LOW VISION CENTER
of CENTRAL NEW JERSEY

Hello,

Welcome and thank you for making an appointment at the Low Vision Center of Central New Jersey. We recognize that many of our patients have not had a low vision evaluation before. Following is more information about what will occur during your evaluation.

Your low vision evaluation will last 45 to 60 minutes. During this time, the doctor will evaluate your vision using specialized eye charts and techniques for patients with low vision. The doctor will prescribe one or more low vision devices based on your level of vision, your specific goals, and the level of magnification you require. You will have the opportunity to use these devices in the office to determine if they may be of use to you.

It is important for the doctor to know your medical history, eye history, and specific goals for your low vision evaluation. To ensure that the time you spend at the Low Vision Center is used most effectively, we have included a questionnaire in this packet. **This should be filled out before your appointment**. Please obtain help from family or neighbors if you are unable to fill out the forms on your own.

Pricing for our services:

1. The low vision evaluation is $350. A non-refundable deposit of $175, taken at the time of scheduling, will be applied to the visit cost. The remaining $175 will be collected on the day of the visit. **The cost for services will be the patient's responsibility and cannot be submitted to any insurance carriers.**

2. Devices and glasses have a wide range of cost, depending on quality and level of technology. They start at $75 and can go up to $5000. The cost of devices and eyewear will be the responsibility of the patient.

Please bring the following to your appointment:

1. Completed Low Vision Questionnaire (included in this packet)
2. Any glasses, magnifying glasses, or other vision aids that you have.
3. A copy of the exam records from the most recent visit to your eye doctor. You can ask your doctor to fax these to the Low Vision Center at (732) 568-0041.
4. Insurance cards and referral forms from your primary care doctor (if your primary insurance requires referrals)

We look forward to seeing you at the Low Vision Center. If you have any questions, please do not hesitate to contact us before your examination at (732) 568-0038.

Jonathan Fishbein, OD OA 5536, OM 122600
Tobin Ansel, OD, FAAO OA 6731, OM 141400
Sukhpreet Kahlon, OD OA 7009, OM 167800

2090 Route 27, Suite 105
North Brunswick, NJ 08902
Ph: 732-568-0038
Fax: 732-568-0041
www.lowvisioncenter.com

THE LOW VISION CENTER OF CENTRAL NEW JERSEY

Name	Sex: M F
Address	
Phone Number	
E-Mail Address	
Date of Birth	
Social Security #	
Emergency Contact	

Who referred you to the Low Vision Center?

Who do you live with?

OCULAR HISTORY

What is the reason for your vision problem?

When was this was initially diagnosed?

Have you received any treatment for this condition?
(Please list any procedures, with dates performed, and doctor who performed procedure)

Do you have any other eye conditions?

Have you had any other eye surgeries?
(Please list, with dates performed, and doctor who performed procedure)

Are you using any medications or nutritional supplements for your eyes (please list)?

VISUAL HISTORY

Do you experience double vision?

Have you experienced a sudden loss in your vision (blackout)?

Do you experience eye pain or discomfort?

To the best of your ability, please describe your vision.

Do you feel that your vision is stable? Getting better? Getting worse?

Which eye do you feel sees better?

Do you currently wear glasses? (Circle One) Distance Near Both

Do you feel that your glasses help you?

Are you currently using magnifiers or other visual aids (please list)?

Is glare a problem?

Do you handle your own finances?

What are your hobbies and interests?

Have you had a low vision evaluation before?

GOALS

Please list activities that you are no longer able to do because of your vision that you would like to be able to do again. Please be specific as possible (i.e. Instead of "reading", tell us exactly what you would like to read.)

If you had to choose one activity on the above list that you would consider "top priority", which would you choose?

Are there any other issues about yourself or your vision that you feel the doctor should be aware of?

PERSONAL MEDICAL HISTORY

(Check the box and list approximate duration of condition)

	NO	YES	DURATION
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Disease			
Kidney Disease			
Thyroid Disease			
Gastrointestinal			
Neurological (Brain)			
Skin Condition			
Arthritis			
Lung or Respiratory Problem			
Cancer			
Stroke			
HIV/Infectious Disease			
Alcohol or Drug Abuse			
Other (please specify)			

List all medications you are currently taking, dosage and frequency: (if you have a list please bring it with you)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any allergies to medications? Yes or No If yes, which ones? _____

Height: Weight:

Do you currently smoke? Yes/No If yes, how many packs a day? _____

Do you currently drink alcohol? Yes/No/Occasional If yes, how many glasses a day? _____

FAMILY MEDICAL HISTORY

(Check the box and list family member affected)

	NO	YES	RELATIONSHIP
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Disease			
Kidney Disease			
Thyroid Disease			
Gastrointestinal			
Neurological (Brain)			
Skin Condition			
Arthritis			
Lung/Respiratory Problem			
Cancer			
Stroke			
HIV/Infectious Disease			
Alcohol or Drug Abuse			
Other (please specify)			

PRIMARY INSURANCE:

Patient Name:

_____

Company:

_____

Insured's Name if different from Patient:

_____

Insured's Date of Birth:

_____

Relationship to Insured:

O Self O Spouse O Other_____

SECONDARY INSURANCE:

Company:

_____

Insured's Name if different from Patient:

_____

Insured's Date of Birth:

_____

Relationship to Insured:

O Self O Spouse O Other _____

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Low Vision Center of Central New Jersey c/o Somerset Eye Care for any services furnished to me by the Low Vision Center of Central New Jersey c/o Somerset Eye Care. 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 service.

