OPHTHALMIC
CONSULTANTS OF
BOSTON
EXCELLENCE IN EYE CARE

Dear Patient,
Welcome to OCB and thank you for choosing us for your eye care needs. Enclosed is your pre-registration packet. Please read all materials carefully prior to your appointment. We want to make your appointment as pleasant as possible starting with the pre-registration process. Please fill out the enclosed forms and bring them with you to your appointment.

In addition to the enclosed forms, please bring the following:
- A list of your current medications and dosage.
- Health insurance cards and a photo ID. A scan of your health insurance cards and photo ID will be taken at the time of your appointment.
- A referral from your primary care physician if required by your insurance. Please call your primary care physician ahead of time to secure one.
- Eyeglass and/or contact lenses with current contact lens prescription or package.
- Previous medical records or any diagnosis relating to your eyes.

New patients should expect to spend a minimum of 1 ½ hours on your first visit and should plan on pupillary dilation. However, patients being referred for consultation or who are seeing a retina specialist may spend 2-3 hours due to dilation and additional testing. The dilating eye drops used during the exam may blur your vision or make your eyes sensitive to light, making driving difficult. Please bring sunglasses and plan accordingly.

***If you are referred for a cataract evaluation and wear contact lenses, please discontinue use of hard lenses 21 days prior and soft lenses 7 days prior to your exam.**

On the day of your visit you will check in with our front desk staff. You will be seen by a specially trained technician prior to being examined by the eye doctor.

Thank you for choosing OCB for your eye care. We value your feedback and want to make your visit a pleasant one. Please call 1-800-635-0489 if you have any questions or visit our website at www.eyeboston.com for further information. If you have provided an email address please watch for a patient satisfaction survey following your appointment. We look forward to seeing you.

OCB On Call Policy and Procedures
(Patient Copy)

OCB's On-Call Policy and Procedures have been developed to assist you in understanding how OCB can respond to your eye care needs outside of OCB's regular office hours.

OCB's regular office hours are Monday through Friday 8:00 AM to 4:30 PM. During regular office hours, please contact OCB using the direct line for the practice location you want to reach, or by calling our toll-free number: 800-635-0489.

OCB telephone lines are staffed 24-hours a day. OCB does provide physician coverage after hours in order to address your questions and concerns.

Please note that while your OCB Doctor is not on-call 24-hours per day, 7-days per week, your Doctor has arranged for coverage by a colleague.

For your after-hours eye care needs, please call OCB's toll-free number 800-635-0489 and proceed as follows:

1) OCB's Answering Service receives your call.

2) You will receive a call from OCB's on-call MD, Fellow or Clinical Technician to discuss your eye care concerns. You can expect to be contacted within 30 minutes of your initial phone call. If you do not receive a call within that time period, please place a second call to the 800 number.

3) If your eye care needs require you to be seen, you will be directed to the location that can best respond to your eye care needs at that time (in some cases, it may be the Boston office or a Hospital). If surgical or laser services are needed, you may be directed to Tufts Medical Center or the Mass Eye & Ear Infirmary for treatment.

Prescription refills and appointment changes or cancelations will be responded to during OCB's regular office hours.

In the event of an emergency, such as a sight-threatening trauma, you should proceed directly to the Hospital Emergency Room.

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Medical History and Review of Systems

Date of Appointment: _____________

Provider: _______________________

Medical Doctor (not eye):
____
Address:

NAME: ____

ADDRESS: ____

____

TELEPHONE:___________________________

Date of Birth: ____________________ **Age:** __________

REASON FOR VISIT: ____

MEDICAL HISTORY **PLEASE CHECK "No or "Yes" for each area**

A) How would you rate your health? **Poor** **Fair** **Good** **Excellent**

B) Please indicate if you currently have or had: **Dates/Explain:**

1) Fever, chills, night sweats, unexplained fatigue ☐ No ☐ Yes _____________________

2) Have you gained or lost more than 10 pounds in the past year? ☐ No ☐ Yes _____________________

3) Ear problems: loss of hearing, vertigo ☐ No ☐ Yes _____________________

4) Nose problems: smell, sinus disease ☐ No ☐ Yes _____________________

5) Throat problems: dry mouth, difficulty swallowing ☐ No ☐ Yes _____________________

