

The Eye Care & Surgery Center

Patient Personal Information

Name: _____
(Last name) (First name) (M.I.)

Home address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Date of Birth: _____ Social Security# _____

Employer: _____ Medical Doctor: _____

Responsible Party: _____

**** Our office is now able to e-mail your medication Rx to your pharmacy*****

Pharmacy Info: _____
(Name, Address & Phone Number)

Insurance Information

We accept Assignment for Medicare as well as private insurance companies. Please note that you are responsible for any deductibles, copays, and any non-covered services. Please check with your insurance carrier for referrals, eligibility and benefits.

PRIMARY Insurance Co.

Name: _____

Insurance Address: _____

Name of Insured: _____ Date of Birth: _____

I.D.# _____ Group # _____

S.S.# _____

SECONDARY Insurance Co. Name: _____

Insurance Address: _____

Name of Insured: _____ Date of Birth: _____

I.D.# _____ Group # _____

S.S.# _____

Payment is expected at the time of service unless you have an insurance plan whose payment comes directly to our office.

MANAGED CARE PATIENTS:

Please be sure to have a referral if your policy requires one. If you do not have a valid referral at the time of your visit you must sign a waiver acknowledging your responsibility for payment. We will allow you to have your primary physician fax a

referral with today's date of service. If our office does not receive the referral before closing, you will be responsible for payment.

MEDICARE PATIENTS:

Upon receiving your signature, it is on file for life, no further signature is necessary for submitting a claim. I authorize payment to ECSC for services rendered. I authorize the release of medical information to the healthcare financial administration to determine benefits.

ALL OTHER INSURANCE CARRIERS:

I authorize payment benefits to be paid directly to ECSC and understand that I am responsible for any balance. I authorize ECSC to release any medical information concerning benefits and payment.

*The many changes in health insurance have recently led to differences in coverage and billing for an examination. The "vision" portion of the exam known as the **refraction**, is the measurement of visual acuity and determination of the proper strength of glasses and/or contacts, has its own procedure code 92015. Contact lens services, which may include evaluation of fit and prescription, also has its own code 92310. These are considered separate from the "medical" portion of the eye exam. Many insurance companies pay for the refraction or include it in the payment of your exam no additional charge to you. **If your insurance company only pays for the "medical" portion of the eye exam (Medicare does not pay) then you will be responsible for the \$40.00 charge for the refraction of the amount of the contact lens service. If you do not wish to have a refraction, please indicate this to the staff or physician prior to your exam.***

SIGNATURE: _____ **DATE:** _____

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length Notice is available upon request.

Date of Last Revision 01-30-2008

Effective Date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we are required to make sure that your protected health information is kept private. How will we use or disclose your information? Here are a few examples (for more details please refer to the Notice of privacy Practices that follow this summary):

- For medical treatment
- For research
- To obtain payment for our services
- To avert a serious threat to health or safety
- In emergency situations
- For organ and donor situation
- For appointment and patient recall reminders
- For worker's compensation programs
- To run our Practice more efficiently and to ensure that our patients receive quality care
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to request restrictions
- The right to amend
- The right to a paper copy of this notice
- The right to an accounting of disclosures
- The right to request confidential communications

For information about these rights please see the detailed Notice of Privacy practices

592 Springfield Avenue, Westfield, N.J. 07090 (908)789-8999 · Fax (908)789-1379

10 Mountain Boulevard, Warren, N.J. 07059 (908) 754-4800 · Fax (908)754-4803

517 Route 1 South, Iselin N.J. 08830 (732) 636-7355 · Fax (732)636-7497

Website www.newjerseyvision.com

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our Office.

You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment of health care operations. We are not required to agree to this restriction, but if we do so, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This consent was signed by: _____
Signature – Patient or Representative

Print Name **Date: mo/day/year**

Relationship to patient (if other than patient): _____

In front of: _____
Printed name – Practice Representative

The Eye Care and Surgery Center

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

The practice will disclose information about patient status to persons other than the patient only in limited circumstances. The practice understands that patients often wish for family members or representatives to be able to learn information about the patient's status. As a result, the practice will disclose information about patient status to family members and others as authorized by you only in limited situation where the patient agrees, or if the patient is unable to agree, where the disclosure is determined to be in the best interest of the patient. As a general principle, if the patient is competent, the Practice will not disclose information regarding such patient unless the patient has expressly agreed to such disclosure.

Please list below the relatives or spouse that may receive information regarding your health status. This authorization may be revoked by you (the patient) at anytime.

Name	Relationship
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Name	Relationship
------	--------------

Name	Relationship
------	--------------

Name	Relationship
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Name	Relationship
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Name	Relationship
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Signature of Patient	Date
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In front of:	Printed name-Practice Representative
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PATIENT HISTORY

NAME: _____ **DATE:** _____

Reason For Visit _____

Past Ocular History:

Past Ocular Surgeries:

Current Eye Medications:

Significant Medical History:

- Alzheimers Disease
- Anemia
- Anxiety Disorder
- Arthritis
- Asthma
- BPH
- Brain Tumor
- Cancer
- Cardiovascular Disorder
- Carotid Artery Disease
- Congestive Heart Failure
- COPD
- Crohns Disease
- Dementia
- Depression
- Other _____

- Diabetes
- Type 1
- Type 2
- Dyslexia
- Gout
- Heart Attack
- Heart Disease
- Hepatitis
- Autoimmune
- Type A
- Type B
- Type C
- Herpes
- HIV/AIDS
- Hypertension

- Lupus/SLE
- Migraines
- Rhematoid Arthristis
- Rosacea Acne
- Seasonal Allergies
- Seizure Disorder
- Shingles/HZV
- Sinusitis
- Stroke/CVA
- Temporal Arteritis
- Thyroid Disease
- Graves disease
- Hyperthyroidism
- Hypothyroidism

If FEMALE, please complete the following:

Currently Pregnant YES NO
 Currently Nursing YES NO

Past Significant Surgical History:

Current Systemic Medications:

Review of Systems

Eyes:

Previous Surgery	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Contact Lens Wearer	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Pain	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Double Vision	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Glaucoma	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cataracts	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Macular Degeneration	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Dry Eyes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Flashes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Floaters	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tearing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Blurred Vision	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Ear, Nose & Throat:

Hard of Hearing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Ringing in Ears	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Vertigo	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Cardiovascular:

Chest Pain	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Dizziness	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Fainting Spells	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Shortness of Breath	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Irregular Heartbeat	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Difficulty Lying Flat	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Respiratory:

Cough	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Congestion	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Wheezing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Asthma	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Sleep Apnea	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Gastrointestinal:

Heartburn	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Nausea/Vomiting	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Jaundice	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Genito-Urinary:

Pain/Difficulty	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Blood in Urine	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Kidney Stones	YES <input type="checkbox"/>	NO <input type="checkbox"/>
History of STDs	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Psychiatric:

Anxiety	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Depression	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Mood Swings	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Sleep difficulty	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Blood/Lymphnodes:

Easy Bruising	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Gums Bleed	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Prolonged Bleeding	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Aspirin Use	YES <input type="checkbox"/>	NO <input type="checkbox"/>

MusculoSkeletal:

Stiffness	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Joint Pain/Swelling	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Skin:

Rash/Sores	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Lesions	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hives/Eczema	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Keloid History	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Neurological:

Seizures	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Weakness/Paralysis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Numbness	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tremors	YES <input type="checkbox"/>	NO <input type="checkbox"/>