GLAUCOMA INSTITUTE
OF NORTHERN NEW JERSEY

Paul J. Lama, M.D.
Glaucoma Physician and Surgeon
87 W. Passaic Street, Rochelle Park, NJ 07662
Tel: (201) 343-3499 • Fax: (201) 343-1799

INTRODUCTION

Welcome to the Glaucoma Institute of Northern New Jersey. Our mission is to provide you with the highest level of medical care by assisting you and your primary eye doctor in the management of your glaucoma. The initial consultation is highly detailed. It consists of a thorough examination of both eyes with state of the art glaucoma diagnostic testing to determine the disease stage and develop an appropriate plan of action for you condition. Expect to be in our office for 3 hours for an initial consultation and longer depending upon the complexity of your condition and need for diagnostic testing.

WHAT YOU NEED TO BRING

1. These forms along with your insurance cards
2. A Referral from your primary care doctor if indicated on your insurance card
3. A consultation request form if you are being referred here
4. Exam records for your primary eye doctor if you are being referred here
5. A list of all your medications (for your eyes and all medical conditions)
6. The bottles of eye drops and the medications that you take
7. A list of your allergies (including medications, food, etc.)
8. A list of your medical conditions and dates of hospitalizations or procedures

IMPORTANT INFORMATION

With the exception of a few patients (those referred with a diagnosis of narrow angles), initial consultation almost always involves administration of dilating drops to exam the optic nerve and retina. If you have never been dilated before or have never operated a motor vehicle after a being dilated, you may want to make arrangements for someone to drive and accompany you to our office. Dilating drops are used to enlarge the pupils of the eye to allow Dr. Lama to get a better view of the inside of your eye. These drops frequently blur vision for a length of time that varies from person to person. Bright lights may be bothersome. It is not possible for Dr. Lama to predict how much your vision will be affected.

CONSENT FOR TREATMENT AND DILATION

I have requested medical services from Glaucoma Institute of Northern New Jersey for my child or myself. I agree to and understand that my/my child's eye will be dilated in order for Dr. Lama t thoroughly check the optic nerve and retina. I understand that if my pupils are dilated, I may not be able to operate a motor vehicle and that I was informed to find alternate transportation or have someone drive me. I authorize Dr. Lama and/or his assistants that may be designated by him to administer dilating eye drops. These drops are necessary to diagnose my condition, if any exists.

_____ _____

Signature or Patient/Responsible Party Date

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Directions

From ROUTE 17 NORTH:
Take Route 17 North to the Passaic Street/Rochelle Park/Maywood exit. At the end of the ramp, turn left onto W Passaic Street. Go through the first traffic light. We are approximately ½ mile down the road on the left hand side. Parking is in back of the building. Entrance to our office is on the side.

From ROUTE 17 SOUTH:
Take Route 17 South to Rochelle Park/ Rochelle Ave. At the top of the ramp, turn left onto Rochelle Ave. At the 2nd traffic light, make a right onto W. Passaic Street. We are approximately ¼ mile down the road on the left hand side. Parking is in back of the building. Entrance to our office is on the side.

From GARDEN STATE PARKWAY NORTH:
Take Garden State Parkway North to Exit 160 (New Jersey 208/Fair Lawn/ Hackensack). At the bottom of the ramp, turn right onto Paramus Road. Paramus Road becomes W Passaic Street. We are approximately 1 mile down the road on the right hand side. Parking is in back of the building. Entrance to our office is on the side.

From GARDEN STATE PARKWAY SOUTH:
Take Garden State Parkway South to Exit 163 (Route 17 South). Take Route 17 South to Rochelle Park/ Rochelle Ave. At the top of the ramp, turn left onto Rochelle Ave. At the 2nd traffic light, make a right onto W. Passaic Street. We are approximately ¼ mile down the road on the left hand side. Parking is in back of the building. Entrance to our office is on the side.

From ROUTE 4 (East and West):
Take Route 4 to Route 17 South exit. Stay on Route 17 for approximately 1/4 mile. Take exit to Rochelle Park/Rochelle Ave. At the top of the ramp, turn right onto Rochelle Ave. At the 2nd traffic light, make a right onto W. Passaic Street. We are approximately ¼ mile down the road on the left hand side. Parking is in back of the building. Entrance to our office is on the side.