6) Heart or circulation problems

Heart attack, angina ☐ No ☐ Yes ____________________
Congestive heart failure, shortness of breath ☐ No ☐ Yes _____________________
Irregular or rapid heartbeat ☐ No ☐ Yes _____________________
Cardiac pacemaker or heart valve ☐ No ☐ Yes _____________________
High blood pressure or high cholesterol ☐ No ☐ Yes _____________________

7) Respiratory problems

Asthma ☐ No ☐ Yes _____________________
Chronic cough, emphysema, bronchitis, sleep apnea ☐ No ☐ Yes _____________________
Tuberculosis, positive skin date ____ ☐ No ☐ Yes _____________________

8) Gastrointestinal problems

Ulcer, diverticulitis, colitis, frequent diarrhea ☐ No ☐ Yes _____________________
Liver disease, hepatitis (type _____________) ☐ No ☐ Yes _____________________

9) Genitourinary

Kidney, bladder, prostate problems stones, infections, frequency, VD ☐ No ☐ Yes _____________________

10) Muscle or joint problems

Weakness, inflammation, low back pain ☐ No ☐ Yes _____________________
Osteoarthritis, rheumatoid, gout,fatigue arthritis, joint swelling ☐ No ☐ Yes _____________________

11) Skin, nail or hair problems

Eczema, psoriasis, rosacea, infections ☐ No ☐ Yes _____________________

12) Nervous system problems

TIA, stroke, seizures, difficulty walking, tremor, Parkinson's disease ☐ No ☐ Yes _____________________
Memory loss, disorientation, hallucinations ☐ No ☐ Yes _____________________
Depression, anxiety, other ☐ No ☐ Yes _____________________

13) **Endocrine problems**

Diabetes: **Date of onset:** ____________________ **Duration:**_________________________

Complications: ☐ kidney ☐ neuropathy ☐ vascular ☐ ocular

Treatment: ☐ diet ☐ oral agents ☐ insulin

Thyroid Disease ☐ underactive ☐ over active treatment_____________________________

☐**Adrenal** ☐ **Pituitary** (*hair loss, unusual hand/foot growth, abnormal menstrual cycle, heat/cold intolerance, change in libido)*

14) **Blood disorders** ☐ easy bruising ☐ anemia ☐ clot in legs ☐ recurrent infections ☐ swollen glands

15) **Transfusions of blood or plasma:**____

16) **AIDS or HIV positive (date of test):**____

17) **Cancer or tumor: Type, location, date, treatment:**____

18) **If applicable, are you pregnant?** ☐No ☐Yes Expected Date of Delivery____________________________

19) **Other medical problems:**

____

ALLERGIES: Medications, foods, chemicals, environment. (Please describe reaction and when it occurred.)

____

____

PHARMACY: ____

MEDICATIONS: (give name, dosage, frequency)

Eye Medications:____

____

Prescription Medications:____

____

Non-Prescription Medications:____

____

When did you last take aspirin in any form?____

SURGERY: Have you had any previous **eye surgery, laser eye surgery** or **eye injury**? ☐ No ☐ Yes

If yes, please give name(s) of operation(s) or injuries and date(s):____

____

What non-ocular operations or hospitalizations have you had? Please give type(s) and date(s): _______________________

____

____

Date of last **general** anesthesia: __________________ Any anesthesia complications? ☐ No ☐ Yes

If yes, describe: ____

DESCRIBE THE EYE PROBLEM(S) YOU ARE HAVING TODAY:_______________________________________

____

____

____

SOCIAL HISTORY:

1. Do you smoke? ☐ Yes ☐ No Former smoker? ☐ Yes ☐ No If yes, how many cigarettes per day? ________
Chewing Tobacco? ☐ Yes ☐ No E-cigarettes? ☐ Yes ☐ No Quit date? _______________

2. Do you drink alcohol? ☐ Yes ☐ No If yes, drinks per day? _______ Drinks per week: ________

3. Gender: Male ☐ Female ☐

4. Race: ☐ Caucasian ☐ African American ☐ Asian Other ____________ ☐ Refused

5. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ____________________

7. Work Status: ______________________ Current Occupation: ______________________________

8. Any known toxic exposures? ☐ Yes ☐ No

9. Living arrangements: ☐ Home ☐ Apartment ☐ Nursing home ☐ Other: ____________________

10. Education Level: ☐ Grade School ☐ High School ☐ College ☐ Post-Graduate Degree ☐ Other: _____

11. Are there other problems affecting your health (family illness, deaths, stress, etc)? _________________

____

FAMILY HISTORY: Among your **blood relatives**, is there a history or the following: ☐ Unknown ☐ Adopted

