

## 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:** \_\_\_\_\_

**PATIENT:**

**Date:**

PATIENT NAME	AGE	DOB	TODAY'S DATE

**REASON FOR VISIT:**

DOES YOUR CHILD	NO	YES	DETAILS
HAVE ANY ALLERGIES TO MEDICATIONS?			
TAKE ANY MEDICATIONS?			
HAS ANOTHER CHILD OF YOURS SEEN ONE OF OUR DOCTORS IN THE PAST?			

BIRTH HISTORY	NO	YES	DETAILS
WAS YOUR CHILD PREMATURE?			
ANY PROBLEMS WITH THE PREGNANCY OR DELIVERY?			
WAS YOUR CHILD ADOPTED?			

EYE HISTORY	NO	YES	DETAILS
DOES YOUR CHILD'S EYES TURN IN OR DRIFT OUT?			
DOES YOUR CHILD WEAR GLASSES NOW?			
HAS YOUR CHILD WORN GLASSES IN THE PAST?			
HAS YOUR CHILD WORN BIFOCALS?			
DO YOU PATCH YOUR CHILD'S EYE NOW?			
HAVE YOU PATCHED YOUR CHILD'S EYE IN THE PAST?			
HAS YOUR CHILD HAD EYE SURGERY?			
DOES YOUR CHILD TURN OR TILT HIS/HER HEAD?			

DOES YOUR CHILD HAVE ANY PROBLEMS WITH:	NO	YES	DETAILS
EYES (OTHER THAN LISTED ABOVE)			
DEVELOPMENTAL DELAYS?			
FEVERS? WEIGHT LOSS OR GAIN?			
EARS, NOSE OR THROAT?			
LUNGS? ASTHMA			
STOMACH / GASTROINTESTINAL?			
GENITAL, KIDNEY OR BLADDER?			
MUSCLES, BONES OR JOINTS? SKIN?			
NEUROLOGICAL? SEIZURES? ADD? ADHD? AUTISM?			
PDD? CEREBRAL PALSY?			
PSYCHIATRIC?			
ENDOCRINE?			
BLOOD OR LYMPHATIC SYSTEM?			
ALLERGIC / IMMUNOLOGIC?			
RECENT TRAUMA?			
CHROMOSOME ABNORMALITIES OR SYNDROMES?			

LIST ANY OTHER MEDICAL PROBLEM(S): \_\_\_\_\_

LIST ANY SURGICAL PROCEDURES AND DATES: \_\_\_\_\_

FAMILY HISTORY: (MOTHER, FATHER, GRANDPARENT, SIBLING)

DOES ANY FAMILY MEMBER HAVE THESE DISEASES (CIRCLE ALL THAT APPLY)?    YES    NO    UNKNOWN

AMBLYOPIA, STRABISMUS, LAZY EYE, ADVERSE REACTION TO ANESTHESIA, GLAUCOMA

ANY OTHER HERITABLE DISEASE: \_\_\_\_\_

SOCIAL HISTORY	NO	YES	DETAILS
DOES YOUR CHILD ATTEND SCHOOL?			
DOES YOUR CHILD STRUGGLE IN SCHOOL?			
DOES YOUR CHILD HAVE DIFFICULTY LEARNING?			
IS YOUR CHILD IN SPECIAL EDUCATION?			

**PHYSICIAN'S 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 01-30-2006

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 your 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 One South, Suite 1100, Iselin, N.J. 08830 (732) 636-7355

Website [www.newjerseyvision.com](http://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 under stands 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 of 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.

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Name	Relationship
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Name	Relationship
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Name	Relationship
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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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