S I G H T L I N E

Laser Eye Center & Ophthalmic Associates

2591 WEXFORD-BAYNE ROAD, SUITE 104 SEWICKLEY, PA 15143 P (724) 933-5588 F (724) 933-6051

Dear_____

Thank you so much for scheduling an appointment in our office. We are honored that your doctor has selected us to participate in your care. Our role is to deliver excellent patient care and to meet the high expectations of you and your doctor. Your doctor is in a unique position to evaluate our services. This is a strong motivating force for us and should be a source of comfort for you.

You are scheduled to see Dr. _____ on

_____at_____ in the _____office.

Please complete both sides of the enclosed HEALTH HISTORY FORM and bring with you. Completed forms will expedite the organization of your chart and have you seen by the doctor in a timely manner. We also ask that you bring a photo identification and your most current health insurance card(s) to include in your chart. If you have an insurance plan that requires a referral from your primary care provider, you must contact their office in advance of your appointment. Co-pays must be paid at the time of service. If you have any questions regarding your health insurance coverage, please contact your insurance company prior to your visit.

FOR CATARACT AND REFRACTIVE SURGERY EVALUATIONS, WE ASK THAT YOU REMOVE CONTACT LENSES AT LEAST 48 HOURS BEFORE YOUR VISIT (THE LONGER THE BETTER).

Your eyes may be dilated at your appointment in order for us to examine the back of your eyes. The necessary drops may cause temporary blurred vision or light sensitivity; therefore, you may need to bring a friend or family member to drive you home. Please plan to be at the office for 2 hours.

Please call your insurance carrier prior to your visit to determine what surgery center or hospital is in network with your insurance to help facilitate scheduling your surgery. You will need the NPI number of the surgery center or hospital you would like to go to when calling your insurance company. Below is the list of NPI numbers of the locations Sightline is affiliated with:

Armstrong Hospital	1568577724	The Surgery Center at Cranberry	1902876212
Gamma Surgery Center	1821036138	Western PA Surgery Center	1447220082
UPMC Jameson Hospital	1477538312	Western PA Surgery Center Beaver	1568060655
SW Ambulatory Surgery Center	1912933680		

Once again, we welcome you as a patient, and hope your experience with us is a pleasant one. Please feel free to contact the office with questions you may have.

Sincerely,

The Sightline Doctors and Staff

Cataracts, Surgery, and Lens Options

A cataract forms when the eye's natural lens gets cloudy. When this clouding affects vision, a cataract operation is required to remove the clouded lens that is then replaced with a clear, plastic lens. Modern medicine and technology have given us several options that will give you the benefit of becoming less dependent on glasses after surgery. Our staff and doctors will help you determine which lens would be best for you. Please review the information below prior to your visit.

Premium Refractive Options (To reduce dependence on glasses)

1. Multifocal Lens Package

The multifocal lens package includes the implantation of a special lens after the cloudy, natural lens is removed. This lens is designed to reduce your dependence on glasses for both distance and near tasks. The goal of this option is to eliminate the need for glasses in most activities, with the understanding that you still may need glasses for best vision for some situations. Multifocal lenses are not covered by insurance or Medicare. **There is an additional fee of $3000/eye for this option that is the responsibility of the patient. This fee is in addition to any copays, coinsurance or deductibles.**

2. Custom Refractive Package

The custom refractive package includes special testing and calculations as well as techniques to reduce or eliminate astigmatism. This will help to limit the need for glasses to see objects in the distance. The goal of the custom refractive package is to drastically reduce your dependence on glasses. Depending on the option chosen, glasses will still be required on a part-time basis. This service is not covered by insurance plans or Medicare. **There is an additional fee of $1300/eye for this service that is the responsibility of the patient. This fee is in addition to any copays, coinsurance, or deductibles.**

Standard Cataract Surgery

With standard cataract surgery, the cloudy lens will be removed and replaced with a single vision lens. Measurements and calculations will be made to limit the amount of eyeglass prescription needed after surgery. **However, you will likely need to wear glasses after surgery full time for best distance and near vision.** The surgery is covered by Medicare or your insurance. There is no additional cost for the implant lens with this option. You will be responsible for any copays, coinsurance or deductibles per your insurance contract.

Please remove your contact lenses at least 3 days prior to your visit.

Please complete the questionnaire on the reverse side.

Patient Name: _____

1. **Considering the options listed on the opposite side and the associated costs:**

   □ I am interested in one of the advanced cataract options to reduce my need for glasses and would like to discuss further.

   □ I would not mind wearing glasses full-time and elect to have standard cataract surgery.

2. **Do you have any difficulty, even with glasses, with glare from headlights or other lights at night?**

   □ Yes □ No

3. **Do you have any difficulty, even with glasses, reading small print such as labels on medicine bottles, a telephone book or food labels?**

   □ Yes □ No

4. **Do you have any difficulty, even with glasses, reading a newspaper or book?**

   □ Yes □ No

5. **Do you have any difficulty, even with glasses, seeing steps, stairs or curbs?**

   □ Yes □ No

6. **Do you have any difficulty, even with glasses, reading traffic signs, street signs, or store signs?**

   □ Yes □ No

7. **Do you have any difficulty, even with glasses, reading box scores and other print on a television?**

   □ Yes □ No

Patient signature: _____ Date: _____

HEALTH HISTORY

Patient Information

Patient Name _____ D.O.B. _____/_____/_____

Address _____ City_____

State _____ Zip Code _____ Social Security #_____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Employer _____ Occupation _____