1. Glaucoma ☐ No ☐ Yes __________________________
2. Macular degeneration ☐ No ☐ Yes __________________________
3. Retinal Detachment ☐ No ☐ Yes __________________________
4. Diabetes mellitus ☐ No ☐ Yes __________________________
5. Breast Cancer ☐ No ☐ Yes __________________________
6. Colon Cancer ☐ No ☐ Yes __________________________
7. Coronary Artery Disease ☐ No ☐ Yes __________________________
8. Heart disease ☐ No ☐ Yes __________________________
9. Osteoporosis ☐ No ☐ Yes __________________________

Do you have a health care proxy? ☐ No ☐ Yes If yes, please bring a copy of your proxy to your appointment.

Please give the name, address, and telephone of **any other eye Doctors:** ______________________________

____

____

Form completed by: ☐ Patient ☐ Family ☐ Staff

Mass HIway Consent

Patient Consent/Opt-in to the Mass HIway

The Mass HIway is a special computer network, also called a "Health Information Exchange." It allows your doctors at different institutions to quickly and securely share important information about you when it is needed for your care.
What is different about the Mass HIway is it provides a secure way of sending an electronic summary directly from one medical provider to another.
Examples of ways the Mass HIway is used include:

- hospitals may send a discharge summary to the facility/doctor caring for you next
- primary care doctors may send a referral summary to a specialist
- clinicians treating you in an emergency may look up and find who your doctors are so they can communicate with them and get information about your health that is needed to treat you during the emergency (including your allergies, medications and problems)

I have been given information on the Massachusetts Health Information Highway ("Mass HIway"). **I give Ophthalmic Consultants of Boston (OCB), Partners HealthCare System, Inc. (Partners HealthCare) and my health care providers (defined below) permission to use the Mass HIway to:**

1. Send, request, and receive my health information to and from other health care organizations that use the Mass HIway.

    - This information may include information about HIV, alcohol and drug abuse treatment, mental health treatment, sexually transmitted diseases, rape, sexual assault, domestic abuse, abortion and genetic testing.

2. Send my name, date of birth, gender, email, home address, phone number, and medical record number to a Mass HIway database. This allows providers treating me, who use the Mass HIway, to know that I have received care with OCB and Partners associated providers (defined below) and to ask for information when needed for my care.

I know that OCB and Partners HealthCare has developed an electronic health record for patient care. This electronic health record is used by:

- Partners HealthCare, connected organizations, and health care providers, and
- Other non-Partners health care providers, such as Dana-Farber Cancer Institute (DFCI), Massachusetts Eye and Ear Infirmary (MEEI), Ophthalmic Consultants of Boston (OCB) and some community physicians and physician groups.

I know that the terms "my health care providers" and "Partners associated providers" as used in this form includes all of the above users of the Partners HealthCare electronic health record.
I may take back my consent or opt out of the Mass HIway. To do so, I must:

- Contact a Partners Health Care site privacy office (see the Partner HealthCare Privacy Notice for contact information). The privacy office will provide me with the opt out form to complete.
- If I have a Partners Patient Gateway account, I can log into my account and update my Mass HIway consent (to opt in or opt out) at any time.

Patient Copy: You will be asked to sign an acknowledgement of receipt at your visit

External Information Medication Consent

What is Surescripts?
Surescripts connects pharmacies, care providers, benefit managers, and operates a network to allow for the movement of electronic clinical health information between different health information systems. Through the Surescripts network, authorized prescribers and pharmacies can gain access to prescription information and related information for use in providing clinical care to patients.

What is the Medication History?
The Surescripts Medication History service allows prescribers and pharmacists to use the Surescripts network to access a patient's medication history across providers, at the point of care. This service can be used in the course of providing routine care, as well as during emergencies. In both cases, Medication History enables health care providers to make a more informed clinical decision. To provide this service, Surescripts connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers. Surescripts then presents that data to prescribers through software from a certified vendor.

