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www.eye-physicians.com

Wills Eye Institute
840 Walnut Street
Philadelphia, PA 19107

1140 White Horse Road
Voorhees, NJ 08043
Phone 856-784-3366
Fax 856-784-4388

Dear New Patient

I want to take this opportunity to welcome you to our practice and offer assistance in making your visit an enjoyable one.

This download includes all of the forms we ask you to complete prior to your arrival. On the day of your appointment, please bring the completed forms along with your insurance identification card and the appropriate referral if necessary.

Please call if I can be of any further assistance.

Sincerely,

A handwritten signature in black ink that reads "Lori Fidanza". The signature is fluid and cursive.

Lori Fidanza
Office Manager



Personal Information:

Date of Birth _____ Social Security # _____

Name _____

Street Address _____

City _____ State _____ Zip _____

Email Address _____

Telephone (Home) _____ Telephone (Work) _____

Cellphone _____ Gender (Male / Female)
Circle

Occupation _____ Employers Name _____

Person to notify in the event of an emergency _____

Relationship of emergency person _____

Telephone of emergency person _____

Insurance Information:

Primary Insurance _____ ID # _____

Secondary Insurance _____ ID # _____

Name of Subscriber (only if different from patient) _____

Subscriber's Birthdate _____ Subscriber's Social Security # _____

Physician Information:

Name of Family Physician _____

Address _____

Phone _____

Name of Specialist Physicians _____



Name _____

Health Questionnaire

OCULAR HISTORY

1. What was the approximate date of your last eye exam? _____

2. Who was the last doctor to examine your eyes? _____

3. Have you ever worn glasses? no yes

4. Have you ever worn contact lenses? no yes (Type) _____

5. Have you ever been told you have an eye disease? no yes

If yes, please list (for example cataract, glaucoma, etc.) _____

6. Have you ever had any eye surgery? no yes

If yes, please list procedure and approximate date _____

7. Is there a history of any of the following eye diseases in your family (parents, siblings or children)?

Glaucoma no yes Cataract no yes Macular Degeneration no yes

Color Blindness no yes Other _____

MEDICAL HISTORY

1. Have you ever had, been told you have, or been treated for :

(please circle any positive answers)

a) rheumatic fever, angina, chest pain or pressure, palpitations, heart murmur, heart attack or any other disorder of the heart, or circulatory system. no yes

b) high blood pressure, anemia, phlebitis, varicose veins or any other disease or disorder of the blood or blood vessels. no yes

c) allergy, asthma, bronchitis, emphysema, pleurisy, tuberculosis or any other disorder of the lungs or bronchial tubes. no yes

d) colitis, hernia, ulcer, cirrhosis; any disease or disorder of the mouth, esophagus, digestive system, intestines, rectum, liver, pancreas, or gall bladder. no yes

(OVER)

- e) blood, sugar, pus or albumin in your urine. no yes
- f) kidney stones, kidney disease, prostate disease, or sexually transmitted diseases (including AIDS or HIV infection) no yes
- g) cancer or other tumors no yes
- h) diabetes or thyroid disease no yes
- I) epilepsy, convulsions, dizziness, fainting, paralysis or any other diseases or disorders of the brain or nervous system no yes
- j) mental illness, anxiety, claustrophobia, depression, or any psychological or emotional condition or disorder. no yes
- k) arthritis, gout or any disease of muscles, joints, bone or skin. no yes

2. Please list current medications and dosages if known _____

3. Have you ever had surgery (other than for your eyes)? no yes
 If yes, please list _____

4. Are you allergic to any medications? no yes
 If yes, please list _____

5. Have you ever smoked tobacco? no yes quit _____ pack per day _____ years

6. Do you drink alcohol? no yes _____ drinks per day

7. Has a parent or sibling had diabetes, hypertension, or a hereditary disease? no yes

8. Please **circle** any of the following symptoms you have **recently** experienced:

flashing lights, floaters in your vision, eye pain, sudden loss of vision, headaches, hearing loss, sore throat, pain while chewing food, chest pain, shortness of breath, cough, leg pain, nausea, vomiting, diarrhea, vomiting blood, constipation, black stool, weight loss, arthritis, joint pain, muscle pain, back pain, rashes, bruises, skin ulcers, blackouts, seizures

9. Are you pregnant? no yes



PATIENT'S NAME: _____

SOCIAL SECURITY # _____

Authorization For Medical Treatment / Insurance Signature on File / Privacy Notice

I hereby authorize the physicians and designated professional and paraprofessional employee of Eye Physicians, P.C. to perform such examinations, and treatments as are necessary to care for the medical condition of the patient, now and in the future.

I certify that no guarantee or assurance has been made as to the outcome of the results that may be obtained, nor is one expected.

Authorization is hereby granted to release to a third party with legitimate interest such information as may be necessary for treatment, payment or health care operations. I authorize use of this form on all my insurance submissions now and in the future unless I explicitly rescind this authorization in writing.

I understand that I am responsible for my bill.

I acknowledge receipt of Eye Physicians, P.C. Notice of Privacy Practices.

This authorization must be signed by the patient or by an authorized person in the case of a minor or when patient is physically or mentally incompetent.

SIGNATURE: _____ DATE: _____
PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE

WITNESS: _____

Medicare Signature of File

“I request that payment of authorized Medicare benefits be made either to me or on my behalf to Eye Physicians, P.C. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.”

