RETINA SPECIALISTS OF NEW JERSEY

DIAGNOSIS, TREATMENT & SURGERY OF THE RETINA

Patient Demographics Page 1

Dear Patient: Please fill out these forms in their entirety. Although it may seem redundant, we will need you to fill in all of your insurance information and kindly submit your insurance cards to the front desk. Your cooperation in this process is greatly appreciated.

LAST NAME :_____(Mrs. Mr. Ms.) Circle **PHONE NUMBER:** (_____)_____

FIRST NAME: _____ **M.I.**_____ WORK PHONE: (_____)_____

EMAIL:_____

STREET ADDRESS: _____

CITY: _____**STATE:**_____ **DATE OF BIRTH:** _____

ZIP CODE: _____SEX M___F_____ **SS#:**_____

EMPLOYED: YES_____NO_____ MARITAL STATUS: SINGLE___MARRIED__OTHER___

EMPLOYER/SCHOOL: _____ **RACE**: _____ **ETHNICITY**: ____ Hispanic/Latino
____ Not Hispanic/Latino
____ Unknown/Not Reported

ADDRESS: _____

Street City State **LANGUAGE**: _____

IF PATIENT IS A MINOR 18 YEARS OF AGE OR YOUNGER: MOTHER'S FIRST NAME_____
FATHER'S FIRST NAME_____

REFERRING DOCTOR: _____ Is the referring doctor your: Ophthalmologist_____
Optometrist_____ PCP/internist_____ Other_____

STREET ADDRESS: _____CITY:_____STATE:_____ZIP:_____

TELEPHONE NUMBER OF REFERRING DOCTOR: _____

INTERNIST/PRIMARY CARE PHYSICIAN _____

STREET ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE NUMBER _____

NAME OF EMERGENCY CONTACT_____ Emergency Phone#_____

Emergency Relationship_____

RETINA SPECIALISTS OF NEW JERSEY

DIAGNOSIS, TREATMENT & SURGERY OF THE RETINA

Patient Demographics Page 2

INSURANCE INFORMATION: ***IS YOUR VISIT NO FAULT OR WORKMENS COMP RELATED? YES____ NO____***
IF YES, PLEASE SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK

PRIMARY CARRIER: _____ **CLAIMS ADDRESS:** _____
POLICY HOLDER: _____ _____
POLICY HOLDER DOB: _____
POLICY HOLDER SS#:_____ **POLICY HOLDER ID #:**_____

EMPLOYER: _____

SECONDARY CARRIER: _____ **CLAIMS ADDRESS:** _____
POLICY HOLDER: _____ _____
POLICY HOLDER DOB: _____ **POLICY HOLDER ID#:** _____
POLICY HOLDER SS#:_____
EMPLOYER: _____

PHARMACY & PHONE_____

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Individual (Parent/Guardian) Name: _____

Authorized Individual Signature: _____

Basis of Authority (e.g., parent, guardian): _____

Patient's ID verified: YES_____ NO_____ Form of ID: _____ Initials: _____

RETINA SPECIALISTS OF NEW JERSEY
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Medical History Questionnaire Page 1

Name: Date:

Date of Birth _____ Date of last eye exam _____

List any medications you currently take (Rx and over-the-counter) _____

_____

Do you have any allergies to medications? Yes No

If yes, list the medications _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): _____

_____

List any surgeries you have had (cataracts, appendectomy, etc.): _____

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach ache, diarrhea, constipation, hernia, ulcers, etc.)			
GENITALS, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, growths, warts, rash, etc.)			
NEUROLOGICAL (numbness, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

330 South St, Suite 1, Morristown NJ 07960 • 500 Willow Grove Street, Suite 2 NJ 07840 • 422 Coventry Drive, Phillipsburg NJ 08865
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RETINA SPECIALISTS OF NEW JERSEY

DIAGNOSIS, TREATMENT & SURGERY OF THE RETINA

Medical History Questionnaire Page 2

FAMILY HISTORY **(Mother, Father, Grandparents, Sibling)**

Has any member of your family had these diseases (circle all that apply)? YES NO

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable diseases:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?.....YES NO

Have you ever had a blood transfusion?.....YES NO

Do you drink alcohol?.....YES NO If YES, how much?_____

Do you smoke?.....YES NO If YES, how much?_____ How many years?_____

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Individual (Parent/Guardian) Name: _____

Authorized Individual Signature: _____

Basis of Authority (e.g., parent, guardian): _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Retina Specialists of New Jersey may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Retina Specialists of New Jersey's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Retina Specialists of New Jersey reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Retina Specialists of New Jersey, Privacy Officer at 330 South Street Suite 1, Morristown, New Jersey 07960.