Consent
I understand that Ophthalmic Consultants of Boston and Partners HealthCare System, Inc. ("Partners HealthCare") and/or its affiliated entities has deployed an integrated electronic medical record that is used by Partners HealthCare, its affiliated entities and healthcare providers and other non-partners healthcare providers such as Dana-Farber Cancer Institute, Massachusetts Eye and Ear Infirmary, OCB and certain community physicians and physician groups. I acknowledge that by signing this form below I consent to and agree that Partners HealthCare and its affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) may request, access, and receive my medication history data from Surescripts.

I understand that I can withdraw my consent for Partners HealthCare and its affiliated entities and healthcare providers and all other users of the Partners integrated electronic medical record (including but not limited to Dana-Farber Cancer Institute and Massachusetts Eye and Ear Infirmary) to access my medication history data from Surescripts by contacting any of the Partners HealthCare hospital privacy offices and completing the Partners HealthCare Surescripts Opt-out form. I understand that revoking this consent will not have any effect on actions taken prior to such revocation.

Patient Copy: You will be asked to sign an acknowledgement of receipt at your visit

HIPAA Privacy Notice

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

In accordance with the privacy standards issued by the United States Department of Health and Human Services, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby consent to Ophthalmic Consultants of Boston using and disclosing my protected health care information for the purposes of treatment, billing, and health care operations.

Federal law requires that all patients be given a copy of the Ophthalmic Consultants of Boston Privacy Notice. The Privacy Notice describes in detail how patient health information is used and shared with others.

Ophthalmic Consultants of Boston has reserved the right to change the Privacy Notice at any time. You may obtain a current copy of the Privacy Notice at the Front Desk or by contacting the office.

All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example, by e-mail or facsimile mail.

I have been offered a copy of the Ophthalmic Consultants of Boston Privacy Notice.

Patient Copy: You will be asked to sign an acknowledgement of receipt at your visit

Assignment of Insurance Benefits

I request that payment of authorized insurance or Medicare benefits be made on my behalf to Ophthalmic Consultants of Boston for services furnished me by Ophthalmic Consultants of Boston. I authorize any holder of medical information about me to release to the insurance company or to CMS (Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that if a MediGap policy or other health insurance is indicated on the claim form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Ophthalmic Consultants of Boston.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.

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Financial Agreement with Ophthalmic Consultants of Boston

Ophthalmic Consultants of Boston is devoted to providing you with the best possible care. If you have health insurance, we are committed to helping you receive your maximum allowable benefits. We must emphasize that as health care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients; all charges are your responsibility from the date the services were rendered.

I understand that I am financially responsible for any services **not** covered or allowed, but not paid due to the terms of my insurance coverage. I understand that it is my responsibility to comply with the guidelines set by my insurance company.

I understand that all co-payments, deductibles, and non-covered charges are due at the time of service.

I accept full responsibility for payment of services and/or for securing necessary primary care referrals or pre-approval for medical visits. If applicable, I understand that I have an obligation to obtain a referral for specialist services from my primary care physician (PCP) **prior** to having services rendered. I acknowledge that if the appropriate referral/authorizations are not on file at the time services are rendered, that I am financially responsible for any charges denied by my health insurance carrier as a result.

If uninsured, full payment for all services is due on the date of service. I understand that future appointments may be contingent upon having met my financial obligations within the office, or having made appropriate arrangements with Ophthalmic Consultants of Boston.

If the visit is a work related injury, I acknowledge that it is my responsibility to obtain an authorized claim number from my employer's worker's compensation insurance carrier and maintain approval for every visit. I am financially responsible for all non-authorized charges.

I hereby authorize payment directly to Ophthalmic Consultants of Boston for services rendered otherwise payable to me. I authorize release of information required to complete insurance claims.

My signature below affirms that I understand this statement and have accepted responsibility for all fees incurred for my medical care.

Patient Copy: You will be asked to sign an acknowledgement of receipt at your visit

Missing Referral or Prior Authorization

Unfortunately, we did not receive a *Referral or Prior Authorization* from your Primary Care Physician (PCP) for today's visit.

Under these circumstances, a managed care plan will deny coverage of this visit.
Your signature below indicates that *you chose to receive care by a Specialist without a referral* from your Primary Care Physician.

You understand that *you will be financially responsible* for any and all charges associated with this visit if no referral or prior authorization is obtained.

You have been advised to contact your Primary Care Physician to immediately obtain a Referral or Prior Authorization for this visit.

Patient Copy: You will be asked to sign an acknowledgement of receipt at your visit