DIANE P. KARALEKAS, M.D.
65 Boston Post Road West, Suite #250
Marlborough, MA 01752
Phone: 508-481-0815 Fax: 508-481-0820

Welcome to the office of Diane P. Karalekas, MD.

As a new patient, we request that you complete the attached paperwork and bring it with you to your scheduled appointment. This will reduce the amount of time you spend at our office. A new patient exam is an extensive exam which usually includes having your eyes dilated. Please plan on being at this visit for approximately 1-1/2 hours. If you are being seen for a glaucoma evaluation or for another medical condition which requires a more extensive exam, please be aware that this may extend your appointment time. We ask that you consider bringing a driver and dark glasses, as your vision may be blurry and light sensitive following the exam, especially if you have never been dilated before.

For your exam, please bring a list of current medications that you are taking along with your prescription eyeglasses.

If you have specific questions for the physician, please write them down and bring them with you to your appointment.

Dr. Diane Karalekas is considered a specialist. Therefore, if your insurance company requires you to obtain an insurance referral to see a specialist, please do so prior to your office visit. We regret that we will not be able to see you without a proper referral in place, if it is required.

If you were referred to our practice from another ophthalmologist or optometrist, please be sure that information indicating the reason for the medical referral is received prior to your visit. This may be in the form of a medical letter from the referring doctor, or a copy of their most recent office visit. Please note that a physician cannot release your medical records without your signed consent.

Also, please note that our office charges a $25 fee (per service scheduled) for all missed or less than 24 hour canceled appointments. Therefore, please make every effort to keep your scheduled appointment or contact us in a timely manner to change it.

Please contact our staff with any questions or concerns that you may have. We will be happy to assist you in any way that we can.

DIANE P. KARALEKAS, M.D.

Patient Name**:** _____ Date of Birth: ____/____/_____

Marital Status: _____ Male ☐ Female ☐

Mailing Address**:** _____

City: _____State _____ Zip: _____

Home Phone: _____-_____-_____ Cell/Work Phone**:** _____-_____-_____

Please circle which number you prefer to be reached at: HOME CELL WORK

Preferred method for appointment reminders: CALL TEXT

Employer: _____Position: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone Number: _____

Primary Insurance: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Policy ID #: _____ Group # (if applicable): _____

Secondary Insurance: _____

Primary Care Physician: _____Telephone: _____-_____-_____

Primary Care Physician Address: _____

Please read the following and sign

I hereby authorize Diane P. Karalekas, MD to administer such treatment as may be deemed necessary or advisable for the above patient.

Patient (OR Guardian) Signature: _____**Date:** _____

Please Print Name: _____ **Relationship**: _____

I authorize the release of any payments and medical information necessary to process this and any other related claims and certify that the above information is correct.

Signature: _____ **Date**: _____

DIANE P. KARALEKAS, M.D.

65 BOSTON POST ROAD WEST MARLBOROUGH MA 01752

SIGNATURE ON FILE

Any monies payable will be authorized to **Diane P. Karalekas M.D. P.C.**

I authorize the release of any medical information to my insurance carrier as requested by them. I permit a copy of this authorization to be used in place of the original.

_____

Patient Signature **Date**

I authorize any medical benefits payable on my behalf to be paid directly to **Diane P. Karalekas, M.D.P.C.**

_____

Patient Signature **Date**

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration of its intermediaries or carriers any information needed for this or related to Medicare claim. I permit a copy of this authorization to be used in placed of the original, and request payment of medical insurance benefits either to my myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my health treatment. (Section 1128B of Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

_____

Medicare Recipient **Date**

DIANE P. KARALEKAS, M.D.

65 BOSTON POST ROAD WEST MARLBOROUGH MA 01752

HIPAA PRIVACY STATEMENT

I, _____, acknowledge that a copy of
(Please Print Name)

Diane P. Karalekas, MD Privacy Notice is available for my review at the front desk.

_____ _____
Patient Signature Date

If legal guardian is completing this form:

_____ _____
Legal Guardian (Please Print Name) Relationship

_____ _____
Legal Guardian Signature Date

Diane P. Karalekas, M.D., P.C.

Please initial each item and sign and date the form below to confirm acknowledgement and understanding of our office policies:

- ____ **Co-Payments.** Payment is due at the time of your visit. We accept cash, check, MasterCard, Visa, Discover, and American Express.

- ____ **Routine Exams.** Due to the specialty nature of the practice, most insurance carriers will not cover routine eye exams. At the end of the visit, if the diagnosis is routine (blurred vision, need for glasses, etc.) you will be responsible for payment if the claim is denied by your insurance carrier.

- ____ **Refraction.** If you request a prescription for glasses it is usually not covered by your insurance carrier, as we do not accept Vision Plans and do not provide routine eye care. You will be responsible for that portion of the exam.

- ____ **Missed/Cancelled Appointment.** We reserve the right to charge $25.00 (per service and diagnostic test scheduled for that visit) for no-shows and appointments cancelled with less than 24 hours' notice. The fee is due before the next appointment can be rescheduled. This fee is your responsibility and is not billable to your insurance carrier. Patients who repeatedly miss appointments or repeatedly reschedule without proper notice may be asked to seek care from another ophthalmology practice.

- ____ **Prescriptions.** Please allow at least two business days for prescription refills. Refills are done electronically at the end of each business day.