I understand that the financial responsibility for the account is mine, not the insurance company's. I understand that any balances not covered by insurance are my sole responsibility and that if my account is sent to a collection agency due to unpaid balances, then a $30 collection fee will be added to my account.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician for services rendered. I have read and understand the Notice of Privacy Practices for Somerset Eye Care, and understand that Somerset Eye Care will release my protected health information only as allowed by law.

_____

Beneficiary Signature Date

In compliance with HIPAA rules and regulations, The Low Vision Center of Central New Jersey will need authorization to disclose any protected patient health information. By signing below, I hereby authorize use or disclosure of protected health information about me as described below.

The doctors and staff are allowed to discuss my result(s) and treatment plan(s) with:

Name(s) and relationship to patient: _____

Address: _____

_____

LOW VISION CENTER
of CENTRAL NEW JERSEY

Date: _____

Name: _____

DOB: _____

Please release all medical records and pertinent information for the above named patient.
The records can be faxed to **732-568-0041**.

Patient/Guardian Signature: _____

Regards,

The Low Vision Center of Central New Jersey
2090 Route 27, Suite 105
North Brunswick, NJ 08902
Phone: 732-568-0038
Fax: 732-568-0041

NOTICE OF PRIVACY PRACTICES: Low Vision Center of Central NJ

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND what rights you have regarding it. PLEASE REVIEW IT CAREFULLY.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

By law, we are allowed to use or disclose your protected health information (**PHI**) without your written consent for the purpose of treatment, payment or health care operations. Examples include scheduling appointments; examinations; prescribing corrective lenses, vision aids, or medications and providing prescription information to suppliers; referrals for other medical care; getting copies of past records; acquiring guarantor/insurance information; processing bills or claims; financial or billing audits; internal quality assurance; personnel decisions; credentialing; legal defense; business planning; and outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your PHI without your permission. Examples include reporting for public health purposes and oversight; FDA requirements; suspected abuse or neglect; threats to health or safety; subpoenas or court orders; relating to organ procurement; knowledge relating to a crime; worker's compensation disclosures; disclosures of de-identified information, disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures and disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your **PHI**. Any information that is disclosed will be limited to the minimum information required and will only be given to parties with the proper authorization to obtain this information.

Unless you object, we will also share relevant information about your care with family or friends who are helping with your care.

APPOINTMENT REMINDERS/ NOTIFICATIONS

We may call or write to notify you of routine examinations due, appointment confirmation, order status or services available at our office. Unless you tell us otherwise, we will mail you an appointment reminder on a post card and/or call you at the number you have given us. We may leave a message on your phone or with whoever answers your phone if you are not available.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your PHI unless you sign a written "authorization form" the content of which is determined by federal law. You are not required to sign the authorization, however, if you do not, we cannot use or make the disclosure. The authorization may be revoked at any time by writing to the contact below. Previous disclosures are not effected.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

All requests must be made in writing (address below) and will be responded to within the time allowed by law (usually 30 days).

- You may ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.
- You may ask us to communicate with you in a confidential way, such as using a specific phone number or address. We will accommodate these requests if they are reasonable. There may be a charge for any extra cost involved with the request.
- You may ask to see or to get photocopies of your **PHI**. You may have to pay for photocopies in advance. By law, there are a few limited situations in which we can refuse to permit access or copying. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available.
- You may ask us to amend **PHI** that you think is incorrect or incomplete. If we agree, we will amend the information and send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your file along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your **PHI**, we will include it anytime we disclose your **PHI**.
- You may request a list of our disclosures of your **PHI** within the past 6 years. By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge.
- You can receive additional paper copies of this Notice of Privacy Practices upon request.

OUR NOTICE OF PRIVACY PRACTICES (NPP)

By law, we must abide by the terms of this **NPP** until we change it. We reserve the right to change this notice at any time as allowed by law. If we change this notice, the new **NPP** will apply to any **PHI** that we already have as well any that we may generate in the future. If we change our **NPP**, we will post the new notice in our office, on our website and have copies available in our office.

COMPLAINTS

If you think we have not properly respected the privacy of your PHI, you are free to complain without fear of retaliation. You may discuss your complaint with us in person, by phone or by sending a written complaint to our office or the U.S. Dept. of Health and Human Services, Office for Civil Rights.

