**Scott Forman, MD**
**Neuro-Ophthalmology**
**Somers Eye Center**
**380 Route 202**
**Somers, NY 10589**

**Phone: 914-277-5550**
**Fax: 914-277-5735**
**www.somerseye.com**

Dear Patient:

Thank you for making an appointment with Dr. Forman. Your Neuro-Ophthalmology appointment will involve a comprehensive examination. Since a comprehensive examination requires a lengthy visit, please anticipate being in the office for at least **2 HOURS.**

If you have seen another physician or optometrist prior to your appointment, please bring any pertinent material with you. This may include: recent blood work of the last 12 months, ultrasound studies, visual fields testing, and the results of any Neuro-Imaging such as CT scan or MRI of the head within the last 2 years. Also, bring the actual CD of CT/MRI scan so that we may review them. Also, bring a photograph of yourself that clearly shows your face including eyelids and pupils that was taken prior to the onset of your current medical condition if there is visible change.

**Please bring your eyeglasses with you.** If you wear contact lenses, **please be prepared to remove them and put them in your own personal contact lens storage case.** During your exam it will be necessary to **dilate your pupils. It is helpful to wear sunglasses to drive home**. If you think you may have difficulty driving home, make arrangements to have a friend or relative accompany you.

Please bring all appropriate insurance information, including your insurance card, co-payment, and referral if required. You cannot be seen unless you have the proper paperwork. If we do not take your insurance or you do not have insurance, payment is required on the day of your examination. Please complete the attached form in its entirety prior to coming to the office and be sure to bring it with you.

## CHECK LIST

- **Prior records from Neurologist, Ophthalmologist, or eye care professionals**
- **Result of blood work of the past 12 months**
- **CT and MRI results and actual CD**
- **Prior photograph to onset of current medical condition**
- **Eyeglasses/contact lens material**
- **Sunglasses**
- **Insurance cards, referral, and co-payment**
- **Complete patient information and health history form**
- **Eyeglasses prescription and prism prescription**

Thank You,
Dr. Scott Forman and Staff

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# *Patient Information*

Name:_____ Sex:_____

Address:_____ Marital Status:_____

City_____ State_____ Zip_____ Date of Birth:_____

Home Phone#_____ Social Security #:_____

Work/Mobile#_____ Responsible Party:_____

Email:_____ Relationship:_____

Language:_____ Race:_____ Ethnicity:_____

## *Referring Physician*

Name:_____ Phone#_____ Fax#_____

Address:_____ City_____ State_____ Zip_____

## *Insurance Information*

Company:_____ Company:_____

Address:_____ Address:_____

_____ _____

Phone:_____ Phone:_____

ID #_____ ID #_____

Group #_____ Group #_____

Insured Party:_____ Insured Party:_____

Insured DOB:_____ Insured DOB:_____

Relationship to Insured:_____ Relationship to Insured:_____

Insured Social Security #_____ Insured Social Security #_____

I request the payment of authorized Medicare, government and/or commercial insurance benefits be made on behalf to Scott Forman, MD for services rendered to me by the provider. I authorize the release of any medical or other information necessary to process the insurance claim. ***In the event that my insurance does not cover the billed services, I understand that I am personally responsible for payment.***

Signature:_____ Date:_____

### *Reason for Neuro-Ophthalmic Consult*

Please explain in your own words, the nature of the difficulty that you are experiencing. Please be as specific as you can. For example, *I lost the vision of my right eye four days ago* –or- *I have double vision that is worse at the end of the day,* etc.

_____
_____
_____
_____

## Review of Systems

Please, indicate if you currently have or have had any of the listed conditions. Please indicate when the condition began where appropriated. Space has been provided for an additional description if needed.

| **EYES** | **YES** | NO |
|---|---|---|
| Previous Surgery | ☐ | ☐ |
| Contact lens | ☐ | ☐ |
| Pain | ☐ | ☐ |
| Double Vision | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Cataracts | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Dry Eye | ☐ | ☐ |
| Flashes | ☐ | ☐ |
| Floaters | ☐ | ☐ |
| Loss of Vision | ☐ | ☐ |
| **EAR, NOSE, AND THROAT** | | |
| Hard of Hearing | ☐ | ☐ |
| Ringing in Ears | ☐ | ☐ |
| Vertigo | ☐ | ☐ |
| Frequent Sore Throat | ☐ | ☐ |
| Sinus Allergies | ☐ | ☐ |
| **CARDIOVASCULAR** | | |
| Chest Pain | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Fainting Spells | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| Irregular Heart Beat | ☐ | ☐ |
| Difficulty Lying Flat | ☐ | ☐ |
| Heart Attack/Failure | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| **CONSTITUTIONAL** | | |
| Fatigue/Weakness | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Weight Gain/Loss | ☐ | ☐ |
| Night Sweats | ☐ | ☐ |
| Cancer | ☐ | ☐ |

