

******PLEASE FILL OUT IF YOU ARE A NEW PATIENT, HAVE NOT BEEN IN THE OFFICE FOR 1 YEAR, OR HAVE NEW ADDRESS OR INSURANCE. WE MUST HAVE A CREDIT CARD ON FILE FOR SERVICES AND COVID CONSENT FORM MUST BE FILLED OUT EVERYTIME. MASKS ARE REQUIRED FOR YOUR VISIT!**

Dawn P. Rush, MD PLLC & Renee Richards, MD
Pediatric Ophthalmology and Adult Strabismus
Phone: 914-962-0684 FAX: 914-962-0415 Email: rushmdpllc@gmail.com

Welcome to Our Practice

Please fill out prior to your visit. Documents can be emailed, faxed or brought in with you the day of your appointment. This will help to avoid delays in the office. **Please bring your insurance card and 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 to the physician unless my account has been paid in full. I have recieved Dawn P. Rush, MD PLLC notice of privacy practice

Responsible party signature: _____ 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 <input type="radio"/>	Local <input type="radio"/>	Abdominal <input type="radio"/>	Systemic <input type="radio"/>		
Reaction	Rash localized <input type="radio"/>	Rash Generalized <input type="radio"/>	Itchy <input type="radio"/>	Patchy-Swelling <input type="radio"/>	Facial-Swelling <input type="radio"/>	Hives <input type="radio"/>
Severity	Very Mild <input type="radio"/>	Mild <input type="radio"/>	Moderate <input type="radio"/>	Severe <input type="radio"/>		

Eye History:

Main reason for appointment today? _____

Does your child's eye(s) turn in or drift out? N / Y Do you patch your child's eye now? N / Y

Does your child wear glasses now/ past? N / Y Does Your child have a habitual head tilt? N / Y

Has your child worn bifocals? 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 ONLY) 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?

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

Do you have any allergies to any medications?

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

Medication Name What reaction did you have?

Which eye medications do you currently take?

- None 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?

- None 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

Have you ever had any of these eye problems?

- Cataract Serious eye injury
 Glaucoma Iritis / uveitis
 Macular degeneration Lazy eye
 Wore eye patch as a child Retinal detachment

Other: _____

Do you have any allergies? N Y _____

Have you ever had any of these conditions?

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

Have members of your family had any eye diseases?

(This would be your father, mother, sister, brother, grandparents)

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

Please list any eye operations you have had:

- None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any other operations you have had:

- 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?

- Yes 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

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.

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, supply of contact lenses

**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.

Cardholder Name: _____ Patient Name: _____

Cardholder Billing Address: _____

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

_____ - _____ - _____ EXP Date ____ / ____
Account Number MO YR

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.

ADDITIONAL FEES

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

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