CONTACT INFORMATION:

For more information about our privacy practices you may call, write or visit our office. All requests concerning your PHI must be made in writing to:

DO YOU HAVE TROUBLE WITH ANY OF THE FOLLOWING AREAS?

1. Reading labels on your meds?	Yes	No	Gave Up
2. Reading newspaper print?	Yes	No	Gave Up
3. Reading your mail/bills?	Yes	No	Gave Up
4. Seeing price labels?	Yes	No	Gave Up
5. Reading hand written notes?	Yes	No	Gave Up
6. Seeing colors?	Yes	No	Gave Up
7. Seeing to sew/knit/crochet or play cards	Yes	No	Gave Up
8. To do your housework?	Yes	No	Gave Up
9. To cook/see stove dials?	Yes	No	Gave Up
10. To see the food on your plate?	Yes	No	Gave Up
11. To cut fruits and vegetables?	Yes	No	Gave Up
12. To dial and use a phone?	Yes	No	Gave Up
13. To groom yourself?	Yes	No	Gave Up
14. To see a computer screen	Yes	No	Gave Up
15. Writing/signing your name?	Yes	No	Gave Up
16. To write checks/pay bills?	Yes	No	Gave Up
17. Seeing curbs and stairs?	Yes	No	Gave Up
18. Seeing faces?	Yes	No	Gave Up
19. Seeing the TV?	Yes	No	Gave Up
20. Seeing at the theatre or sports events?	Yes	No	Gave Up
21. Seeing to drive a car?	Yes	No	Gave Up
22. Seeing traffic lights or street signs?	Yes	No	Gave Up
23. Crossing Streets?	Yes	No	Gave Up

Directions

Somerset Eye Care, 2090 Route 27 Suite 105 North Brunswick, NJ 08902 (732) 658-6765

From East Brunswick
Take Route 18 North (Towards New Brunswick) to Exit Route 1 South/Trenton/Princeton. Continue on Route 1. Make a right onto Adams Lane. Adams Lane becomes Cozzens Lane. Follow this until you come to Route 27. At the traffic light intersection, make a left onto Route 27 South. Continue on Route 27 South, turning left onto Schmidt Lane. Make the first right into the plaza. Follow the road to the back of the parking lot. Our office will be on the left, Suite 105.

From Bound Brook
Take Route 287 South to Exit 10 (Easton Avenue towards New Brunswick). Continue on Easton Avenue. Make a right onto Demott Lane. Continue on Demott Lane. Make a right onto Amwell Road, then a left onto South Middlebush Road. Continue down S Middlebush Road, turning left onto Skillmans Lane. Follow Skillmans Lane until you come to Route 27. Make a right onto Route 27 South, turning left onto Schmidt Lane. Make the first right into the plaza. Follow the road to the back of the parking lot. Our office will be on the left, Suite 105.

From Princeton
Take US-206 North. Make a slight right onto Princeton Avenue. Continue on Princeton Avenue. Make a right onto Washington Street. Cross over the Millstone River. Continue straight onto Georgetown Franklin Turnpike. Make a left onto Route 27 North. Continue on Route 27 North, passing Hidden Lake. Make a right into our plaza right after Hidden Lake. Follow the road to the back of the parking lot. Our office will be on the left, Suite 105.

From New Jersey Turnpike
Take the NJ Turnpike to Exit 9. Follow signs to Route 18 North (New Brunswick). Take the Route 1 South Exit. Continue on Route 1. Make a right onto Adams Lane. Adams Lane becomes Cozzens Lane. Follow this until you come to Route 27. At the traffic light intersection, make a left onto Route 27 South. Continue on Route 27 South, turning left onto Schmidt Lane. Make the first right into the plaza. Follow the road to the back of the parking lot. Our office will be on the left, Suite 105.

Garden State Parkway North
Take the Parkway to Exit 127. Taking exit 127, merge onto NJ-440 South. Continue onto I-287 North. Take exit 1B to merge onto Route 1 South towards Trenton. Continue on Route 1. Make a right onto Adams Lane. Adams Lane becomes Cozzens Lane. Follow this until you come to Route 27. At the traffic light intersection, make a left onto Route 27 South. Continue on Route 27 South, turning left onto Schmidt Lane. Make the first right into the plaza. Follow the road to the back of the parking lot. Our office will be on the left, Suite 105.

Garden State Parkway South
Take the Parkway to Exit 130. Taking exit 130, merge onto Route 1 South. Continue on Route 1. Make a right onto Adams Lane. Adams Lane becomes Cozzens Lane. Follow this until you come to Route 27. At the traffic light intersection, make a left onto Route 27 South. Continue on Route 27 South, turning left onto Schmidt Lane. Make the first right into the plaza. Follow the road to the back of the parking lot. Our office will be on the left, Suite 105.