	Parent or Guardian (Relationship)
Witness: _____	_____
	Parent or Guardian (Relationship)
Date: _____	Witness: _____
	Date: _____

Client/Guardian **Does/Does Not** wish to have a copy of this Consent.