******PLEASE FILL OUT IF YOU ARE A NEW PATIENT, HAVE NOT BEEN IN THE OFFICE FOR 1 YEAR, OR HAVE NEV ADDRESS OR INSURANCE. WE MUST HAVE A CREDIT CARD ON FILE FOR SERVICES. THANK YOU!**

Dawn P. Rush, MD PLLC & Renee Richards, MD

Pediatric Ophthalmology and Adult Strabismus

Phone: 914-962-0684 FAX: 914-962-0415 Email: eyespypediatrics@gmail.com

Welcome to Our Practice

'lease see attached Registration, medical history, and credit card authorization. Please fill out prior to your visit. ›ocuments can be emailed, faxed or brought with you the day of your appointment. This will help to avoid delays in the office. Please bring your insurance card.

If your insurance requires a referral please call your pediatrician prior to your appointment.

Patient's Last Name________________ First Name________________ MI____

Date of Birth__________ Age________ Sex: F M

Address________________________ Apt #___ City____________ State____ Zip_______

Home Phone:______________ Day Phone:______________ Cell Phone:______________

Emergency Contact:______________ Relationship__________ Phone:______________

Primary Care Physician______________ Referring Physician______________

Email:______________ Pharmacy:______________ Location:__________

Please list all family members seen in this office:

Name______________ DOB__________ M F Name______________ DOB__________ M F

Name______________ DOB__________ M F Name______________ DOB__________ M F

Primary Medical Insurance: Does your insurance require a referral? Y N

Policy Holder Name______________ DOB__________ Relationship______________

Insurance Carrier______________ Policy #______________ Group #__________

Employer:______________ Occupation______________ Co-Pay Amount________

Secondary Medical Insurance: Does your insurance require a referral? Y N

Policy Holder Name______________ DOB__________ Relationship______________

Insurance Carrier______________ Policy #______________ Group #__________

Employer:______________ Occupation______________ Co-Pay Amount________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made the physician unless my account has been paid in full. I have recieved Dawn P. Rush, MD PLLC notice of privacy practice

PATIENT:______________________ **M/ F DOB:**__________ **Age:**______ **Date:**__________

Medical History Questionnaire

Does Your Child:
Have brothers?_________ Sisters? ________(How Many)

Has another child of yours seen one of our doctors in the past?
____

Significant medical history?______________________________

Take any medications? N Y___________________________
Dosage?____
Have any allergies to medications? N Y_____________________

Birth History:
Was Your child premature? N Y

Birth Weight_________# of weeks early?________

Any Problems with the pregnancy or delivery? N Y
____

____
(Please circle one) Delivery? Vaginal C-Section
Is your child Adopted? N Y

Reaction To Medication: Please Fill In Circles

Location	Skin O	Local O	Abdominal O	Systemic O		
Reaction	Rash localized O	Rash Generalized O	Itchy O	Patchy-Swelling O	Facial-Swelling O	Hives O
Severity	Very Mild O	Mild O	Moderate O	Severe O		

Eye History:
Main reason for appointment today? _______________________________________

Does your child's eye(s) turn in or drift out? N / Y
Does your child wear glasses now/ past? N / Y
Has your child worn bifocals? N / Y
Do you patch your child's eye now? N / Y
Does Your child have a habitual head tilt? N / Y
Does your child wear contacts? N / Y
Has your child had eye surgery? if yes when_______________________________

Past Surgical History:
List any surgical procedures and dates:

Does your child have any problems with: Please complete entire Medical History Form
Eyes other than listed above? N Y_________________________
Developmental Delays? N Y_________________________
Recent Trauma? N Y_________________________
Chromosome abnormalities or syndromes? N Y__________________

N Y Endocrine N Y Stomach N Y Blood N Y Allergies: allergic to ____________________________
N Y Diabetes N Y Gastrointestinal N Y Lymphatic system N Y Immunologic

N Y Ears N Y Muscle N Y Genital N Y Psychiatric N Y ADD N Y PDD N Y Fevers N Y Skin
N Y Nose N Y Bones N Y Kidney N Y Neurological N Y ADHD N Y Cerebral Palsy N Y Weight Gain
N Y Throat N Y Joints N Y Bladder N Y Headaches N Y Autism N Y Seizures N Y Weight Loss

N Y Heart Disease N Y Thyroid Disease N Y Cardiovascular:________________________
N Y Lung Disease N Y Anemia N Y Cancer:____________________________

Family History: Does the Mother Father Any Grandparent or Sibling have any of the following?

