Paul Phillips Eye and Surgery Center

6 B Minneakoning Road	64 Walmart Plaza	1 Monroe Street
Flemington, NJ 08822	Clinton, NJ 08809	Bridgewater, NJ 08807
(908) 824-7144	(908) 735-4100	(908) 526-4588

Patient Information

Name: _____ Home Phone: _____ Cell phone: _____
Last First Middle Initial

Mailing Address: _____City: _____ State: ____ ____ Zip: _____

Sex: M ◇ F ◇ Age: _____ Birthdate: ____/_____/_____ Marital status: _____ E-mail: _____

I would like to be referred to as (ex: Mrs. Smith, John, or your nickname) _____ Language: _____ SSN #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____
Name

Primary Care Provider (**PCP**): _____ PCP Phone: _____ PCP Fax: _____

Referring Provider: _____ Referring Provider Phone #: _____

Pharmacy: _____ Pharmacy address: _____
Street City, State, Zip

Ethnicity (please circle): Decline to answer; Hispanic or Latino; Not Hispanic or Latino; Unknown/Not Reported

Race (please circle): American Indian or Alaska Native; Asian; Black or African American; Decline to Answer; Multiracial; Native Hawaiian or Other Pacific Islander; Other Race; Unknown; White

How would you like to be reminded of your appointments? Phone call ◇ Text ◇ E-mail ◇

Insurance

Name and DOB for primary insurance holder:_____

Name and DOB for guarantor of minor: _____

Please list any medications you take, other than eye drops (please include over the counter, supplements, herbs):

Medication Name	Dosage	Reason

Do you have any allergies to medications or other substances (pets, food, etc.)? Yes ◇ No ◇

Allergy	Reaction

Over

When was your last eye examination? _____

Do you presently wear glasses? Yes ◇ No ◇ Bifocals? Yes ◇ No ◇ No line Bifocals? Yes ◇ No ◇

If so, please bring your glasses to your appointment.

Do you or have you ever worn contact lenses? Yes ◇ No ◇

If so, please bring your contact lens information to your appointment.

Have you ever been diagnosed with an eye disease? Yes ◇ No ◇

If so, what is your diagnosis? _____

Have you ever had eye surgery? Yes ◇ No ◇

If so, what was the nature of the surgery? _____

Do you presently take any eye medication? Yes ◇ No ◇

If so, please list: _____

Medical History

Please list all present and past medical history that pertains to you:

Surgical History

Please list all past surgeries and hospitalizations with the approximate date:

Procedure/Hospitalization	**Approximate Date**	**Complications**

Family History

Do any blood relatives have/had any of the following? (Please write an "X" where applicable)

	Relative		**Relative**
Glaucoma		Diabetes	
Cataracts		Thyroid/Graves' Disease	
Macular Degeneration		Heart Disease	

I authorize the release of any medical information necessary to process all insurance claims. I authorize the release of payment for medical benefits to Paul Phillips Eye & Surgery Center. A Notice of Privacy (Right of Patients) is available for all patients upon request.

_____ _____

Signature of patient/guardian Date

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Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

◇ I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

◇ I do not authorize the release of this information to anyone.

The release of information will remain in effect until terminated by me in writing.

Messages

Please call: ◇ my home _____ ◇ my work _____ ◇ my cell_____

If unable to reach me:

◇ You may leave a detailed message

◇ Leave a message asking me to return your call

◇ _____

Unified Chart

I understand that information contained in my NextGen chart may be shared electronically with other providers and affiliates that are involved in my care at Hunterdon Healthcare. I also understand that information contained in my NextGen chart may be available electronically to the Hunterdon Medical Center Emergency Department in the event of an emergency.

Signature: _____ **Print Name**: _____ **Date**: _____
Patient or guardian

FINANCIAL POLICY METHOD OF PAYMENT:

You can choose to pay by cash, check, credit card, or money order.

APPOINTMENT:

- It is your responsibility to verify that the physician is currently under contract with your insurance plan.
- **IF your insurance requires a referral,** it is your responsibility to obtain a referral **BEFORE** you arrive for your appointment. (Failure to confirm this may result in your responsibility for charges or reschedule)
- Please inform the receptionist of any demographic changes (name change, phone number, address, insurance information, etc.) Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.
- In the event you provide the incorrect insurance card, you will be responsible for the charges incurred.

PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED:

- Copays and co-insurance amounts, deductibles and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-out process.
- If you receive more than one type of service on the same day (contact lens evaluation, contact lens refit, Optos at your request) you may be responsible for more than one copayment.
- There is a separate fee for the **Contact Lens Evaluation** each year. A contact lens evaluation is required each year to write a prescription for contact lenses. This service is not covered by insurance. You will be required to pay at the time of service.

REFRACTION:

- Refraction is a test done to determine the prescription of your eyes, or the need for glasses and/or contact lenses.
- Refraction (CPT code 92015) is a **non-covered** service by Medicare. As a result, your healthcare provider is required by CMS (the department with the federal government that controls Medicare) to charge this service. Most other insurances (other than vision plans) follow Medicare's rules. All these plans consider refraction a "vision" service and not a "medical" service. You will be required to pay at the time of service.

CONTACT LENS EVALUATION:

- A contact lens evaluation is a separate part of a comprehensive eye examination and requires additional testing. A contact lens prescription is valid for one year. There is an additional fee which is due at the time of service.
- **Contact Lens Refit -** There is an additional fee for changing the type of contact lenses.

AUTO ACCIDENTS/WORKERS COMPENSATION:

- Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to receive payment within 30 days of the date of service may result in your responsibility to pay.
- If applicable, our office will send appropriate workers compensation forms for services rendered on your behalf. If a claim related to our services and allowable costs is determined to be uncovered by governing law, we will expect payment in full from you within 30 days of receipt of our bill following such determination, (an initial deposit payment of 25% of the amount owed is required should we agree to a longer term of repayment.)

PAST DUE ACCOUNTS:

- If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred including, but not limited to, reasonable attorney fees and costs.

COLLECTIONS AND OUTSTANDING BALANCES:

- Any outstanding balance after 90 days of date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency will be subject to a collection fee of 25% of the amount owed, which will be added to the total balance due.

RETURNED CHECKS:

- There is a $25 fee for any checks returned by the bank.

MISSED APPOINTMENT:

- There is a $25 fee for any missed appointment.

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Paul Phillips Eye & Surgery Center for professional services rendered. I understand I am financially responsible for all charges not covered by my insurance.

RELEASE OF INFORMATION: I authorize the release of any and all information necessary to process my insurance claim.

ACCEPTED AND AGREED:

Signed _____Date_____

Print Patient's Name_____Date of Birth_____

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