CHILDREN'S EYE SPECIALISTS, PLLC
FARAH S. IKRAM, MD
Pediatric Ophthalmology and Adult Strabismus
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9700 Park Plaza Ave., Ste. 205
Louisville, KY 40241

Diplomate 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.

We would like to advise you that our office is located on the second floor and the building does not have an elevator.

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

Children's Eye Specialists, PLLC
Farah S. Ikram, M.D.
9700 Park Plaza Avenue, Suite 205
Louisville, KY 40241
Phone (502) 425-3148 Fax (502) 425-3149

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Children's Eye Specialists may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operation. Please refer to Children's Eye Specialists Notice of Privacy Practices for a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Children's Eye Specialists reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the above address.

With my consent, Children's Eye Specialists may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out medical care and billing, such as appointment reminders, test results, insurance information, etc.

With my consent, Children's Eye Specialists may discuss the details of my medical care and test results with the following (Please check authorized box(es):

□ Parent(s) □ Step-Parent(s) □ Grandparent(s) □ Spouse □ Other (please list) _____

With my consent, Children's Eye Specialists may inform me of the details of my test results via the following methods in addition to personally discussing the results with me:

□ Home Answering Machine □ Voice Mail (list phone number/ext.) _____

□ Email (address) _____ □ Other (please list) _____

With my consent, Children's Eye Specialists may mail to my home, or other designated location any items that assist the practice in carrying out medical care and payment, such as appointment reminder cards, billing statements and test results.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Children's Eye Specialists, may decline to provide treatment to me.

_____ DATE: _____
Patient's Name

_____
Signature of Patient/Legal Guardian

Email Disclosure

I give consent to Children's Eye Specialists to email to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operation and the disclosure of Protected Health Information, such as appointment reminder, patient statement, insurance items and any information pertaining to my clinical care including test results among others. I have the right to a written request that Children's Eye Specialists restrict how it uses or discloses my PHI to carry out treatment, payment and healthcare operation. The practice will inform me in writing if my request will be granted. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ DATE: _____
Signature of Patient/Legal Guardian

Employee Initials _____

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	☐ YES ☐ NO	Cataracts	☐ YES ☐ NO
Amblyopia (Lazy Eye)	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO
Misaligned Eye	☐ YES ☐ NO	Previous Eye Surgery/Laser	☐ YES ☐ NO
Eye Injury	☐ YES ☐ NO	Glasses	☐ YES ☐ NO
Droopy Lids	☐ YES ☐ NO	Patching	☐ YES ☐ NO

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

SYMPTOMS RELATED TO EYES

Decreased Vision Up Close	☐ YES ☐ NO	Loss of Side Vision	☐ YES ☐ NO
Decreased Vision at Distance	☐ YES ☐ NO	Eye Pain/Soreness/Burning	☐ YES ☐ NO
Distorted Vision	☐ YES ☐ NO	Headaches	☐ YES ☐ NO
Double Vision	☐ YES ☐ NO	Redness/Watery/Itchy	☐ YES ☐ NO

Other Symptoms/Reason for Visit: _____

_____

MEDICAL HISTORY & REVIEW OF SYSTEMS

Have you ever had or still have:

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

FAMILY HISTORY

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

Heart Disease	☐ YES ☐ NO	Blindness or Impaired Vision	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO
HTN	☐ YES ☐ NO	Cataract	☐ YES ☐ NO
Lazy Eye	☐ YES ☐ NO	Glasses	☐ YES ☐ NO
Misaligned Eyes	☐ YES ☐ NO	Retinal Disorder	☐ YES ☐ NO
Cancer of the Eye	☐ YES ☐ 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: