

FARAH S. IKRAM, MD

Pediatric Ophthalmology and Adult Strabismus

PH 502.425.3148

FAX 502.425.3149

9700 Park Plaza Ave., Ste. 205
Louisville, KY 40241Diplomate American Board of Ophthalmology
Fellow American Academy of Ophthalmology

Welcome to Children's Eye Specialists. We are very pleased that you have selected our practice for your eye care needs.

We have enclosed new patient registration forms and directions to our office. To expedite the check in process please bring the completed forms at the time of your scheduled appointment. We will also need your insurance and vision plan information, and a referral from your primary care physician (if applicable). Please verify your eligibility for routine and medical eye examinations prior to your appointment date. Co-payment and deductible are due at the time of service. We accept cash, check, Visa and MasterCard. There is a \$20.00 fee for returned checks.

It is our priority to make your wait time as short as possible. Our practice involves examining children that requires time and patience. Please allow at least ninety minutes for your first visit.

Your appointment time slot will be reserved for you. Please notify us at least 24 hours in advance if you are unable to keep your appointment. There will be a charge of \$30.00 for no show and missed appointments. We appreciate your consideration.

Feel free to call us for any questions or special needs. We look forward to your visit.

Farah S. Ikram, MD and Staff

PATIENT REGISTRATION

PATIENT'S NAME _____ SEX MALE FEMALE

DOB: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE # _____

GUARANTOR INFORMATION (if responsible party is not the patient)

MOTHER'S NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE # _____

PLACE OF EMPLOYMENT: _____ PHONE # _____

*Is it ok to call you at work? YES or NO

FATHER'S NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE # _____

PLACE OF EMPLOYMENT: _____ PHONE # _____

*Is it ok to call you at work? YES or NO

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE # _____

ADDRESS: _____

CITY/STATE/ZIP: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

DOB OF POLICY HOLDER: _____ POLICY HOLDER'S SS # _____

POLICY # _____ GROUP # _____

PLACE OF EMPLOYMENT: _____

SECONDARY/VISION PLAN INSURANCE: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

DOB OF POLICY HOLDER: _____ POLICY HOLDER'S SS # _____

POLICY # _____ GROUP # _____

PLACE OF EMPLOYMENT: _____

Please provide your insurance card to obtain a copy for your records. Insurance co-pay/deductible and referral (if applicable) are due at the time of service. By signing below you agree to these terms and authorize Children's Eye Specialists to bill your insurance.

PATIENT/PARENT/GUARDIAN SIGNATURE

DATE

FINANCIAL POLICY
Children's Eye Specialists, PLLC

Thank you for choosing Children's Eye Specialists PLLC as your health care provider. It is our goal to provide you the highest quality of care and service. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

We will make every effort to work with you and your insurance company to maximize your health care benefits. We accept assignment of benefits from many insurance plans however; it is the patient's responsibility to verify that we accept payment from your insurance plan. Please bring your insurance identification card to each appointment. Our patient registration will verify the coverage on file each visit.

CO-PAYS: All co-pays are due at the time of registration. If you are unable to pay at the time of service then your appointment will need to be rescheduled.

DEDUCTIBLES/CO-INSURANCE: Your insurance benefit information is verified prior to your visit. Any deductible or co-insurance amounts will be collected at the time of service. As a patient, you are expected to pay any patient due balances at each appointment. If you are unable to pay the balance in full, you will be required to set up a payment plan.

NON-COVERED SERVICES: Charges considered non-covered or not medically necessary by your insurance will be your responsibility and payable at the time of service.

INSURANCE CLAIMS: Patients will become responsible for any charges if the insurance information given to our office at the time of service does not result in payment within 45 days. It is your responsibility to immediately inform us of any changes in your insurance coverage or carrier.

COLLECTIONS: If your account becomes delinquent with our office, our billing department will make several attempts to secure the balance in full or set up a payment arrangement. If the attempt to secure the balance or the payment arrangement fails, we will forward your account to an outside collection agency. If this should occur an additional collection fee will be added to the outstanding balance and a termination of care letter will be sent by certified mail.

APPOINTMENTS: Our office will call approximately two business days prior to your appointment date to remind you of the appointment. It is the patient's responsibility to remember the appointment and to supply this office with a 24 hour notice if you must cancel. We have a 24 hour cancellation access: 502-425-3148. Our office will extend a \$30.00 service charge for all missed appointments. Minor patients must be accompanied by a parent or legal guardian each visit. The parent/legal guardian accompanying the minor to the first visit will be assigned as guarantor on the account, accepting full responsibility for patient co-pays, deductibles or coinsurance on the minor's account.

MEDICAL RECORDS: Our office will provide you with one free copy of your medical records according to Kentucky law. You will be required to sign a release and pick up the copy at our office. Additional copies are charged at \$1.00 per page with a postage and handling fee if required. Also, the completion of any form such as disability, FMLA or other forms will be subject to a fee paid at the time the form is completed.

RETURNED CHECKS: There will be a \$20.00 charge for any check returned to our office for insufficient funds. Cash, MasterCard, Visa or money order must then pay the balance.