AMBLYOPIA STRABISMUS LAZY EYE ADVERSE REACTION TO ANESTHESIA GLAUCOMA
Any other heritable disease:____
Family history of childhood eye problems:_________________________________
Does anyone in the family wear glasses? Y N Who?__________________________as a child? Y N

Social History: Does your child: Attend school? Y N Have difficulty learning? Y N
is your child in Special Education? Y N Use Tobacco? Y N

PATIENT:___________________________**M/ F DOB:**__________**Age:**____**Date:**_______

Physicians signature:____________________________ Date:______________________

ADULT Medical History Questionnaire

Please print clearly and use the back of this page if you need more space

Today's date:____
Name :____
Your age:________________________
Who is your medical doctor?____________________________
What is the main reason for your visit today?____________

____

Do you have any of these eye symptoms?

O Blurred distance vision O Glare, halos around lights
O Blurred reading vision O Itching or burning eyes
O Constant double vision O Eye mattering or tearing
O Flashing lights or floaters O Foreign body sensation
O Red eyes O Dry eye O Eye pain

Do you have any allergies to any medications?

O None known O Yes, which ones? (list below)

Medication Name	What reaction did you have?
____________	________________
____________	________________
____________	________________
____________	________________

Which eye medications do you currently take?

O None O Artificial Tears

Medication Name	Amount	How many times/day
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime

Which other medications do you currently take?

O None O Aspirin on a daily basis?

Medication Name:	Amount	How many times/day
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime
____________	_____	1 2 3 4 at bedtime

Have you ever had any of these eye problems?

O Cataract O Serious eye injury
O Glaucoma O Iritis / uveitis
O Macular degeneration O Lazy eye
O Wore eye patch as a child O Retinal detachment
Other:____

____

Do you have any allergies? N Y_____________________________

____

Have you ever had any of these conditions?

O None
O Stroke O Dizziness O High blood pressure
O Arthritis O Allergies O Heart disease
O Diabetes O AIDS, HIV O Lung disease
O Cancer O Anemia O Thyroid disease
O Headaches O Other: ______________________________

____

Have members of your family had any eye diseases?
(This would be your father, mother, sister, brother, grandparents)

O Glaucoma O Diabetic eye disease or diabetes
O Cataract O Crossed eyes O Macular degeneration
O Iritis/uveitis O Blindness O Retinal detachment
O Poor vision O Other:______________________________

____

Please list any eye operations you have had:

O None

Type of Eye Surgery	Which Eye	Year
________________	Right Left	______
________________	Right Left	______
________________	Right Left	______
________________	Right Left	______

Please list any other operations you have had:

O None

Type of Surgery	Year
______________________	______
______________________	______
______________________	______
______________________	______

What non-surgery illness have caused a hospital stay?

____

____

If you have glaucoma:

In what year was the diagnosis first made?______________
Month and year of your last visual field test?_____________
Name of your previous ophthalmologist?___________________

Social History:

Smoker? Y N # of packs per day?_____________
# of packs per week?_____________
Ex-smoker? Y N

Would you like to wear contact lenses?

O Yes O Not interested at this time

What was the approximate date of your last eye Examination:_________________________________

Physician Signature: ________________________________

Patient Name : ________________________________ DOB: __________ Todays Date: __________

Patient Name : ________________________________ DOB: __________

Patient Name : ________________________________ DOB: __________

All patients and parents visiting our office during the COVID-19 Pandemic must read and complete this form and comply with the policies below.

PATIENT AFFIRMATION

In the last two weeks have you had or do you have the following new symptoms (please circle Y / N)

Loss of smell/ taste	Diarrhea	Persistent cough	Chest pain	Loss of appetite	Fever	Hoarse voice	Fatigue	Abdominal pain	Confusion	Shortness of breath
Y / N	Y / N	Y / N	Y/ N	Y / N	Y/ N	Y / N	Y / N	Y / N	Y / N	Y / N

(please circle Y / N)

I have / I have not tested positive for COVID -19 in the last thirty (30) days.

I have / I have not been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a positive COVID-19 test result in the last thirty (30) days.

PATIENT CONSENT and WAIVER for VISIT (Initial Each Paragraph)

_____I will not hold (DAWN P. RUSH, MD, PLLC), its doctors, nurses, or staff legally responsible should I become positively or presumptively diagnosed with the COVID-19 virus.