Emergency Contact Name _____ Relation _____

Emergency Contact Phone _____ Eye Doctor _____

Family Doctor _____ Family Doctor Phone _____

Preferred Pharmacy _____ Phone/Location _____

Social History

Does your vision limit any activities of daily living? (please check)

☐ driving ☐ reading ☐ sports ☐ work ☐ other _____

Do you drink alcohol? No / Yes How often? _____

Do you smoke? No / Yes How much? _____ For how many years? _____

☐ Cessation of Smoking Intervention given to patient

Family History

Is there any family history of the following? (please circle) If yes, list family member:

Blindness No / Yes _____ Cataract No / Yes _____

Glaucoma No / Yes _____ Diabetes No / Yes _____

Macular Degeneration No / Yes _____

Past Visual & Medical History

Have you ever had any eye injuries or surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

_____

Have you ever had any other surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

_____

Do you have any history of cancer? ☐ No ☐ Yes If yes, please explain:

_____

please complete other side

NAME______________________________________

Please list any medications and why you are taking them:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Are you, or have you ever, taken the following medications:
Flomax (tamsulosin), Hytrin (terazosin) or Minipress (prazosin)? ☐ No ☐ Yes

Ozempic (semaglutide), Trulicity (dulaglutide) or Mounjaro (tirzepatide)? ☐ No ☐ Yes
Are you allergic to any latex products? ☐ No ☐ Yes

Are you allergic to any medications? ☐ No ☐ Yes, please list: ____________________________

Do you use oxygen? ☐ No ☐ Yes, only at night ☐ Yes, all the time

Please check any boxes that apply to conditions that you currently have or have had in the past:

Allergic/Immunologic
☐ drug allergy
☐ environmental allergy
☐ other allergy
☐ rheumatoid arthritis
☐ lupus
☐ other _______________
☐ **NONE**

Lungs/Breathing
☐ cigarette smoker
☐ asthma
☐ bronchitis
☐ COPD
☐ emphysema
☐ sleep apnea CPAP: Y N
☐ other _______________
☐ **NONE**

Endocrine
☐ non-insulin diabetic
☐ insulin diabetic
☐ thyroid dysfunction
☐ hormonal dysfunction
☐ pregnant/breastfeeding
☐ other ______________
☐ **NONE**

Eyes
☐ glaucoma
☐ cataracts
☐ macular degeneration
☐ inflammatory disorders
☐ previous surgery
☐ other ______________
☐ **NONE**

Gastrointestinal
☐ Crohn's
☐ colitis
☐ ulcer
☐ digestive problems
☐ other ______________
☐ **NONE**

Cardiovascular
☐ heart disease
☐ defibrillator
☐ high blood pressure
☐ stroke
☐ poor circulation
☐ high cholesterol
☐ other _______________
☐ **NONE**

Musculoskeletal
☐ arthritis
☐ muscular dystrophy
☐ fibromyalgia
☐ ankylosing spondylitis
☐ other ______________
☐ **NONE**

Genitourinary
☐ STD
☐ urinary problems
☐ prostate problems
☐ other _______________
☐ **NONE**

Neurological
☐ multiple sclerosis
☐ epilepsy
☐ other ______________
☐ **NONE**

Skin
☐ eczema
☐ rosacea
☐ psoriasis
☐ other ______________
☐ **NONE**

Constitutional
☐ developmental disability
☐ sudden weight loss
☐ fatigue
☐ trauma
☐ other ________________
☐ **NONE**

Psychiatric
☐ depression / anxiety
☐ panic disorder
☐ schizophrenia
☐ dementia/Alzheimer's
☐ other _______________
☐ **NONE**

Blood/ Lymphatic
☐ leukemia
☐ anemia
☐ large volume blood loss
☐ other ________________
☐ **NONE**

Ear, Nose, Throat
☐ upper respiratory tract infection
☐ other ______________
☐ **NONE**

CURRENT: HEIGHT _____ ft. _____ in. WEIGHT ______ lbs.

For Office Use Only

Medical History Updates: Date: ______________ Tech Initials: _____________ Doctor Initials: ____________

Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
			BMI _______

SightLine Laser and Ophthalmic Associates
ADVANCE NOTICE & ACKNOWLEDGEMENT OF POLICIES

HIPAA PRIVACY POLICY

A copy of our Notice of Privacy Practices is posted at the front desk and can be found in our 'Privacy Binder'. You have the right to have a copy of this policy. Please see a staff member to request a copy of our HIPAA policy for your records. Signing below acknowledges that you have had the opportunity to review the Notice of Privacy Practices and have been offered a copy.

REFRACTIONS

A refraction may be performed at your evaluation and/or subsequent follow-up visits. This is a test to determine the best possible vision. This test is a separate component to the medical exam and is NOT COVERED BY INSURANCE PLANS. Our current fee for this service is $45.00. If you choose to pay for the refraction on the day of service, a $10 cash discount will be extended.

ASSIGNMENT OF BENEFITS

Signing below authorizes and directs your insurance carrier(s), including Medicare and private insurance plans, to issue payment check(s) directly to SightLine Ophthalmic Associates for medical services rendered to you and/or your dependents. You also authorize the release of any information needed to determine benefits and submit claims for these services.

FINANCIAL RESPONSIBILITY

Fees (including co-pays) are due and payable on the date that services are rendered. You have requested medical services from SightLine Ophthalmic Associates, and by making this request, you become fully financially responsible for any and all charges (including co-insurance, deductibles and non-covered services) incurred in the course of the treatment authorized.

By signing below, I am confirming that I have read and understand this notice and confirm that I have been given the opportunity to ask whatever questions that I might have and that they have been answered to my satisfaction.

_____
Patient Name (print)

_____ _____
Signature Date