RICHARD JAMES PICCIONE, M.D. **ERICA V. LUKASKO, O.D.**

Patient Last Name_____First Name _____MI ____

Address_____ M____ F____ Age_____

City/State/Zip_____

Date of Birth _____ Social Security #_____

Employer_____Occupation_____

Employer's Address_____Phone # _____

Preferred Language_____ Race_____

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino _____Unknown ____Refuse to answer

Main phone number where you can be reached:_____

Preferred Method of Contact: Email_____

Text_____ Phone_____

Spouse's Name_____Spouse's Cell #_____

Spouse's Employer_____Phone #_____

Name & Number of person not living at home in case of an emergency_____

_____

*****INSURANCE INFORMATION*****

Insurance Name: _____

Policyholder's Name_____

Policyholders Date of Birth_____Policyholders SSN_____

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination provided during the period of such care to my insurance company and/or health practitioners.

I authorize payment of benefits to the physician for services provided. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents and all collection, attorney and court fees are added to any unpaid balance. I permit a copy of this authorization to be used in place of the original.

Parent/Patient
Signature_____Date _____

Medical History Questionnaire / Review of Systems

Name: _____ Birth Date: _____ Sex: M F

Please circle either "Yes" or "No" for each of the following questions.

Eyes
Loss of vision? Yes No
Blurred vision? Yes No
Loss of side vision? Yes No
Double vision? Yes No
Dryness? Yes No
Redness? Yes No
Itching? Yes No
Excessive tearing/watering? Yes No
Glare/light sensitivity? Yes No
Strabismus (crossed eyes)? Yes No
Amblyopia (lazy eye)? Yes No
Glaucoma? Yes No
Retinal detachment? Yes No
Macular degeneration? Yes No

Neurological
Headaches/migraines? Yes No
Cerebral Palsy? Yes No
Seizures? Yes No
Stroke? Yes No
Hydrocephalus? Yes No

Gastrointestinal
Reflux? Yes No
Ulcers? Yes No

Cardiovascular
High blood pressure? Yes No
Heart condition? Yes No

Respiratory
Asthma? Yes No
Emphysema? Yes No

Psychiatric
Anxiety? Yes No
Depression? Yes No

Endocrine
Diabetes (NIDDM/IDDM)? Yes No
Thyroid (Hyper/Hypo)? Yes No

Musculoskeletal
Osteoarthritis? Yes No
Rheumatoid arthritis? Yes No

Genitourinary
Kidney stones? Yes No

Dermatological
Eczema? Yes No
Rosacea? Yes No

Hematologic/Lymphatic
Anemia? Yes No
Bleeding disorders? Yes No

Allergic/Immunologic
Seasonal allergies? Yes No
Sinus problems? Yes No

Other patient conditions or complaints? _____

_____

Patient's primary physician/pediatrician: _____

Please list all medications patient is currently taking:

_____

_____

Past history
Illnesses or injuries:

_____

_____

Surgeries:

_____

_____

For pediatric patients only:
Child's weight at birth: _____ *Was pregnancy full-term? Yes No If no, how many weeks?* _____
Complications or problems during pregnancy/delivery? _____

In Office Use Only
Physician's Signature _____ Date _____

Patient Name: _____ DOB: _____

RICHARD JAMES PICCIONE, M.D. ERICA V. LUKASKO, O.D.

Family and Social History

Place corresponding letter into Eye Problems / Medical Problems that immediate family has been diagnosed with:

RELATIONSHIPS	
No family history of	
Aunt	A
Brother	B
Cousin	C
Daughter	D
Father	F
Grandfather	GF
Grandmother	GM
Mother	M
Nephew	NE
Niece	NI
Sister	S
Son	SO

EYE PROBLEMS	
Amblyopia	☐
Angle-closure glaucoma	☐
Astigmatism	☐
Cataract	☐
Choroidal melanoma	☐
Corneal dystrophy	☐
Corneal graft finding	☐
Diabetic retinopathy	☐
High myopia	☐
Macular degeneration (ARMD)	☐
Primary open angle glaucoma	☐
Retinal detachment	☐
Strabismus	☐

MEDICAL PROBLEMS	
Complication of anesthesia	☐
Bleeding (coagulation) disorder	☐
Brain tumor	☐
Cancer	☐
Diabetes	☐
Heart	☐
Hypertension	☐
Lupus erythematosus	☐
Migraine	☐
Neurofibromatosis syndrome	☐
Rheumatoid arthritis	☐
Stroke	☐
Thyroid disorder	☐

Patient lives with: _____

_____

Occupation / Hobbies / Child's interests:

_____

_____

_____

IS PATIENT ALLERGIC TO:

Medications? Yes No

List: _____

_____

Foods? Yes No

List: _____

_____

Latex? Yes No

History of anesthesia problems? Yes No

Does patient smoke? Yes No

Drink alcohol? Yes No

Recreational drugs? Yes No

Pharmacy Name: _____

Location: _____

In Office Use Only

Physician's Signature _____ Date _____

Richard J. Piccione, M.D.
4906 Ambassador Caffery Parkway, Bldg. G
Lafayette, LA 70508

****FINANCIAL POLICY****

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

We accept Cash, Check, Visa, MasterCard and Discover.