| **RESPIRATORY** | **YES** | NO |
|---|---|---|
| Cough | ☐ | ☐ |
| Congestion | ☐ | ☐ |
| Wheezing | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Coughing up Blood | ☐ | ☐ |
| Emphysema/Pneumonia | ☐ | ☐ |
| **Gastrointestinal** | | |
| Heartburn | ☐ | ☐ |
| Nausea/Vomiting/Hepatitis | ☐ | ☐ |
| Dry Mouth/Difficulty Swallowing | ☐ | ☐ |
| Diarrhea/Constipation/Rectal Bleeding | ☐ | ☐ |
| **GENITO-URINARY** | | |
| Pain/Difficulty | ☐ | ☐ |
| Blood in Urine | ☐ | ☐ |
| History of Kidney Stones | ☐ | ☐ |
| History of STD's | ☐ | ☐ |
| **PSYCHIATRIC** | | |
| Anxiety/Depression | ☐ | ☐ |
| Mood Swings | ☐ | ☐ |
| Difficulty Sleeping | ☐ | ☐ |
| Suicidal Thoughts | ☐ | ☐ |
| Mental Illness | ☐ | ☐ |
| **ENDOCRINE** | | |
| Increased Thirst | ☐ | ☐ |
| Increased Hunger | ☐ | ☐ |
| Increased Urination | ☐ | ☐ |
| Increased Sweating | ☐ | ☐ |
| Fingernail Changes | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ |
| Hormones Problems | ☐ | ☐ |

| **BLOOD/LYMPHNODES** | **YES** | **NO** |
|---|---|---|
| Easy Bruising | ☐ | ☐ |
| Gum Bleed Easily | ☐ | ☐ |
| Prolonged Bleeding | ☐ | ☐ |
| Heavy Aspirin Use | ☐ | ☐ |
| Anemia/Leukemia/Sickel-Cell Disease | ☐ | ☐ |
| Blood Disorder/Swollen Glands | ☐ | ☐ |
| **MUSCOLOSKELETAL** | | |
| Stiffness | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Joint Pain/Swelling | ☐ | ☐ |
| Jaw Pain with Chewing | ☐ | ☐ |
| Herniated Discs/Broken Bones | ☐ | ☐ |
| **SKIN** | | |
| Rash/Sores | ☐ | ☐ |
| Lesions | ☐ | ☐ |
| Hives/Eczema | ☐ | ☐ |
| Skin Cancer | ☐ | ☐ |
| Scalp Tenderness/ Psoriasis | ☐ | ☐ |
| **NEUROLOGICAL** | | |
| Seizures | ☐ | ☐ |
| Weakness/Paralysis | ☐ | ☐ |
| Numbness | ☐ | ☐ |
| Tremors | ☐ | ☐ |
| Brain Tumor/Hemorrhage | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| **IMMUNOLOGIC** | | |
| Hives | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Runny Nose | ☐ | ☐ |
| Sinus Pressure | ☐ | ☐ |

Please mention any other conditions you might have not on the list:

_____

_____

_____

_____

## Previous Medical History

Please, list all previous surgeries (including eye surgery):

Type of Surgery Hospital Month/Year

1._____
2._____
3._____

Please, list all previous hospitalizations and reason for hospitalization:

Reason for Hospitalization Hospital Month/Year

1._____
2._____
3._____
4._____

## Social History

Occcupation_____ Marital Status_____
Highest Level of Education_____ Children_____
Do you have a driver's license?_____ Who lives with you?_____
Do you use tobacco products? If so, how much and for how long? _____
Have you ever used or are currently using any drugs not prescribed by a physician, including any type of "street drugs"?
_____
Have you ever been under the care of a mental health professional? _____

