www.theprecisioneye.com

Welcome to Precision Eye Institute!

At PEI, we are committed to providing you with exceptional eye care using the latest advancements in ophthalmology. Our dedicated team of doctors, managers, and staff work together to ensure you receive the best possible experience and outcomes. Your vision and well-being are our top priorities, and we are honored to be a part of your eye health journey.

We look forward to serving you!

Dr. Krajnyk & the Precision Eye Institute Team

_____ _____

Patient's Name (print) Date

How did you hear about us?

(Please check or write the name of the referral)

- Google
- Bing
- Yahoo
- Walk-In / Drove by
- Yellow Pages
- Church Bulletin
- Yelp
- Facebook
- Hometown News
- Insurance Company
- Other: _____

Doctor Referral:_____

Personal / Patient Referral:_____

PRECISION EYE INSTITUTE

PATIENT PRIVACY NOTICE AND CONSENT

Our notice of privacy practices describes how we may use and disclose protected health information about you (HIPAA). It also contains a patient rights section that describes your rights under the law. You have the right to review our notice before signing the consent form. If the terms of our notice change, you will be provided with a revised copy, or you may request an updated copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in relationship to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient or representative/guardian understands that:

- Protected health information may be disclosed or used for treatment, payment, or health operations.
- The practice has a notice of privacy, and I have received this notice.
- The practice reserves the right to change the notice of privacy policies.
- I have the right to restrict the use of their information, but the practice does not have to agree with those restrictions.
- I may revoke this consent in writing at any time, and all future disclosures will then cease.
- The practice may provide or perform necessary and agreed-upon condition treatment upon the execution of this consent.

I have read and understand the above policies.

_____ _____

Patient's Signature Date

_____ _____

Name (print) Date

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Patient Demographics

Did a doctor refer you? [ ] YES [ ] NO If yes, name of doctor:_____

Last Name:_____ **First Name**:_____ **MI**:_____

DOB:_____ **Sex**: [ ] M [ ] F
SSN: (for insurance purposes only) _____
Marital Status [ ] Single [ ] Married [ ] Widowed [ ] Divorce
Race: [ ] Caucasian [ ] African American [ ] Hispanic/Latino [ ] Asian [ ] Other _____

Local Address:_____

City:_____ **State**:_____ **Zip Code**: _____

Home Phone:_____ **Mobile Phone**:_____
Can PEI leave messages that contain medical info at this number?[] Yes [] No
Can PEI send text messages regarding upcoming appointments? [] Yes [] No
Email:_____
Can PEI contact you via email? [] Yes [] No

****Worker's Comp Patients Only****

Employee Name:_____

Employer Address:_____

Responsible Party (for minors or authorized signer for non-signing adults)
Relationship to patient:_____ Name Last,First:_____
Address (if different from patient's):_____
_____
Phone number (if different from patient's):_____

Person to Contact in Case of Emergency:
Last Name:_____ First Name:_____
Phone Number:_____ Relationship to patient:_____
The above information is true and correct to the best of my knowledge.

_____ _____ _____
Patient's Signature Name (print) Date

PRECISION EYE INSTITUTE

Precision Eye Institute Refraction Policy/Fee

A Refraction is a diagnostic test performed by the technician and/or physician. It provides essential information about the function of your eyes and may alert us to any medical problems related to decreased visual acuity. We also perform this test with you looking at an eye chart through multiple sets of lenses. This allows us to find the prescription that will enable you to see optimally and sometimes indicates a need for glasses, contacts, or voluntary surgical revisions.
Medicare and most other major insurance companies consider Refraction a non-covered service, and insurance benefits do NOT cover it. Therefore, the refraction fee is 100% the patient's financial responsibility. Payment will be collected for this test on the date of service or after insurance has been processed.
***Please initial below to indicate that you understand and agree to the Refraction Policy and are responsible for the $50 charge.*_____**

Consent for Dilating Eye Drops

To thoroughly examine your eyes and diagnose certain eye diseases, such as glaucoma and macular degeneration, it is usually necessary to administer dilating drops. Dilating drops enlarge the pupil of the eye to allow for the examination of the inside of your eye. Without pupil dilation, the doctor gets only a limited view of the eye. These drops usually cause blurred vision and make reading/focusing on near objects difficult or impossible until pupils return to their normal size. The length of time your vision will be blurred and the degree of the eyesight impairment varies from person to person. It is not possible to predict how much or how long your vision will be affected. We strongly advise wearing sunglasses to reduce your increased sensitivity to light while driving. If you do not feel comfortable driving after dilation, we recommend having someone accompany you.