Payment is expected at the time services are rendered. Your insurance company will provide an attending physician statement in order for you to file for reimbursement. If you have Medicare or are enrolled in a PPO plan in which we are currently participating, we will file a claim on your behalf for services rendered. However, payment of applicable deductibles and co-pay amounts are due at the time services are rendered. Most insurance plans (PPO's) will consider our fee as "in network" even though Dr. Piccione is not listed as a participating provider, as he is the only fellowship trained pediatric ophthalmologist and adult strabismus specialist in this area.

The responsibility for payment of services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

If surgery is necessary, as a courtesy to you, we will file with your insurance carrier. If you do not have insurance, payment in full is expected prior to surgery if the fee is under $1,000. If the fee is over $1,000, 50% is due prior to surgery and arrangements can be made to pay the balance in three to six monthly payments. The fee for surgery includes the surgery and office visits for three months following surgery.

If your remaining balance (after insurance has paid its portion) is less than $1,000, payment in full is expected within three months from the date of surgery. If the balance is over $1,000, payment in full is expected within six months from the date of surgery. It is recommended that you start payment on your estimated portion immediately. If your insurance company has not paid its portion within 75 days of the surgical procedure, please begin making payments towards the balance. You will be immediately refunded any credit balance on your account.

You are responsible for payments in full regardless of any insurance company's arbitrary determination of usual and customary rates.

**Please note a 1.5% monthly interest rate (18% annual) will be charged to your account each month for any unpaid balance. All payments are due by the 15th of each month. **

If my account becomes delinquent, I agree to pay all collection, attorney and court fees.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

I have read, understand and agree to the above financial policy.

Date _____ Signature _____

Relation to patient _____

Richard J. Piccione, M.D., APMC
Erica V. Lukasko, O.D.
4906 Ambassador Caffery Pkwy-Bldg. G
Lafayette, LA 70508

Phone: 337-989-2600
Fax: 337-989-2601

Precautions Following Dilation

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation drops are used to dilate or enlarge pupils of the eye to allow the doctor to get a better view inside your eye. Dilating drops can blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your doctor to predict how much your vision will be affected. We provide free disposable sunglasses or dark sunglass inserts. Patients should wear sunglasses, be cautious walking and going up or down stairs. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Refraction Service and Fee

- ✓ A refraction is the process of determining your best corrected vision and if there is need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses.
- ✓ A refraction is NOT a covered service by Medicare or most insurance plans. These plans consider refraction a "vision" service not a "medical" service.
- ✓ We will NOT file the charge for refraction with a health insurance plan unless we know that your plan covers the refraction charge.
- ✓ Our office fee for refraction is $20.00 and this fee is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will reimburse your accordingly.

Contact Lens Evaluation and Fee

- ✓ If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine the present appropriateness of your lenses.
- ✓ The fee for this service is $60 to $120 (depending upon the type of contact lenses required) and is collected in addition to the fee for an eye examination without contact lenses.

I have read and understand the above information. I accept full financial responsibility for the cost of refraction and/or a contact lens evaluation, *if provided*, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction fee or contact lens evaluation fee.

Patient's Name (Printed) _____ **Date** _____ **Relationship to Patient** _____

Patient's Signature (Legally Responsible Adult for minor) _____

(Revised 01/2013)

Richard J. Piccione, M.D.
Erica V. Lukasko, O.D.

4906 Ambassador Caffery Pkwy., Bldg. G, Lafayette, LA 70508
Phone: 337-989-2600 Fax: 337-989-2601

AUTHORIZATION TO DISCUSS HEALTHCARE INFORMATION WITH SPECIFIC FAMILY MEMBERS OR INDIVIDUALS

Individual Information:	Patient Name: _____ Social Security Number (last 4 digits): _____	Date of Birth: _____
Authorize to discuss **ALL HEALTHCARE INFORMATION** WITH:	Name: _____ Name: _____ Name: _____	Relationship to Patient _____ _____ _____
Authorize to **BRING MY CHILD AND DISCUSS HEALTHCARE INFORMATION:**	Name: _____ Name: _____ Name: _____	Relationship to Patient _____ _____ _____

I understand my and/or my child's medical condition and financial standing will be discussed with the above named individuals. I also understand this authorization will remain in force and effect until it is revoked in writing.

Parent / Guardian Signature: _____ Date Signed: _____

Printed Name: _____