____________________	____________________	____________________
PRINT LEGAL NAME	SIGNATURE	DATE

MEDICALLY NECESSARY ***(PARENT/ GUARDIAN)*** AFFIRMATION (if Applicable)

I do not currently have, nor have I had in the last two weeks the following new symptoms (Please circle Y/ N)

Loss of smell/ taste	Diarrhea	Persistent cough	Chest pain	Loss of appetite	Fever	Hoarse voice	Fatigue	Abdominal pain	Confusion	Shortness of breath
Y / N	Y / N	Y / N	Y/ N	Y / N	Y/ N	Y / N	Y / N	Y / N	Y / N	Y / N

(please circle Y / N)

I have / I have not tested positive for COVID -19 in the last thirty (30) days.

I have / I have not been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a positive COVID-19 test result in the last thirty (30) days.

MEDICALLY NECESSARY (PARENT / GUARDIAN CONSENT) for VISIT (Initial Paragraph)

_____I will not hold (DAWN P. RUSH, MD, PLLC), its doctors, nurses, or staff legally responsible should I become positively or presumptively diagnosed with the COVID-19 virus.

____________________	____________________	____________________
PRINT LEGAL NAME	SIGNATURE	DATE

Credit Card Authorization for outstanding balances
(TO BE SUBMITTED BEFORE YOUR VISIT)

Dr. Rush's office policy requires a credit card to be on file due to changes in the healthcare industry.

If we are not provided with a credit card, the office will refuse services.

Our apologies for any inconvenience this has caused. Please bring with you the day of your appointment or fax to us at 914-962-0415

I, ______________________________ hereby willingly authorize **Dawn P. Rush, MD PLLC** to charge my credit card for the balance of charges not paid by my insurer in the event there is an outstanding balance due after the bills submitted to my insurance company for reimbursement were reviewed by my insurance company. I understand that generally I will be notified via electronic mail or regular mail as to the amount of the charge to allow me to check my credit card statement to be sure that its right.

I am aware that if my insurer pays **Dawn P. Rush, MD PLLC** after my credit card has been charged, my credit card will be promptly reimbursed in the amount paid by my insurance company; in the alternative, if I so desire, I can request that **Dawn P. Rush, MD PLLC** retain all or some part of that amount, as a credit on my account for my next visit. If I have any questions, I can contact **Dawn P. Rush, MD PLLC** at 914-962-0684.

You will receive a copy of this credit card authorization via email and if you wish it can be also printed for you at our office.

Balance of charges not paid by insurance to include:
Copays, coinsurance, deductibles, refraction charges $85.00, visual field exams, Fundus photography, Contact lens supply

INSURANCE COMPANIES THAT DO NOT COVER REFRACTION:
EMPIREPLAN / OXFORD / CIGNA / CERTAIN BCBS PLANS & UMR PLANS

An administrative fee of $100.00 will be applied for missed appointments if not canceled within 24 hours---

Credit card information will be entered in secured system and immediately shred
I affirm that the statements contained herein are true to the best of my knowledge; that I am authorized to incur this charge to my credit card and hereby authorize future credit card charges necessary; to pay outstanding balance as stated above.

Please check one ( ) MasterCard ( ) Visa ( ) Discover ( ) AMEX

__________-__________-____________-__________EXP Date ____/____
Account Number MO YR

( ) **Authorized over the phone** ( ) **verbally given in the office** ( ) **Signed in the office**

Cardholder Name:______________________________Patient Name:______________________________

Cardholder Signature: ____The parent signing this document is the person responsible for payment. In situations where the patients are divorced or separated, the parent bringing the child for the exam (and signing this document) is the responsible party.. We do not bill the other parent.

WHAT IS REFRACTION?

Refraction is a vision test given by the Doctor using lenses to determine the best corrected vision. This may or may not result in a new eye glass prescription.

The REFRACTION FEE IS $85.00

Depending on your insurance, this service may not be covered. You will, therefore, be responsible for the refraction fee in addition to your copayment for the visit.

INSURANCE COMPANIES THAT NEVER COVER EYE REFRACTION ARE…

OXFORD

POMCO

EMPIREPLAN

OTHER INSURANCE COMPANIES MAY VARY DEPENDING ON DIAGNOSIS

FUNDUS AND EXTERNAL PHOTOGRAPHY

POMCO AND EMPIREPLAN CHARGE ADDITIONAL COPAY FOR FUNDUS AND EXTERNAL PHOTOS.

