OFFICE OF RICHARD J. MANGANIELLO, M.D.

LAST NAME: _____ FIRST NAME: _____ MID INITIAL: _____

STREET ADDRESS: _____ TOWN: _____

STATE: _____ ZIP CODE: _____ EMAIL ADDRESS: _____
(PLEASE WRITE LEGIBLY)

☐ MALE ☐ FEMALE SOCIAL SECURITY # _____ - _____ - _____ DATE OF BIRTH: _____/ _____ / _____

CELL: (_____)_____ HOME TEL: (_____)_____ WORK TEL: (_____)_____ EXT. _____

MARITAL STATUS: ☐MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ PARTNERSHIP

1) LANGUAGE: ☐ **ENGLISH** ☐ **SPANISH** ☐ **OTHER**: _____

2) ETHNICITY: ☐ **HISPANIC OR LATINO** ☐ **NOT HISPANIC OR LATINO** ☐ **REFUSED TO ANSWER**

3) RACE: ☐ **AMERICAN INDIAN** ☐ **BLACK OR AFRICAN AMERICAN** ☐ **HAWAIIAN OR PACIFIC ISLAND**
☐ **ASIAN** ☐ **WHITE** ☐ **UNKNOWN** ☐ **REFUSED TO ANSWER**

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT / SECONDARY CONTACT PERSON:

NAME:_____ PHONE:(_____)_____ RELATIONSHIP: _____

PRIMARY CARE DOCTOR: _____
(FULL NAME) (ADDRESS/TOWN)

PHARMACY- RETAIL: _____
(NAME) (ADDRESS/TOWN)

PHARMACY- MAIL ORDER: _____ REFERRING PHYSICIAN:_____
(NAME)

INSURANCE INFORMATION

1) PRIMARY INSURANCE**:** _____ ID# _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S D.O.B.: _____ / _____ / _____

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER: _____

2) SECONDARY INSURANCE**:** _____ ID# _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S D.O.B.: _____ / _____ / _____

RELATIONSHIP TO PATIENT: _____SELF _____SPOUSE _____PARENT OTHER: _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

___ DECREASED DISTANCE VISION ___ CHANGE IN FLOATERS ___ DIMMING OF VISION

___ DECREASED NEAR VISION ___ FLASHES OF LIGHT ___ WORSENING NIGHT VISION

___ ITCHING, REDNESS, OR TEARING ___ DOUBLE VISION ___ SEEING HALOS / GLARE ISSUES

___ **OTHER (please explain)**: _____

HOW DID YOU HEAR ABOUT US? ☐ FAMILY ☐ FRIEND ☐ HOSPITAL ☐ WEBSITE
☐ YELLOW PAGES ☐ INTERNET ☐ INSURANCE DIRECTORY ☐ PHYSICIAN ☐ OTHER: _____

SIGNATURE AND FINANCIAL AUTHORIZATION: I certify that insurance information I have provided is accurate. Insurance submission is provided as a courtesy to me and I am responsible to provide correct insurance information and obtain any required referrals. I am responsible for all co-payments, deductibles, refraction fees, & balances not covered by my health insurance. **I agree to pay any co-payments, refraction fees, & deductibles at the time of service.** In the event of default, I understand a finance charge may be added to my outstanding account after 30 days. The minimum monthly finance charge is $15.00 or 18% per annum (whichever is greater). Unless I have made previous arrangements, any outstanding balance will be sent to collections after 3 statements. I agree to pay all collections costs & legal fees associated with collecting the debt and a $35.00 fee for any returned or NSF check. CEPS 12-09-19

SIGNATURE: _____ DATE: _____

NAME (PRINT): _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ **DOB:** _____

PAST EYE CONDITIONS & SURGERIES: [None ☐] _____
_____
_____

OTHER HEALTH CONDITIONS: [None ☐] _____
_____
_____

PAST NON-EYE RELATED SURGERIES (Surgery type, affected body part, and year): [None ☐]
_____
_____
_____

DRUG <u>ALLERGIES</u>/REACTIONS: [None ☐] _____
_____
_____

CURRENT MEDICATIONS (all medications, not just eye-related):

☐ **Check here if you are attaching a list instead**

MEDICATION NAME	STRENGTH	DOSAGE/FREQUENCY	ROUTE OF ADMINISTRATION							
			Oral	Eyedrop	Topical	Nasal	Inhaler	Injection	Infusion	Suppository

