

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 # _____

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 _____

*****RESPONSIBLE PARTY INFORMATION*****

Father's Name _____ Social Security # _____

Home Address: _____

Home Phone # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

Mother's Name _____ Social Security # _____

Home Address: _____

Home Phone # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

Name & Phone # 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.

<u>Eyes</u> 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	<u>Gastrointestinal</u> Reflux? Yes No Ulcers? Yes No <u>Cardiovascular</u> High blood pressure? Yes No Heart condition? Yes No <u>Respiratory</u> Asthma? Yes No Emphysema? Yes No <u>Psychiatric</u> Anxiety? Yes No Depression? Yes No <u>Endocrine</u> Diabetes (NIDDM/IDDM)? Yes No Thyroid (Hyper/Hypo)? Yes No <u>Musculoskeletal</u> Osteoarthritis? Yes No Rheumatoid arthritis? Yes No	<u>Genitourinary</u> Kidney stones? Yes No <u>Dermatological</u> Eczema? Yes No Rosacea? Yes No <u>Hematologic/Lymphatic</u> Anemia? Yes No Bleeding disorders? Yes No <u>Allergic/Immunologic</u> Seasonal allergies? Yes No Sinus problems? Yes No
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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.

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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	<input type="checkbox"/>
Angle-closure glaucoma	<input type="checkbox"/>
Astigmatism	<input type="checkbox"/>
Cataract	<input type="checkbox"/>
Choroidal melanoma	<input type="checkbox"/>
Corneal dystrophy	<input type="checkbox"/>
Corneal graft finding	<input type="checkbox"/>
Diabetic retinopathy	<input type="checkbox"/>
High myopia	<input type="checkbox"/>
Macular degeneration (ARMD)	<input type="checkbox"/>
Primary open angle glaucoma	<input type="checkbox"/>
Retinal detachment	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>

MEDICAL PROBLEMS	
Complication of anesthesia	<input type="checkbox"/>
Bleeding (coagulation) disorder	<input type="checkbox"/>
Brain tumor	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Heart	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Lupus erythematosus	<input type="checkbox"/>
Migraine	<input type="checkbox"/>
Neurofibromatosis syndrome	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>

Patient lives with: _____

Does patient smoke? Yes No

Drink alcohol? Yes No

Occupation / Hobbies / Child's interests: _____

Recreational drugs? Yes No

Pharmacy Name: _____

Location: _____

IS PATIENT ALLERGIC TO:

Medications? Yes No

List: _____

Foods? Yes No

List: _____

Latex? Yes No

History of anesthesia problems? Yes No

<i>In Office Use Only</i>
Physician's Signature _____ Date _____

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: _____

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 you 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)