If the doctor performs one of these procedures, payment is expected at the time of visit.

DAWN P. RUSH, MD PLLC
OFFICE POLICIES AND PATIENT- PROVIDER AGREEMENT

Scheduling:

The receptionist schedules all appointments. Please call during regular office hours to schedule an appointment. We suggest you make follow up appointments before you leave the office as our schedules can fill quickly or please visit us at **dawnrushmd.com to schedule online**

Cancellations/No Shows: Please provide us with at least 24 hours' notice of appointment cancellations. We charge the full price for a late cancellation or a no show appointment unless there are special circumstances beyond your control. We will not offer to reschedule late cancellations or no shows for the initial evaluation session.

Late Appointments: One late patient can delay the whole schedule and inconvenience other patients. If you arrive late, the provider will decide whether there is enough time to complete a brief visit. If so, you will be seen for the time remaining of your appointment. If not, you will be charged as a late cancellation. If the provider is running behind, you will still have your allotted time

Emergency Appointments: Every effort will be made to accommodate crisis situations and the need for earlier appointments; however you may need to keep in day to day contact with our office to check for cancellations if no appointments are immediately available.

Billing: Please refer billing questions to the medical biller at **dawnrushmdbilling@gmail.com**. Billing insurance companies is done as a courtesy to you. It is important to stress that the patient or responsible party maintains full responsibility for payment of services regardless of what the insurance company pays. A 1.5% per month late fee shall be assessed on all accounts more than 60 days past due

Insurance Panels: Currently, we are on several insurance panels. If we are not on your plan, you can self-submit our bill as an "out of network" provider and possibly be reimbursed a portion of the bill. We can provide you with a super-bill to submit to your insurance company.

Medication Refills: Normally, you will be provided with enough medication to last until your next follow up appointment. If you need a refill, please call your pharmacy to fax over a refill request. Please be attentive to the amount of medication you have left and call for refills at least 3 days before you run out.

Phone Services: Our office is open Tuesday through Thursday Friday from 9am-4pm and Friday 9am-12pm. Our receptionist is available to answer and screen all calls. Outside of these hours, if you have a question, refill request, want to schedule or cancel an appointment, etc. it will have to wait for regular business hours. These are NOT medical emergencies. If you have an after-hours emergency, you can call our number and leave a message for a return call by the physician on call. If you have a serious medical emergency, please don't wait to call us, call 911 or go to the nearest emergency room.

Vacations and Coverage: We do take vacations and will provide medical coverage as needed.

Confidentiality: You are entitled to confidentiality regarding your health care. However, the law under special circumstances also obligates us to report to authorities any significant suspicion of imminent danger: to the patient by self-harm, to someone the patient is targeting for harm, or to dependent children/elders being subjected to abuse or neglect. Furthermore, the legal system can subpoena medical records relevant to a legal matter without patient

consent. If you want us to be able to speak to someone such as a family member or teacher or psychologist, please sign the release forms at your appointments. We cannot send letters to your employer, school, etc. without written consent.

Termination: You have the option of terminating our treatment relationship if you are unsatisfied with your care. Likewise, we reserve the right to discontinue our relationship under certain circumstances. These circumstances include, but are not limited to:

Non-payment for services, including no show or late cancellation fees

Non-compliance with treatment recommendations, including follow-up intervals; three or more no show or late cancellations within a year

Discourteous treatment of the staff or provider

Office Hours: The receptionist's phone hours are Tuesday through Thursday from 9:00 AM to 4:00 PM and Friday 9:00 AM to 12:00 PM, excluding major holidays.

You will receive written notice of our intent to terminate our treatment relationship, and will be provided with up to 30 days of continued care in order to minimize the impact of your needing to transition to another provider. Our termination of the treatment relationship under the above noted circumstances, in no way implies that we are of the medical opinion that further treatment is not necessary.

I ____ have read, understood, received a copy of the above "Patient-Provider Agreement," and agree to abide by its terms while under the care of DAWN P. RUSH, MD PLLC

Please initial one:

______I DO give consent for Dawn P. Rush, MD to communicate with my primary care physician.

______I DO NOT give consent for Dawn P. Rush, MD to communicate with my primary care physician.

____ ____________________

Signature of Patient (or Parent/Guardian, if Patient is a Minor) Date

____

Patient Name