I, the undersigned, hereby agree that I have read and understand all of the Financial Policy stated above. If I have any questions or concerns, I will contact the billing department. Otherwise, I agree to be financially responsible for the full treatment I will receive by Children's Eye Specialists PLLC.

DATE: _____

Signature of patient or responsible party

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:

I hereby authorize insurance payment directly to Dr. Farah S. Ikram/Children's Eye Specialists for medical/surgical services rendered. I hereby authorize Children's Eye Specialists to release any information acquired during the course of my examination or treatment to my physician(s) and/or my insurance company.

DATE: _____

Parent/Guardian of patient under 18 years old

HEALTH HISTORY

DATE: _____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

AGE: _____ BIRTH WEIGHT: _____ Was the Patient: PREMATURE FULL TERM

IF PREMATURE: GESTATIONAL AGE AT BIRTH _____ DUE DATE _____

OCULAR HISTORY

Retinopathy of Prematurity	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cataracts	<input type="checkbox"/> YES <input type="checkbox"/> NO
Amblyopia (Lazy Eye)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO
Misaligned Eye	<input type="checkbox"/> YES <input type="checkbox"/> NO	Previous Eye Surgery/Laser	<input type="checkbox"/> YES <input type="checkbox"/> NO
Eye Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glasses	<input type="checkbox"/> YES <input type="checkbox"/> NO
Droopy Lids	<input type="checkbox"/> YES <input type="checkbox"/> NO	Patching	<input type="checkbox"/> YES <input type="checkbox"/> NO

If previous Eye Surgery/Laser Treatment, Where & When performed: _____

SYMPTOMS RELATED TO EYES

Decreased Vision Up Close	<input type="checkbox"/> YES <input type="checkbox"/> NO	Loss of Side Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO
Decreased Vision at Distance	<input type="checkbox"/> YES <input type="checkbox"/> NO	Eye Pain/Soreness/Burning	<input type="checkbox"/> YES <input type="checkbox"/> NO
Distorted Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO
Double Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO	Redness/Watery/Itchy	<input type="checkbox"/> YES <input type="checkbox"/> NO

Other Symptoms/Reason for Visit: _____

MEDICAL HISTORY & REVIEW OF SYSTEMS

Have you ever had or still have:

Ear/Nose/Throat Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV/AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ear Infection	<input type="checkbox"/> YES <input type="checkbox"/> NO	Developmental Delay	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Learning Disability	<input type="checkbox"/> YES <input type="checkbox"/> NO
Seasonal Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cerebral Palsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	JRA	<input type="checkbox"/> YES <input type="checkbox"/> NO
Lung Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	ADD	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shunt/Hydrocephalus	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Child Abuse	<input type="checkbox"/> YES <input type="checkbox"/> NO
Skin Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Brain Tumor	<input type="checkbox"/> YES <input type="checkbox"/> NO
Muscular/Joint	<input type="checkbox"/> YES <input type="checkbox"/> NO	Prematurity	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stomach/Intestine/Liver	<input type="checkbox"/> YES <input type="checkbox"/> NO	ROP	<input type="checkbox"/> YES <input type="checkbox"/> NO
Endocrine	<input type="checkbox"/> YES <input type="checkbox"/> NO	Birth Complications	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes Mellitus	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any Syndromes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Seizure Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Significant Injuries: _____	
Neurological Condition	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any Other Problems: _____	

FAMILY HISTORY

Do any blood relatives of the patient have the following condition:

Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blindness or Impaired Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO
HTN	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cataract	<input type="checkbox"/> YES <input type="checkbox"/> NO
Lazy Eye	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glasses	<input type="checkbox"/> YES <input type="checkbox"/> NO
Misaligned Eyes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Retinal Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer of the Eye	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any other Eye Disorder: _____	
		Any Hereditary Condition: _____	

ALLERGIES:

PCN _____
Sulfa _____
Other _____

MEDICATIONS:

Systemic _____

Eye Drops/Ointment _____

SOCIAL/PERSONAL

For Adult Patients:

OCCUPATION: _____ EDUCATION LEVEL: _____

DO YOU SMOKE: YES NO

HAD OR HAVE AN ALCOHOL PROBLEM: YES NO

USE RECREATIONAL DRUGS: YES NO

For Pediatric Patients:

Who does the child live with (Parent/Other)? Please specify: _____

Name of Child's School: _____

Family Physician or Pediatrician: _____

Address: _____ Phone: _____

Who referred you to our office? _____

Address: _____ Phone: _____

Has the patient had any of the following testing done:

CT Scan/MRI	_____	Visual Field	_____	X-Rays	_____
Lab Work	_____	EEG	_____	VER	_____
ERG	_____	Flourescein Angiogram	_____		

Date of Testing (month/year): _____

Please list anyone you would like the Patient's records sent to:

1. NAME: _____

ADDRESS: _____

2. NAME: _____

ADDRESS: _____

I testify that the above information is correct to the best of my knowledge. I authorize Dr. Ikram to perform Eye Exam and necessary treatment related to this visit.

Signature

Date

FOR DOCTOR USE: