Bellport Perspective Eye Care

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5 Bellport Ln, Bellport NY 11713

REGISTRATION FORM

(Please print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms.	Birth date: / /	Age:	Gender: ❑ M ❑ F
Street address:		Social Security #:		Marital Status (circle one): Single / Married / Other		
City:	State:	ZIP Code:		Cell Phone #: ( )		
Preferred Language: ❑ English ❑ Español	Email Address:			Home Phone #: ( )		
Referring Doctor:		Pharmacy Name:				

INSURANCE INFORMATION

(Please present to the receptionist all insurance cards when returning this form)

Name of primary insurance:	Subscriber's name:	Policy #:
Does your insurance require a referral to see a specialist? ❑ Yes ❑ No		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Policy #:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		

IN CASE OF EMERGENCY

Name (living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize St. Mar's Eye & Surgery Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PATIENT PRIVACY DIRECTIVE

In our efforts to comply with the Health Insurance Portability and Account Activity (HIPAA), we need to be certain that we guard your privacy according to your wishes. Please provide the names and phone numbers of assigned person(s) to whom we may discuss the following matters:

1. Leave messages regarding appointments, treatments, and/or test results.
2. Discuss your appointments and billing issues.

Authorized Individual (please print) *Phone number*

I ACKNOWLEDGE I HAVE SEEN A COPY OF THE "NOTICE OF PRIVACY PRACTICES" POSTED IN THE OFFICE LOBBY. _____

Initials

BELLPORT
PERSPECTIVE EYE CARE

PRACTICE POLICY

Treatment Consent

I hereby authorize and consent to treatment at Bellport Perspective Eye Care. This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis and treatment.

Authorization and Assignment

I authorize Bellport Perspective Eye Care and/or my doctor to furnish information to my insurance carriers concerning my diagnosis and treatment. If I do not make payments in full for such services, I assign to Bellport Perspective Eye Care all payments for services rendered to my dependents or me.

Medicare Claims

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Payment Guarantee

PATIENT RESPONSIBILITY – I understand that I am responsible for any amount not covered by insurance, with no exception. I agree to provide payment within 30 days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether covered by an HMO, PPO, or a traditional group health plan. I understand that Bellport Perspective Eye Care cannot bill my insurance company unless supplied with accurate and up-to-date insurance information and/or an original claim form. If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to, collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. If my account is placed with a collection agency, I understand that Bellport Perspective Eye Care may terminate availability of its services to me.

NON-PAYMENT AND ASSIGNMENT TO COLLECTION AGENCY – Bellport Perspective Eye Care offers flexible payment arrangements and would like to help settle any balances that are my responsibility in a prompt manner. If I am experiencing difficulty in paying my bill, it is my responsibility to contact the billing office to resolve my issue. Overdue patient and insurance balances may be submitted for collections activity of non-payment. I am aware that any account assigned for collection activity cannot be "removed" from collections once it has been placed with the collection agency.

CONTRACTED INSURERS – If Bellport Perspective Eye Care participates (is contracted) with my insurance plan, it will file claims as a courtesy to me. I will be responsible for:

- Co-payments
- Coinsurances
- Annual deductibles
- Non-covered services

NON-COVERED SERVICES – Insurers routinely state, "The determination of coverage is made at the time the claim is submitted." Providers often do not know if treatments will be covered until they receive the insurer's EOB (explanation of benefits). After the EOB for my submitted claim has been received at Bellport Perspective Eye Care, I will be billed for any items not covered by my insurance plans. Services may be denied for coverage because the carrier considers the services: 1)

medically unnecessary, 2) preexisting condition, or 3) cosmetic. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment.

TRANSFER OF CREDIT BALANCE – A credit balance resulting from payment to Bellport Perspective Eye Care from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

PATHOLOGY AND LABORATORY CHARGES – Final laboratory charges cannot be anticipated at the time of service and are not within our control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. I will be responsible for any amount not covered by insurance.

FEES

CO-PAY REBILLING CHARGE – Bellport Perspective Eye Care's contract with my insurer requires them to collect any co-payments in full at the time of service. If, for any reason, the correct co-pay is not collected at the time of service, a $10.00 service charge will apply for additional billing to collect the correct co-pay.

INSURANCE REBILLING CHARGE – If my insurance claim requires a second submission because of incorrect insurance policy information, there will be an additional $15.00 service charge. This charge will be the patient's responsibility. If the correct insurance information and/or patient referral is not obtained before my insurer's claim filing deadline, I will become responsible for the full cost of the visit.

REBILLING CHARGES – After the first 30 days, any outstanding charges will be subjected to an additional $5.00 charge each billing period for mailing and handling fees.

RETURNED CHECKS – A $35.00 processing fee will be charged for returned checks. Returned checks may also be forwarded to St. Mary's Eye & Surgery Center's collection agency for further action.

APPOINTMENT CANCELLATION OR "NO SHOW" – As a courtesy, the office has an automated appointment reminder system that calls 2 days before and a day before to verify my appointment. This provides adequate time to cancel or change my appointment if needed. Twenty four hour notice is required to avoid the $25.00 late cancellation or no-show charge. This charge is not billable to any insurance carrier.

Medication Refills

Patients are given enough medication to sustain them until their next visit. A follow-up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given.

No Insurance Card

If I arrive without my insurance card for my first visit, I will be charged the standard commercial fee. Bellport Perspective Eye Care is not able to provide an insurance discount or contracted fee without that card and supporting identification. No refunds or insurance discounts will be provided after the fact. Refund of the full amount patient paid is done only after the insurance pays.

A copy of this authorization shall be valid as the original.

_____ / / _____

Print name of patient/legal representative Date

_____

Signature of patient/legal representative

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

1. List the medications you currently take:

_____

2. Do you have allergies to any medications? YES NO
If YES, list the medications:

_____

3. List all major illnesses:

_____

Ex. glaucoma, diabetes, high blood pressure, heart attack, etc., or injuries (concussion, etc.)

4. List any surgeries you had. Ex. cataract, appendectomy:

_____

5. Do you currently have any problems in the following areas? If yes, please circle it.

EYES – poor vision, eye pain, tearing, redness, etc.

GENERAL / CONSITITUTIONAL – fever, heat stroke, weight loss, weight gain, unusually tired, etc.

EARS, NOSE, THROAT – hard of hearing, stuffy nose, earache, cough, dry mouth, etc.

CARDIOVASCULAR – high BP, racing pulse, etc.

RESPIRATORY – congestion, wheezing, shortness of breath, etc.

GASTROINTESTINAL – upset stomach, diarrhea, constipation, hernia, ulcers, etc.

GENITAL, KIDNEY, BLADDER – painful urination, frequent urination, impotence, yellow jaundice, etc.

FEMALES – are you pregnant? Nursing? **YES/ NO** **YES / NO**

MUSCLES, BONES, JOINTS – join pain, stiffness, swelling, cramps, arthritis, etc.

SKIN – pimples, warts, growths, rash, etc.

NEUROLOGICAL – numbness, headache, migraine, 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.

FAMILY HISTORY

Has any member of your family had these diseases? YES NO UNKNOWN

If YES, please check the following:

DIEASES	MOTHER	FATHER	GRANDPARENTS	SIBLINGS
Blindness				
Cataract				
Glaucoma				
Diabetes				
Hypertension				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				

6. SOCIAL HISTORY

Does your vision limit any activities of daily living? Please Check.

	YES	NO
Driving		
Reading		
Sports		
Work		

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? _____