DIABETIC PATIENTS: MOST RECENT A1C results: _____ Date: _____

SOCIAL HISTORY:

<u>1) SMOKING:</u> ☐ Every day ☐ Sometimes ☐ Former smoker ☐ Never

<u>2) ALCOHOL:</u> ☐ Yes ☐ No If Yes, what types & how much/how often: _____
_____

<u>3) DRUGS:</u> ☐ Yes ☐ No If Yes, what types & how much/how often: _____
☐ Past User _____

PLEASE COMPLETE <u>BOTH</u> SIDES!!! ►►►►►►►►►►►►

FAMILY HISTORY: (Please check all that apply & circle relationship) ☐ **No history** ☐ **Unknown** ☐ **Decline to answer**

☐ **Arthritis**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Blindness**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Cancer**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Diabetes**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Glaucoma**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Heart Disease**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **High Blood Pressure**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Kidney Disease**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Lazy Eye**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Macular Degeneration**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Retinal Disease**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Stroke**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Other:**_____	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent

REVIEW OF SYSTEMS

(Symptoms that you are *currently experiencing*- please check yes or no)

EYES

Previous surgery	☐ Yes	☐ No
Contact Lens wearer	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Flashes	☐ Yes	☐ No
Floaters	☐ Yes	☐ No

EAR, NOSE, & THROAT

Hard of Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

CARDIOVASCULAR

Chest Pain	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Difficulty Lying Flat	☐ Yes	☐ No

CONSTITUTIONAL

Fatigue/Weakness	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No

RESPIRATORY

Cough	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

GASTROINTESTINAL

Heartburn	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Jaundice/Hepatitis	☐ Yes	☐ No

GENITO-URINARY

Pain/Difficulty	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
History of Kidney Stone(s)	☐ Yes	☐ No
History of STDs	☐ Yes	☐ No

PSYCHIATRIC

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Difficulty Sleeping	☐ Yes	☐ No

ENDOCRINE

Increased Thirst	☐ Yes	☐ No
Increased Hunger	☐ Yes	☐ No
Increased Urination	☐ Yes	☐ No
Increased Sweating	☐ Yes	☐ No
Fingernail Changes	☐ Yes	☐ No

BLOOD/LYMPH NODES

Easy Bruising	☐ Yes	☐ No
Gums Bleed Easily	☐ Yes	☐ No
Prolonged Bleeding	☐ Yes	☐ No
Heavy Aspirin Use	☐ Yes	☐ No

MUSCULOSKELETAL

Stiffness	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint Pain/Swelling	☐ Yes	☐ No

SKIN

Rashes/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Hives/Eczema	☐ Yes	☐ No

NEUROLOGICAL

Seizures	☐ Yes	☐ No
Weakness/Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

IMMUNOLOGIC

Hives	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Runny Nose	☐ Yes	☐ No
Sinus Pressure	☐ Yes	☐ No

RICHARD J. MANGANIELLO, MD
Connecticut Eye Physicians and Surgeons, LLC
479 Buckland Rd, South Windsor, CT 06074

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

NAME: _____ DOB: _____

May we leave messages/detailed medical information at either of these phone numbers?

Home: (_____)_____ □ Yes □ No Cell Phone: (_____)_____ □ Yes □ No

May we contact you by email? □ Yes (email: _____) □ No

May we contact you at your place of employment? □ Yes □ No

If yes, Work Phone: _____ ext. _____

Do you have any particular person or family member that you authorize to receive and discuss information regarding your personal health information (general, medical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: (_____)_____ Alternate phone number: (_____)_____

Does this person have medical Power of Attorney for you? □ Yes □ No

If Power of Attorney for medical purposes is held by a different person, please provide the information:

Name: _____ Relationship: _____

Phone Number: (_____)_____ Alternate phone number: (_____)_____

I hereby authorize Connecticut Eye Physicians and Surgeons to obtain or release any and all pertinent information regarding my medical care, as needed, to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the CEPS Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

(If signed by other) Name: _____ Relationship: _____

RICHARD J. MANGANIELLO, MD

REFRACTION BILLING POLICY FOR ALL PATIENTS

PLEASE SIGN AND RETURN TO OFFICE

To my patients:

REFRACTION is the process of determining refractive error and is done for diagnostic purposes as well as for establishing any need for corrective lenses (eyeglasses). This is an essential part of an eye examination and is done during a complete medical eye exam as a standard of responsible care. Unfortunately, Medicare and many commercial insurance carriers choose not to cover this service, even while recognizing the need for it.