With my consent, Retina Specialists of New Jersey may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, Retina Specialists of New Jersey may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Retina Specialists of New Jersey may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Retina Specialists of New Jersey restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I am consenting to Retina Specialists of New Jersey's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Retina Specialists of New Jersey may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

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RETINA SPECIALISTS OF NEW JERSEY

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SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to Retina Specialists of New Jersey and/or its providers for services furnished to me. I authorize any holder of medical information about me to release to Medicare Services or any other of my medical carriers any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of original.

***Initials*_____ *Date* _____

PRIVACY POLICY

I have been informed that Retina Specialists of New Jersey has a privacy policy in place. I understand that this policy is posted in the office. I am aware that I may receive a copy of the policy at my request.

***Initials*_____ *Date* _____

CONSENT TO RELEASE INFORMATION:

I permit you to release any medical information to the physicians involved in my care. I consent to the practice calling my home or other designated location and leaving a message on voice mail or in person in reference to appointment reminders and insurance items. In addition, the practice may mail to my home appointment reminders and patient statements.

I designate the following representative(s) who the provider can communicate with on my behalf (example, spouse, son, daughter.) If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.)

Name Relationship

Name Relationship

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR USE OF NON-PARTICIPATING PROVIDERS.

I hereby acknowledge & understand that under the terms of my insurance plan should I at any time & for whatever reason utilize the non-emergent services of any non-participating provider (including, but not limited to, doctor, laboratory, radiology & other ancillary services) I may not be covered in whole or in part for the associated costs and will bear the full financial responsibility for the costs of such services.

SIGNATURE:_____ **DATE**:_____

RETINA SPECIALISTS OF NEW JERSEY

DIAGNOSIS, TREATMENT & SURGERY OF THE RETINA

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR HMO (REFERRAL REQUIREMENT PLAN) SUBSCRIBERS.

I hereby acknowledge & understand that under the terms of my medical insurance plan, should I at any time, & for whatever reason, utilize the services of any provider without first obtaining a carrier specific referral to do so I may not be covered in whole or in part for the associated costs and will bear the full financial responsibility for the costs of such services.

SIGNATURE:_____ **DATE**: _____

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INSURANCE UPDATE

Please be advised that this office (Retina Specialists of New Jersey) and its agents make no assurances, inferences, nor guarantees regarding your insurance coverage (medical, dental, HMO, PPO, etc.). Although we may participate with an insurance carrier, it is simply impossible for this office to be aware of, or versed in, each particular plan's coverage, as there are a multitude of insurance plans and coverage options.

Our staff will do its best to provide you with the necessary information (such as diagnosis and treatment codes); however, it is incumbent upon you, the patient, to verify any insurance coverage regarding your treatment in our office. It is your insurance coverage – it is your responsibility to ascertain benefits.

Certainly our staff will make every effort to assist with insurance questions. Each plan is different and the contract negotiated by your employer may contain restrictions that others do not. You are responsible to know these restrictions. We are aware of the many frustrations of the managed care system. However, we must work within the guidelines of your insurance policy.

Thank you for your understanding.

_____ _____

Date Signature of Patient or Guardian

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Sean C. Lalin, M.D.
Clinical Faculty, New York Eye and Ear Infirmary
Diplomate, American Board of Ophthalmology

Refraction Not a Covered Benefit

Refraction is the process of measuring the eyes to determine a proper eyeglass prescription. During the course of any examination where vision quality is a complaint or is discovered to be below normal, it is necessary to determine the best corrected visual acuity. This helps to distinguish between visually damaging eye disease and the simple need for an updated eyeglass correction.

Medicare and many other insurance carriers do not pay for the service of refraction. Rules require that eye physicians performing a refraction must bill and collect payment for this service. The delivery of this service without charge and collection of the fee is regarded as fraud. Guidelines also require that refraction be billed for denial.

You will be charged **$60** for refraction. This charge is not an office policy, it is a legal mandate. Please realize that it is the insurer, not our office, who has determined that the measurement for correction of vision is a non-covered service for their insured patients.

If you do not want this part of the examination performed, please tell the nurse before the examination has begun.

Please sign below to indicate that you have read and understand this explanation of refraction charges.

_____
Print Name

_____ _____
Signature **Date**

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