***Please indicate your understanding of the consent form for the dilation of your visit.* _____**

I have read and understand the above statements.

_____ _____ _____

Patient's Signature | Name (print) | Date:

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FINANCIAL POLICY

Medical Insurance: Primary:_____ Secondary:_____

Vision Insurance Plan: _____

Name of Insured Person:_____ **DOB**: _____

Relationship to patient: [] self [] spouse [] parent/legal guardian PHONE:_____

At Precision Eye Institute, we are committed to providing exceptional care and want to ensure the billing process is as smooth and transparent as possible. For your convenience, monthly statements will be sent to the address you have provided if there is an outstanding balance on your account. To help keep your account current, we kindly ask that all self-pay charges, insurance co-payments, co-insurance, and deductibles be settled at the time of your visit when applicable.
We offer multiple payment options: cash, check, CareCredit, Visa, Mastercard, American Express, and Discover. Please note that a returned check will result in a $30 service fee, and any future payments must be made using cash or a credit/debit card.

Please inform us of any updates to your insurance, address, or phone number to ensure uninterrupted care.

As a courtesy, we will submit your claims to your insurance provider; however, please keep in mind that our relationship is with you, not your insurance company. It is your responsibility to notify us of any changes to your insurance policy before your appointment, including any vision plan you may have that is separate from your health insurance. While we may be an in-network specialty provider, not all services are fully covered, and you may be responsible for charges applied to deductibles or co-insurance. Because every insurance plan is unique, it is important that you understand what services are covered under your specific plan, as we cannot verify individual policy details. Any non-covered services or charges not payable by your insurance will be your responsibility. Please note that we only file claims to two insurance companies and do not process third-party insurance claims or reimbursement forms.
By signing below, you authorize the release of any necessary medical information to your insurance provider(s) for benefit determination and request that payment for services be made directly to Orest M. Krajnyk, MD PA / Precision Eye Institute. You also acknowledge that any charges not covered by your participating insurance, even after verification, will be your responsibility.
We appreciate your trust in us for your eye care needs, and we are always here to answer any questions or provide assistance!

I have read and understand the above policies.

_____	_____	_____
Patient's Signature	**Name (print)**	**Date**

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Patient History

Please check ANY/ALL that apply to the patient.

Ocular History:

[ ] Cataracts
[ ] Contacts/glasses
[ ] Corneal disorder
[ ] Dry eyes
[ ] Flashes/floaters
[ ] Glaucoma
[ ] Macular Degeneration
[ ] Narrow Angles
[ ] Ocular Migraines
[ ] Retinal tear
[ ] Retinal detachment
[ ] Other Ocular Symptoms

_____

_____

Ocular Surgeries:

[ ] Cataract Surgery
[ ] Corneal Transplant
[ ] LASIK or RK/PRK
[ ] Lid Surgery
[ ] Punctal Plugs
[ ] Retinal Laser
[ ] YAG Capsulotomy
[ ] Glaucoma laser/surgery
[ ] Other:_____

_____

_____

Medical History:

[ ] Anxiety
[ ] Asthma
[ ] Chronic migraine
[ ] Diabetes:
Type: _____
[ ] Heart Disease
[ ] High Cholesterol
[ ] High Blood Pressure
[ ] Stroke
[ ] Thyroid disease:
Hyper OR Hypo
[ ] Arthritis
[ ] Autoimmune disease
[ ] Cancer
[ ] COPD
[ ] Heart Attack
[ ] Hepatitis
Type: _____
[ ] HIV/AIDS
[ ] Staph or MRSA

Surgical History:

Please list any surgeries you've had in the past

_____

_____

_____

_____

_____

_____

Family History:

[ ] Glaucoma [ ] Macular Deg. [ ] Diabetes [ ] Autoimmune disease
[ ]Other:_____

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Pharmacy Name & Location:_____

Primary Care Doctor Name:_____

Medications: Please list all CURRENT RX or OTC medications, including eye drops, or provide a list we can copy.

Name of Medication	Dosage/frequency	Name of Medication	Dosage/frequency
1		6	
2		7	
3		8	
4		9	
5		10	

Allergies: Please list all allergies to medications and latex, etc.	

Social History: Please check any that apply to the patient

Smoker (cigarettes/cigars/chewing tobacco)?

[ ] Current [ ] Former [ ] Never

If current/former, how many years? _____

Drive? [ ] Day [ ] Night [ ] Never

Drink alcohol?

[ ] Occasionally

[ ] Daily

[ ] Never

The above information is true and correct to the best of my knowledge.

_____ _____ _____

Patient's Signature **Name (print)** **Date**