SIGNATURE: _____ DATE: _____
PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE

Medigap Signature on File

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Eye Physicians, P.C. for any services furnished to me by that physician/supplier. I authorize any holder of Medicare information about me to release to my Medigap Insurer any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: _____
PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE



**1140 White Horse Road
Voorhees, NJ 08043
Phone: 856-784-3366**

eyePhysiciansSM

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eyeDesignsTM
Optical

Directions:

From Philadelphia (Ben Franklin Bridge): At end of Ben Franklin Bridge stay in right lanes to proceed on I-676 East. I-676 East becomes I-76 after 5.5 miles. Continue on I-76 for 1.2 mi. and exit onto I-295 North toward Trenton. Travel northbound 5.4 mi. on I-295 North and take exit #32 (Haddonfield/ Berlin/ Gibbsboro).

Follow Interstate 295 directions below

From Philadelphia (Walt Whitman Bridge): Proceed over Bridge on I-76 East. Approximately 1.2 miles after Bridge, exit onto I-295 North toward Trenton. Travel northbound 5.4 mi. on I-295 North and take exit #32 (Haddonfield/ Berlin/ Gibbsboro).

Follow Interstate 295 directions below

From NJ Turnpike: Take exit #4 – Rt. 73 Camden / Philadelphia. Stay right after toll and merge onto Rt. 73 North. Travel 0.4 mi on Rt. 73 and exit onto I-295 South. Travel southbound 4.5 mi. on I-295 South and take exit #32 (Haddonfield/ Berlin/ Gibbsboro).

Follow Interstate 295 directions below

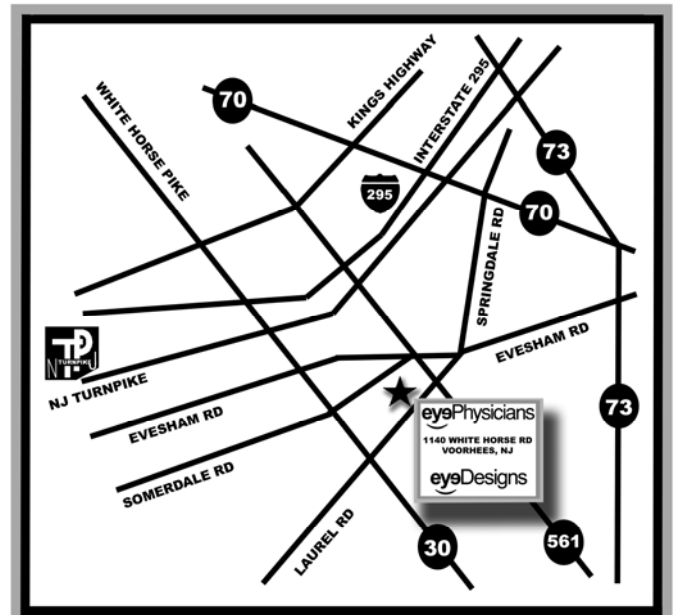
From Interstate 295: Take exit #32 (Haddonfield/ Berlin/ Gibbsboro). At end of exit ramp turn left if exiting from southbound I-295 and right if exiting northbound I-295. Travel approx. 2.2 mi. on Rt. 561 to White Horse Road (6th traffic light after I-295 northbound exit traffic light). Make a right at this traffic light and our office is after next traffic light 0.1 mi. on right.

From Route 73: Turn off Rt. 73 at Evesham Rd heading west (Bradley Funeral Home on corner). Travel 3.0 miles to 8th traffic light and make left turn onto White Horse Rd. Travel 0.6 mi. and our office is on right after 2nd traffic light.

From Route 70: Turn off Rt. 70 at S. Springdale Rd. heading south. Travel 3.7 miles and our office is on right after 8th traffic light (note: Springdale Rd becomes White Horse Rd. at 6th traffic light).

From Atlantic City Expressway: Take AC Expressway toward Philadelphia until end when it becomes Rt. 42 (stay in right lane). Take first exit on Rt. 42 – Exit #7 – Sicklerville/Rt. 168. At exit ramp traffic light turn left. Take next left onto Orr Rd. Travel 1 mi. to end of Orr Rd. and make a right onto College Drive. College Drive becomes Laurel Road and then White Horse Road at White Horse Pike (Rt. 30). After crossing White Horse Pike, our office is 1.8 mi. on the left after 5th traffic light.

From White Horse Pike (Rt. 30): Traveling from Berlin area make right on White Horse Rd. If traveling from Collingswood/Lawnside area take jug handle at Laurel Rd/White Horse Rd and cross over Rt. 30 to proceed onto White Horse Rd. Travel 1.8 miles and our office is on left after 5th traffic light.



EYE PHYSICIANS, P.C.

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

Pursuant to the Privacy Rules established by the Health Insurance Portability and Accountability Act of 1996, we are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short. It includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in our main reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time and can view a copy of this notice on our Web site at www.eye-physicians.com.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. The Privacy Rules require that we get your specific authorization for some of these uses or disclosures. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

According to the Privacy Rules, we may use and disclose your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. For example we may disclose your

demographic information to anesthesia care providers for payment of their services.

3. **For health care operations.** We may disclose your PHI, as necessary, to operate this facility and provide quality care. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. **For health oversight activities.** For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. **To coroners, funeral directors, and for organ donation.** We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders

or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. Uses and Disclosures Where You to Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed

your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Office Manager, Eye Physicians, 1140 White Horse Road, Suite 1, Voorhees, NJ 08043 Phone: 856-784-3366.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice is effective April 14, 2003