## Family History

Does anyone in your family have any of the following conditions:

| | NO | YES | Family Member | Age |
|---|---|---|---|---|
| Diabetes | ☐ | ☐ | | |
| High-Blood Pressure | ☐ | ☐ | | |
| Heart Disease | ☐ | ☐ | | |
| Cancer | ☐ | ☐ | | |
| Glaucoma | ☐ | ☐ | | |
| Migraines | ☐ | ☐ | | |
| Blindness | ☐ | ☐ | | |
| Mental Illness | ☐ | ☐ | | |
| Other | ☐ | ☐ | | |

Please list any other diseases in your family:
_____
_____

## Medications

Please, list all of the medications that you are currently using:
_____
_____
_____
_____

| Do you have allergies | NO | YES | What happens? |
|---|---|---|---|
| Medications | ☐ | ☐ | |
| Dyes/Contrast Agents | ☐ | ☐ | |
| Seasonal | ☐ | ☐ | |
| Other | ☐ | ☐ | |

Is there any additional information which you feel would be important for the doctor to know? Please provide that information._____
Thank you for taking the time to provide the above information. The doctor will discuss these and other health concern with you during your examination.

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## REFRACTION

Is the precision measurement and trial for new corrective lenses. It is part of an eye examination necessary to write a prescription for new glasses. Dr. Forman offers refraction service as a courtesy to his neuro-ophthalmic patients. Most medical insurance plans, including Medicare, do NOT cover routine refractions. Medicare and most medical insurances separate that portion of the examination, since it is routine eye care and not a covered service. Our fee for a precision refraction and prescription for glasses is $75.00. This fee is collected at the time of service, in addition to any copayment your insurance plan may require. If you want new lenses or frames, you need a refraction and a new prescription. You have the option of purchasing the refraction service elsewhere. You may have a Vision plan which would cover this service elsewhere. If you have questions regarding Medicare and insurance policy procedures, please contact your carrier to discuss.

**I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the $75 cost of the refraction service and understand it is due at the time of service. I understand that my copayment, co-insurance, and or deductibles I may have are separate from, and not included in the refraction fee.**

Patient signature Date

## NOTICE OF PRIVACY PRACTICE FOR THE OFFICE OF

## SCOTT FORMAN, MD

**I HAVE RECEIVED A COPY OF DR. SCOTT FORMAN'S HIPPA OMNIBUS RULE POLICY.**

**IT IS UNDERSTOOD THAT I WILL READ THIS NOTICE AT MY CONVENIENCE OR IF I HAVE ANY SPECIAL REQUEST I WILL WRITE THEM.**

**PRINTED**

**NAME:** _____

**SIGNATURE:** _____

**DATE:** _____

**Scott Forman, MD**
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# SCOTT FORMAN, MD - HIPAA OMNIBUS RULE POLICY
# EFFECTIVE SEPTEMBER 2013

**This Notice describes the privacy practice of SCOTT FORMAN, MD in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Final Rule. It applies to all services carried out by the physician of this facility. Please review it carefully*.**

**Privacy Obligations -** By law, we must maintain the privacy of your Protected Health Information (PHI). In the event that we use or disclose your PHI, our practice must operate under the terms of this Notice. Additionally, in the event that we share your PHI with a third party, we will disclose only the minimum amount necessary. We reserve the right to change the terms of our notice, at any time.

**Your Rights Under The Privacy Rule -** Following is a statement of your rights under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff. You have the right to receive, and we are required to provide you with a copy of the Notice of Privacy Practices - We are required to follow the terms of the notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

**You have the right to authorize other use and disclosure -** This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication –** This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if by other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI -** This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information -** This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability -** This means that you may request a listing of disclosures that we have made of your PHI to entities or persons outside of our office.

**You have the right to receive a privacy breach notice -** You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact Dr. Forman staff at 914-277-5550.

**How We May Use or Disclose Protected Health Information -** The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the possible types of uses and disclosures.

**Treatment -** We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices -** We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices and each such notice will include instructions for opting out.

**Payment -** Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits. If you pay out of pocket, you can elect that we do not share your PHI with a third party.

**Research –** We may combine conditioned and unconditioned authorizations for research participation as long as you can opt-in to the unconditioned authorizations activities. The authorizations extend to future research.

**Marketing –** We need written consent to provide marketing entities with your information.

**Healthcare Operations -** We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization –** Our office may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare -** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures -** We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

**Privacy Complaints -** You have the right to complain to us or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may also file a complaint with us. Complaints should be directed to Scott Forman, MD, Somers Eye Center, 380 Route 202, Somers, NY 10589

We will not retaliate against you for filing a complaint.