NEWMAN EYE CENTER

Bruce L. Newman, M.D., P.C.

PATIENTS NAME _____ **D.O.B.** ____/____/_____ **AGE** _____ **SEX**____**MARITAL STATUS** _____

LOCAL ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

HOME PHONE (_____) _____ **SOCIAL SECURITY #** _____ - _____ - _____

EMERGENCY PHONE (_____) _____ **E MAIL** _____

SUMMER ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

SPOUSE NAME AND RESPONSIBLE PARTY _____ **ADDRESS** _____

RESP PARTY EMPLOYER _____ **EMPLOYER PHONE #** _____ **EXT** ___

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ARE YOU COVERED BY MEDICAL INSURANCE? YES _____ **NO** _____

HOW MUCH IS YOUR YEARLY DEDUCTIBLE? $ _____ **CO PAY? $** _____

HAS YOUR YEARLY DEDUCTIBLE BEEN MET? _____ **IF NOT HOW MUCH REMAINS? $** _____

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******* PLEASE ALLOW OUR STAFF TO PHOTO COPY FRONT AND BACK OF ALL INSURANCE CARDS ******

WHICH INSURANCE IS PRIMARY? _____ WHICH INSURANCE IS SECONDARY _____

NAME OF INSURED _____ SEX _____ INSURED SSN _____ - _____ - _____

RELATIONSHIP _____ DOB ____/____/____ MARITAL STATUS _____ INSURED IS THROUGH_____

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A REFRACTION IS USUALLY A NON-COVERED CHARGE. (This is done to determine your best corrected visual acuity.) The fee for this is $65.00. Payment is expected from you at time of service. If later covered by insurance carrier, we will refund allowable amount. ********** initial _____ **********

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Release and Assignment

The undersigned have insurance coverage with _____ **and assign directly Bruce L. Newman,M.D., P.C. (Newman Eye Center) all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance , unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has executed. I am responsible to pay my deductible and for co-payment and non-covered services under the terms of my insurance. I understand that any payments which are due, starting 30 days after insurance coverage has been complete, will be charged a $3.00 monthly late service charge (or) of a rate of 1.5 interest per month bases on the unpaid balance, whichever is larger. I understand that I am financially liable in the event of non-payment, I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.**

_____ _____

Signature of Insured / Guardian **Date**

I request that payment of authorized Medicare benefits be made either to me or on my behalf of Bruce L. Newman, M.D,,P. C. (Newman Eye Center) for any service furnished one by physician. I authorize my holder of medical information about me to release to HCFA and its agents needed to determine these benefits payable for related services. I understand my signature request that be made and authorized release of medical information necessary to pay claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge and patient is responsible only for deductible, co-insurance and non-covered services. Coinsurance and deductibles are due upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

NEWMAN EYE CENTER'S
BILLING POLICY

Welcome to the NEWMAN EYE CENTER. With the continued change of insurance policies, we have found it necessary to give our patients and insight into our billing policies. If at any time you have questions regarding your account, please feel free to call and alleviate any confusion and assumptions. The following are some basic rules which may apply to you depending upon the insurance coverage you have. Please remember that each patient has an individual policy and coverage may vary from plan to plan. Therefore, we may direct you to contact your insurance company to answer further questions.

REMEMBER ------- It is **YOUR** responsibility to know the particulars and coverage of **YOUR INSURANCE PLAN.**

INSURANCE: As a service to our patients and in an attempt to speed reimbursement we will do the following with respect to your primary insurance carrier.

1) We will file your insurance claims promptly.
2) We will cooperate with your insurance company to the fullest in handling questions regarding your claims.
3) We will file secondary insurance at your request. (Medicare patients secondary claims will automatically be filed for you.)
4) We will verify your insurance benefits, however this is not a gurarantee of payment by them.

In return, we expect our patients to do the following:

1) You will provide us with accurate insurance information.
2) You will assist us in contacting your insurance on any claim reaching 45 days past due.
3) As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

PREFERRED PROVIDER ORGANIZATIONS: If you have a co-pay, payment is due at time of service. If there is a deductible, we will ask for a partial payment in advance. You(the patient) are responsible to confirm the verification of your benefits and know your responsibility.

NO INSURANCE / SELF PAY: Payment is due at time of service.

Collections: We believe it is reasonable to expect payment for service within 60 days from the date of service. It is important to be involved with your insurance and the processing of your claims. It is our hope that mutual effort and understanding will result in your account being paid in a timely manner.

I have read the above policies and in the event of default understand, I will be responsible for all legal and collection cost incurred to bring my account to a zero balance.

_____ _____

Signature Date

To: **All Patients** Re: **Missed Appointments**

A missed appointment is a loss to all concerned, including patients who are in need of eye care but could not obtain an appointment.

Please notify us at least 24 hours prior to your appointment if you will need to cancel. We understand that emergencies may occur, but please be considerate and notify us so we can use that space for other patients who are in real need of care.

The usual & customary fee for missed appointment is $25.00 I have read & understand the missed appointments policy.

