SUSAN M. YEOMANS, M.D.

65 BOSTON POST ROAD WEST
MARLBOROUGH, MA 01752

PHONE: 508-481-0815 FAX: 508-481-0820

Welcome to our office!

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 in our office. A New Patient exam is an extensive exam which includes having the eyes dilated, and usually lasts 1 – 1 ½ hours. If you are being seen for glaucoma or another medical condition which requires more expanded testing, please be aware that this may extend your appointment time. We ask that you consider having someone drive you and wear dark sunglasses, as your vision may be blurry and light-sensitive following the exam, especially if you have never been dilated before. For your exam, please also bring **your prescription eyeglasses and a list of current medications you are taking – including over-the-counter meds.**

Dr. Yeomans is considered a Specialist. Therefore, if your insurance company requires you to obtain a referral to see a Specialist, please do so **prior** to your visit. We regret that we will not be able to see you without a referral in place (if needed).

If you were referred to our Practice by another eye care provider, or are transferring your ongoing care here, please arrange to have a referral letter and/or records sent to our office prior to your appointment. The release of medical records requires your written/signed consent.

Please contact our Staff with any questions or concerns you may have, so that we can assist you, even in advance of your visit.

Also, please note that our office charges a $25 fee for all missed appointments or diagnostic test scheduled, as well as those cancelled with less than 24-hour notice. Please keep this in mind if you wish to change your appointment.

SUSAN M. YEOMANS, M.D.

Patient Name: _____

Date of Birth: _____/_____/_____ Marital Status: _____ Male: ____ Female: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____-_____-_____ Work/Cell phone: _____-_____-_____

_

Employer: _____

Emergency Contact: _____ Phone: _____-_____-_____

Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____-_____-_____

Primary Care Physician Address: _____

_____

Primary Insurance: _____ Policy ID# _____

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

Secondary Insurance: _____ Policy ID#_____

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

Signature: _____ Today's Date: _____

IF the patient is a minor or unable to sign:

I hereby authorize Susan M. Yeomans, M.D. to administer such treatment as may be deemed necessary or advisable for the above patient.

Guardian's Signature: _____ Today's Date: _____

Print Name: _____ Relationship: _____

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SIGNATURE ON FILE

Any monies payable will be authorized to **Susan M. Yeomans, 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
Susan M. Yeomans, 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**

SUSAN M. YEOMANS, M.D.

65 BOSTON POST ROAD WEST
MARLBOROUGH, MA 01752

HIPAA PRIVACY STATEMENT

I, _____ acknowledge that a copy of Dr. Yeomans'
(please print name)

Privacy Notice is available for my review at the front desk.

_____ _____
Patient Signature Date

If a legal guardian is completing this form:

_____ _____
Legal Guardian (please print name) Relationship

_____ _____
Legal Guardian Signature Date

Susan M. Yeomans, 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, if denied by your medical insurance carrier.

- ____ **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 up to four weeks 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. 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 Physician Name / Address: _____
Optometrist: _____ Date of last eye 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 major 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, Hearing loss, Other:
Cardiovascular			Hypertension, Heart Attack, Afib., Carotid, Other:
Dermatologic			Eczema, psoriasis, rash, Other:
Respiratory			Asthma, Emphysema/COPD, Other:
Endocrine			Diabetes (Type 1 or 2), Thyroid, Graves, Other:
Gastrointestinal			Ulcers, Colitis, Crohn's, Other:
Genitourinary			Kidney Stones, Enlarged prostate, Other:
Infectious Disease			Hepatitis, HIV, Other:
Bones, Joints			Osteoarthritis, Other:
Neurologic			Stroke, Seizure, MS, Migraine, Other:
Blood			Anemia, Cholesterol, Acute Blood Loss, Other:
Immunologic			Lupus, Rheumatoid Arthritis, Allergies, Other:
Psychiatric			Anxiety, Depression, Bipolar Disorder, Other:
Cancer			Type:

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, Premature)**

Other eye condition(s): _____

Family Ocular (EYE) History

☐Glaucoma ☐Macular degeneration ☐Blindness ☐Other: _____

Social History

Current occupation: _____
If retired, previous occupation: _____
Marital status: _____
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 to help us care for you?:

_____

_____

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.