- ____ **Medical Records**. If medical records are requested, there is a base fee of $15.00 per request, plus a copying charge of $0.50 per page for the first 100 pages, and $0.25 per page in excess of 100 (per Mass.gov Medical Records Obligations Policy). Please allow one week from the receipt of your payment for processing.

- ____**Insurance and Contact Information.** It is the patient's responsibility to keep our practice informed about any changes in insurance, address or telephone number(s). We cannot be responsible for undeliverable messages/notices/bills/insurance claims due to incorrect information in our files.

- ____ **Appointments/Delays**. As a specialty practice, we are committed to providing quality and compassionate care to our patients. We will give each patient quality time to ensure that their medical needs and concerns are addressed. As such, it is difficult to predict in advance exactly how much time each patient will require or how many hospital/physician consultations or other emergencies the doctor may be dealing with on any given day. For this reason, we appreciate your patience with any delays you may encounter during your visit with us. Your appointment time determines the order in which you will be seen, but if you are late for your appointment and the next patient is already here, you may be asked to wait to be worked back into the schedule, or possibly reschedule your appointment.

Patient Signature: _____ Date: _____

Name: _____ Date of Birth:_____ Date: _____
Primary Care Physician/Location: _____
Optometrist: _____ Date of last optometry exam: _____

General Medical & Health History

List all prescription medications you are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List all over-the-counter (nonprescription) medications you are currently taking: _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you have any allergies to medications? YES NO

If YES, list the medications and reaction: _____

_____

List all surgeries you have had: _____

_____

List all medical conditions (current AND past medical history). Circle all that apply:

Condition	Yes	No	Diagnosis
Ear/Nose/Throat			Sinus, Tinnitus, Other:
Heart			Heart Attack (MI), Atrial Fibrillation, Other:
Vascular			High Blood Pressure, Coronary Artery Disease, Carotid Stenosis, Other:
Respiratory			Asthma, Emphysema (COPD), Sleep Apnea, Other:
Endocrine			Diabetes (Type 1 or 2) , Thyroid, Graves, Other:
Gastrointestinal			Ulcers, Polyps, Colitis, Crohn's, Other:
Kidney, Bladder			Kidney Stones, Urinary Retention, Other:
Prostate			Enlarged prostate, Other:
Bones, Joints			Arthritis, Other:
Neurologic			Stroke, Seizure, MS, Other:
Blood			Anemia, Cholesterol, Acute Blood Loss, Other:
Immunologic			Lupus, Rheumatoid Arthritis, Allergies, Other:
Psychiatric			Anxiety, Depression, Bipolar Disorder, Other:
Cancer			Type:

Ocular (EYE) History

Have you ever had surgery or laser to either eye? YES NO If YES, Please list below:

Right Eye			Left Eye	
Procedure:	**Date:**		**Procedure**	**Date:**
Procedure:	**Date:**		**Procedure:**	**Date:**
Procedure:	**Date:**		**Procedure:**	**Date:**

Do you currently wear glasses? YES [Reading Distance Both] NO
Do you currently wear contact lenses? YES NO
Did you ever receive patching therapy as a child for lazy eye? YES NO
Were you ever treated for "crossed eyes" (strabismus)?
Have you ever had any trauma to either eye? YES [RIGHT EYE LEFT EYE] NO

Have you been told you have any of the following EYE conditions:

☐ **Blepharitis (inflammation of the eyelids)** ☐ **Cataract**
☐ **Recurrent styes (chalazia)** ☐ **Glaucoma**
☐ **Dry Eye Syndrome** ☐ **Macular Degeneration**
☐ **Chronic tearing** ☐ **Retinal Tear/Detachment**
☐ **Chronic allergies** ☐ **Retinopathy (Diabetic, Hypertensive)**
Other eye condition(s): _____

Family Ocular (EYE) History

☐ **Glaucoma** ☐ **Macular degeneration** ☐ **Blindness** ☐ **Other: _____**

Social History

Current occupation: _____
If retired, previous occupation: _____
Education: High School College Graduate/Professional School
Marital status:_____ Living arrangements: _____
Do you drive? YES NO
Do you have difficulty when driving? YES NO
Do you drink alcohol? YES NO [If YES: amount _____]
Smoking history: Current Former Never

Is there any other information you would like us to know about you that would help us to care for you better? _____

(For Office Use Only) Reviewed by: _____ Date: _____

Directions to 65 Boston Post Road WEST, Suite 250

Marlborough, MA 01752

Phone: (508) 481-0815

From Route 495 (North or South): Take Exit 63B towards Northborough/Route 20. Continue straight for a quarter mile. Our office is located on the right as you head down the hill; it is a three-story red brick building just after a taller office building called "33 West". The sign says "Marlborough Executive Park". Loop around the parking area counter-clockwise to the front of the building; our office is off the main lobby on the left.

**If you pass the Embassy Suites hotel, you've gone too far.

From Route 20 Eastbound: Once you reach the RK Plaza (Hannaford's grocery store on the left, and Wendy's on the right), continue up the hill, staying in the left hand lane. Make a U-Turn at the intersection at the top of the hill (at Landry Dr. and Glen St. – St. Mary's Credit Union on your left and the 99 Restaurant on your right). Head back down the hill, past the taller office building "33 West"; ours is the next driveway; our building is a three-story red brick building. The sign says "Marlborough Executive Park". Loop around the parking area counter-clockwise to the front of the building; our office is off the main lobby on the left.

**If you pass the Embassy Suites hotel, you've gone too far.

From Route 20 Westbound: Cross over Route 495; then follow directions "From Route 495" above.