The patient fee for refraction is $40.00 if your insurance plan does not cover this service. This fee is *in addition to* any co-pay, co-insurance, or deductible required by your insurance. In order to keep billing costs down**, we will ask for refraction payment at the time of your appointment if it is not a covered service under your insurance plan.**

The fee for a complete, updated contact lens prescription is also $40.00. This service is provided for those patients who are happy with their current brand of contact lenses and wish to have the fit, prescription strength, and suitability checked so that contact lens refills can be ordered locally or online. You will need to wear your current contact lenses in for the exam and bring the boxes that have the measurements printed on them. **This fee is not covered by medical insurance plans and will be collected at the time of service.**

My office staff and I will be happy to answer any questions regarding this policy.

Thank you,

Richard J. Manganiello, MD

CEPS 12-09-19

☐ ALL PATIENTS: I have read the above information and accept full financial responsibility for the $40.00 patient refraction fee should my insurance plan not cover the service, which may be collected at the time of service if the office staff knows in advance that my plan will not cover it.

☐ CONTACT LENS PATIENTS: I understand that there is an additional $40.00 fee payable at the time of service if I wish to obtain a complete, updated contact lens prescription.

I understand that these fees are in addition to any and all co-pays, co-insurances, and deductibles.

Patient Signature: _____ **Date:** _____

Patient Name (printed): _____

If signed by someone other than the patient, please print name and relationship to patient:

_____

MEDICAL OR ROUTINE?

DR. RICHARD MANGANIELLO is an ophthalmologist, a medical doctor who specializes in providing comprehensive medical eye care. Examinations are usually submitted to your insurance as a medical visit with a medical diagnosis code.

Some patients have "routine vision" coverage. As long as your routine coverage is submitted to and paid by your medical insurance carrier we may be able to submit the claim as a routine visit for you. However, we are not contracted with, do not participate with, and are unable to submit claims to a vision plan (i.e.,VSP, Davis Vision, EyeMed, Blue View, Spectera, etc.) **If your insurance coverage allows for routine exams, and you feel you are coming in for a routine exam *only*, you must notify us when scheduling your appointment.**

ROUTINE EYE EXAMINATION: A routine eye exam is for general screening. It will provide an overall evaluation of the health of your eyes and determine if your vision can be improved with a prescription for eyeglasses or contact lenses. A routine eye exam will NOT treat or monitor medical conditions. Any testing to evaluate medical eye conditions is generally not done during this type of exam.

MEDICAL EYE EXAMINATION: A medical eye examination is for diagnosing and monitoring conditions and diseases that manifest with ocular symptoms, including but not limited to: Corneal disorders such as dry eyes, diabetes, cataracts, glaucoma or glaucoma suspect, double vision, retinal or macular problems, or any acute or sudden symptoms.

If you are being followed for a medical diagnosis, the doctor may not be able to address that issue during a routine eye exam. A separate appointment may need to be scheduled for a more in-depth examination to address any medical concerns.

REFRACTION: A refraction test determines the refractive power of your eyes and the best corrective lenses to be prescribed to correct your refractive error. It is the only way to determine your current visual acuity and provide you with an eyeglasses prescription. In addition, monitoring the changes in your refractive error is integral to the diagnosis and treatment of many eye disorders including those of the cornea, lens (i.e. cataracts), and macula. It is a necessary, standard-of-care element of your exam. Many medical plans, including Medicare, do not cover refraction, regardless of the reason it is performed. Should your insurance plan not cover the cost of refraction, you will be responsible for a $40 glasses refraction fee to cover a portion of the cost. The fee for an updated contact lens prescription is also $40. You will not be given a copy of your prescription unless the fee is paid.

Please understand that each patient's insurance coverage varies and that Connecticut Eye Physicians & Surgeons cannot be held responsible for knowing each patient's insurance coverage or type of insurance. **It is your responsibility to know and understand your insurance benefits, and to provide us with your current coverage information BEFORE your examination.**

We will be happy to assist you in scheduling the correct appointment for your medical eye care needs.