Patient Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____acknowledge that I have received a copy
(Name of Patient)
have received a copy of NEWMAN EYE CENTER'S "Notice of Privacy Practices". This Notice describes how NEWMAN EYE CENTER may use and disclose my protected health Information, certain restrictions on the use and disclosure of my healthcare information.

_____ _____
(Signature of Patient or Personal Representative) (Date)

_____
(Relationship to Patient)

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

Due to the HIPPA laws that are now in effect we must have your written authorization to release your medical information to a person other than yourself. Understand that your information may need to be discussed with your current physician and /or any other medical facility in regards to the scheduling of procedures, testing or surgery. Only the information needed to do this will be released. This release will be valid for one year from the date of signing.

1. Who may we release your medical information to:

A) Spouse _____ B) Sibling _____ C) Parent _____ D) Son/Daughter _____

E) Other _____ F) Doctor's Office _____ G) Insurance Co_____

2. May we send you a reminder post card? Yes No

Dilation Consent Form

As part of a complete eye examination, it may be necessary to administer eye drops that will dilate your pupils, enabling Dr. Newman to view the back of your eye in more detail. Doing so will allow us to better test for certain conditions such as cataracts, glaucoma and macular degeneration.

Side effects include blurred vision, light sensitivity and increased blood pressure. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

Usually dilation is temporary, lasting several hours. It may affect your ability to operate a vehicle, reading fine print, or operating machinery safely. To reduce the side effects of the dilation, you may be provided with temporary inserts. Sometimes only one eye will be dilated.

Most routine vision plans do not cover dilation. This is an extra $50.00 cash if it is not covered.

Please choose and sign one of the options below.

1) I <u>consent</u> to a dilated exam if necessary during today's visit.

_____ _____

Name Date

2) I <u>Do Not</u> consent to a dilated eye exam today, and will schedule another appointment.

_____ _____

Name Date

How did you hear about Newman Eye Center?

Please check one:

RECALL CARD	☐ _____
INSURANCE COMPANY	☐ _____
REFERRAL (NAME OF REFERRING DOCTOR)	☐ _____
RADIO (WHAT STATION?)	☐ _____
NEWSPAPER	☐ _____
MAGAZINE	☐ _____
WEBSITE	☐ _____
SEMINAR	☐ _____

Want to stay in touch with Newman Eye Center?

☐ CONSTANT CONTACT

☐ FACEBOOK

☐ BECOME A FAN OF NEWMANEYECENTER.COM

Patient's Name: _____

Email address: _____

Today's Date _____

TO OUR PATIENTS:

AN EYE EXAMINATION CONSISTS OF TWO SEPARATE PARTS:

1. A MEDICAL EVALUATION WHICH INVOLVES THE DETECTION AND TREATMENT OF EYE DISEASE.

2. THE REFRACTION WHICH DETERMINES WHETHER A PERSON WHO HAS NEVER WORN GLASSES REQUIRES THEM, OR IF THE EXISTING PRESCRIPTION NEEDS TO BE CHANGED.

MOST MEDICAL INSURANCE PLANS, INCLUDING MEDICARE, DO NOT COVER ROUTINE REFRACTIONS OR ROUTINE EYE EXAMINATIONS (when no medical eye problem is known or suspected.) MEDICARE ALLOWS THAT WE CHARGE SEPARATELY FOR THAT PORTION OF THE EXAMINATION, SINCE IT IS NOT A COVERED SERVICE.

A REFRACTION IS NOT A PRESCRIPTION FOR CONTACT LENSES. THERE CAN BE AN ADDITIONAL FEE FOR A CONTACT LENS FITTING FEE.

IF YOU ARE A DIABETIC OR HAVE A MEDICAL EYE CONDITION WE MAY HAVE TO RECHECK YOU ON ANOTHER VISIT FOR THE FINAL REFRACTION.

THE REFRACTION FEE FOR MEDICARE AND MOST OTHER INSURANCES WILL BE COLLECTED AT THE TIME OF SERVICE.

THE REFRACTION FEE IS **$65.00**

_____ YES, I WANT THE REFRACTION DONE TODAY

_____ NO, I DO NOT WANT THE REFRACTION DONE TODAY

_____ PATIENT SIGNATURE _____ DATE

Newman Eye Center

Laser Vision Correction, Cataract & Glaucoma

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Date of last eye exam: _____

List any medications you currently take (prescription and over-the-counter):

_____

_____

Do you have **allergies** to any medications? ☐ YES ☐ NO
If YES, please list the medications:

_____

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

_____

_____

Please list any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

_____

_____

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

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

GENERAL/CONSTITUTIONAL	YES	NO	Explanation of Problem
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia, etc.)			
ENDOCRINE (Diabetes, hyperthyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational, college degree): _____

Marital status (single, married, divorced, widowed): _____

Living arrangements: _____

Are you pregnant or nursing? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1/ day 2-3/day 4+/day

Do you smoke? ☐ YES ☐ NO If YES: occasional ½ pack/day 1 pack/day 1+pack

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

Physician's Signature: _____ Date: _____