From ROUTE 208:
Take Route 208 South to Route 4 East. Proceed to the Route 17 South exit. Stay on Route 17 South for approximately 1/4 mile. Take exit to Rochelle Park/Rochelle Ave. At the top of the ramp, turn right onto Rochelle Ave. At the 2nd traffic light, make a right onto W. Passaic Street. We are approximately ¼ mile down the road on the left hand side. Parking is in back of the building. Entrance to our office is on the side.

From ROUTE 80 EAST:
Take Route 80 East to Exit 62B. Follow signs for Saddle River Road/Fair Lawn/Lodi. Continue onto Railroad Ave. Turn Left onto Rochelle Ave. Turn Left onto W. Passaic Street. We are approximately ¼ mile down the road on the left hand side. Parking is in back of the building. Entrance to our office is on the side.

From ROUTE 80 WEST:
Take Route 80 West to Exit 64A for NJ Rt-17 North toward NJ-Rt-4/Paramus/Rochelle Park. Merge onto NJ-17N. Take Passaic Street Exit toward Passaic Street/ Rochelle Park / Maywood. At the end of the ramp, turn left onto W Passaic Street. Go through the first traffic light. We are approximately ½ mile down the road on the left hand side. Parking is in back of the building. Entrance to our office is on the side.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

Patient's Name:_____Today's Date:_____

Is patient a minor? ____YES _____NO Patient's Date of Birth:_____

PRIVATE HEALTH INFORMATION (PHI) TO BE DISCLOSED

Full names of individuals (not including medical doctors) that PHI can be disclosed/discussed:

1._____Relationship_____

2._____Relationship_____

Please tell us of any restrictions you may have on the release of your PHI to the above listed individuals, if any:

_____

Please mark all options that apply:

_____ DO NOT leave a message on machine regarding appointment times or insurance information
_____OK to leave a message on machine regarding appointment times or insurance information
_____DO NOT release any information regarding appointments or insurance information to anyone
_____OK to leave any information regarding appointments or insurance information to anyone

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices detailing how much health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information. If patient is a minor, or otherwise unable to sign, an authorized representative must sign below.

_____ _____
Patient Signature or Authorized Representative Date

Relationship of Authorized Representative:_____

TERM: PLEASE BE AWARE, THIS INFORMATION WILL REMAIN IN EFFECT FROM THE ABOVE DATE AND WILL REMAIN IN FORCE UNLESS A CHANGE REQUEST IS SUBMITTED IN WRITING.

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Today's Date:_____

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

Home Address:_____**Apt#:**_____**City:**_____

State:_____**ZipCode:**_____**SocialSecurity#:**_____**AGE:**_____

Home#:_____**Cell#:**_____**Work#:**_____

Gender: **Male Female** **Marital Status:** **S M D W** **Race:** **White Black Hispanic Other**

Email Address:_____**Language Spoken:**_____

WE ASK FOR YOUR E-MAIL ADDRESS SO THAT YOU CAN HAVE ACCESS TO YOUR MEDICAL RECORDS AT ANY TIME VIA OUR PATIENT PORTAL. THANK YOU.

Employer:_____**Occupation:** _____

Employer Address:_____

Emergency Contact:_____**Phone:**_____

Address:_____**Relationship:**_____

Insurance Information:

Primary Insurance:_____**ID#:**_____

ID #:_____**Group#:**_____

Policy Holder:_____ **Relationship:**_____

Policy Holder Social Security#:_____**Date of Birth:**_____

Secondary Insurance:_____

ID#:_____**Group#:**_____

Policy Holder:_____**Relationship:**_____

Policy Holder Social Security #:_____**Date of Birth:**_____

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Referring Physicians: (If another doctor did not refer you to our office, please write "NONE")

*It is important for us to know who sent you to our office so that we can communicate with them and keep them informed of your condition and treatment. Thank you.

Referring Ophthalmologist/Optometrist:_____

Address:_____

Phone#:_____Fax#:_____

Primary Care Doctor: _____

Address:_____

Phone#:_____ Fax#:_____

Pharmacy:_____Phone#:_____

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Financial Policy

GINNJ will file claims to your insurance company. It is important for you to understand that the contract exists between you and your insurance carrier. There is no guarantee of payment for services rendered by GINNJ. **We require that co-payments be paid at the time of service** and we will send you a statement for any uncovered charges after your insurance has responded to our claim. Referrals are the responsibility of the patient. If the patient doesn't bring a referral and it is required, the patient is responsible for payment in full for all charges incurred on that day. Non-insured patients are expected to pay in full at the time of service, unless other arrangements have been made. On a disputed claim, GINNJ cannot accept responsibility for collecting payment for any insurance company or for negotiating a settlement. You are responsible for any amount that your insurance company does not pay, including but not limited to, co-insurance, unmet deductible, and any non-covered charges. If any collection proceedings are required to cover any outstanding balance, I understand I will be responsible for said costs, including collection expenses and reasonable attorney's fees of 33.3% of the balance due whether or not suit is filed.

Assignment of Benefits/Authorization to Release Information

I understand that I am fully financially responsible for any and all charges incurring during the course of authorized treatment. I hereby assign all medical and surgical benefits to Glaucoma Institute of Northern New Jersey (GINNJ). I authorize and direct my insurance carrier(s) to issue payment directly to GINNJ for medical services rendered to myself/my dependent. I authorize GINNJ and its agents to release any medical information necessary to my health insurance carrier(s) to help process claims.

_____ _____

Signature of Patient/Responsible Party Date

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GLAUCOMA MEDICAL HISTORY QUESTIONNAIRE

How long have you had or have been treated for glaucoma? Please circle one.

Less than 1 year	1-3 years	4-5 years	6-10 years
11-15 years	16-20 years	Over 20 years	Not sure

Have you ever been told that you have narrow angles?

YES ☐ NO ☐

Do you get headaches?

YES ☐ NO ☐

If the answer is yes, have you ever been told that you have or have been given treatment for migraine?

YES ☐ NO ☐

Have you ever had blackouts or graying out of your vision?

YES ☐ NO ☐

Have you ever had blurred vision with rainbows around lights?

YES ☐ NO ☐

Do your hands and feet get excessively cold in the winter and change color?

YES ☐ NO ☐

Do you snore?

YES ☐ NO ☐

If so, how often do you snore?

Every Night ☐ most nights ☐ rarely snore ☐

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Have you ever been told that you have sleep apnea?

YES ☐ NO ☐

If you have sleep apnea do you wear a CPAP face mask?

YES ☐ NO ☐

Do you have a thyroid condition?

YES ☐ NO ☐

Do you have diabetes?

YES ☐ NO ☐

Do you have or have been told you have low blood pressure?

YES ☐ NO ☐

Do you have or have been told that you have a slow pulse?

YES ☐ NO ☐

Have you ever fainted?

YES ☐ NO ☐

Are you under treatment for high blood pressure?

YES ☐ NO ☐

Do you have or have been told that you have an irregular heartbeat?

YES ☐ NO ☐

Have you ever had a heart attack or stroke? Please specify?

YES ☐ NO ☐

Do you have angina or chest pain?

YES ☐ NO ☐

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GLAUCOMA TREATMENT HISTORY

Have you only been treated with drops?

YES ☐ NO ☐

Please list all the drop medications that you have used for <u>GLAUCOMA</u>.

_____
_____
_____
_____

Which medications are you currently using? Please list all of them.

_____
_____
_____
_____

Have you ever had laser treatment for glaucoma?

YES ☐ NO ☐

If so, <u>what type</u> of laser and <u>when</u>? Please check all that apply to the best of your ability.

Selective laser trabeculoplasty (SLT) ☐ Argon Laser Trabeculoplasty (ALT) ☐
When?_____ When?_____

Laser Iridotomy ☐ Other ☐ Had laser for glaucoma but don't know what kind ☐
When?_____

Have you ever had surgery for Glaucoma?

YES ☐ NO ☐

If so, in which eye, and when?

RIGHT ☐ LEFT ☐ BOTH ☐

Have you ever had cataract surgery?

YES ☐ NO ☐

If so, in which eye and when?

RIGHT ☐ LEFT ☐ BOTH ☐

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GLAUCOMA FUNCTIONAL ASSESSMENT

Have you lost vision from glaucoma?

YES ☐ NO ☐

Lost vision but unsure if it is from Glaucoma ☐ Not sure if I lost vision ☐

Do you have trouble reading or working with a computer?

YES ☐ NO ☐

Do you have trouble watching television?

YES ☐ NO ☐

Do you have trouble driving?

YES ☐ NO ☐

Have you stopped driving because of your vision?

YES ☐ NO ☐

Is your vision at night worse than in the day?

YES ☐ NO ☐

Do you have trouble adjusting when

Going from outdoors to indoors ☐ or from light to dark ☐

Do you need assistance to perform your usual activities because of your vision?

YES ☐ NO ☐