BRANCHBURG EYE PHYSICIANS

Date:_____

Title: Mr.____ Mrs:____ Ms:____ Dr:____ Full Name:_____

Date of Birth:_____ Sex: Male____ Female____ SS#_____

Address:_____ Apt#_____

City:_____ State:_____ Zip code:_____

Phone #:_____ Cell #:_____

E-Mail Address:_____ May we email? Yes___ No___

Emergency Contact:_____ Phone #:_____

Relationship to Patient:_____

Patient's Employer_____ Occupation:_____

Work Address:_____

Work #:_____

Preferred Pharmacy:_____ Zip code:_____

Primary Insurance:_____Secondary Insurance:_____

Do you have a Vision Plan?: Yes____ No____ Vision Carrier:_____

Medical Doctor's Name:_____ Phone #:_____

I herby assign or transfer payment benefits made to me or on my behalf to **BRANCHBURG EYE PHYSICIANS, P.A.** for any services furnished by this physician/supplier. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage for which my insurance has paid me.

I hereby authorize **BRANCHBURG EYE PHYSICIANS, P.A.** to release information acquired during my examination or treatment to my referring physician or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Health Care Financing administration and its agents any information needed to determine benefits payable for related charges.

Patient or Guardian Signature:_____ Date:_____

PATIENT HISTORY RECORD

Name:_____ Date:_____

Any problems with your eyes/vision?_____

_____

Date of your last eye exam:_____

Do you wear eyeglasses for distance?:_____ Do you wear eyeglasses for reading?:_____

Do you wear contact lenses?:_____ Hard:_____ Soft:_____ Type, if known:_____

Have you ever been treated for an eye condition in the past? (Infections, Accidents) Y / N

Explain:_____

Is there any family history of eye diseases? (Glaucoma, Retinal Disease, Blindness) Y / N

Explain:_____

List all current and past medical conditions:_____

_____

List all hospitalizations and surgeries:_____

List all current medications:_____

_____

List any food or drug allergies:_____

Please check off all information pertaining to your medical history and explain in space:

- ☐ Chronic fever, Unexpected Weigh Loss/Gain Explain:_____
- ☐ Ear/Nose/Throat Problems (Hearing Loss, Sinus) Explain:_____
- ☐ Heart Problems (Chest pain, Irregular Heartbeat) Explain:_____
- ☐ Respiratory Problems (Shortness of Breath, Cough) Explain:_____
- ☐ Gastrointestinal (Heartburn, Abdominal pain) Explain:_____
- ☐ Urinary Problems (Pain, Discomfort, Blood in Urine) Explain:_____
- ☐ Skin Problems (Rashes, Dryness) Explain:_____
- ☐ Musculoskeletal Problems (Aches, Joint Pain) Explain:_____
- ☐ Neurological Problems (Numbness, Headaches) Explain:_____
- ☐ Psychiatric Problems (Depression, Anxiety) Explain:_____
- ☐ Thyroid ☐ Hypo ☐ Hyper Explain:_____
- ☐ Diabetes ☐ Type I ☐ Type II How long?_____
- ☐ HIV/AIDS

Flu Vaccine? Y / N Pneumonia Vaccine? Y / N

Do you smoke? Y / N How much?_____ Do you drink? Y / N How much?_____

Branchburg Eye, Physicians, P.A.
Kenette Sohmer, M.D.
3461 Rt.22 Branchburg, NJ 08876
Phone: (908) 526-5424
Fax: (908) 707-8054

Assignment of Benefits, Financial Agreement & Financial Policy

REFRACTIONS: A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contacts. A refraction is NOT a service covered by Medicare or most medical insurance plans. These plans consider a refraction a "vision service" not a "medical service." Our office fee for a refraction is $70.00. This service is typically done on all annual exams, before cataract surgery and if there is a significant decrease in your vision. **If you do not have the refraction on the day of your exam, you will not be able to receive your current eyeglass prescription.**

ROUTINE AND MEDICAL EYE EXAMS: Our office contracts with certain vision plans for routine eye exams. Routine eye exams are considered a "regular checkup" with no medical complaints other than a change with your vision. If the doctor detects any medical conditions, (dry eyes, floaters, itchy eyes, red eyes, etc.) that exam will then become a medical examination and will be submitted to your medical insurance. You will then have to reschedule your routine visit. Due to insurance company regulations, routine and medical exams may not be permitted on the same day.

INSURANCE COVERAGE: It is YOUR responsibility to provide our office with accurate insurance information. It is also YOUR responsibility to know whether your visit with us is covered by your insurance plan. If you notify us of different coverage after your exam, we will gladly provide you with an itemized statement to submit to your insurance company for reimbursement.

ASSIGNMENT OF BENEFITS: For the insurance plans we participate in, you will receive an explanation of benefits (EOB) from your insurance carrier. It simply explains your benefits, services covered, your responsibility and payments made on your behalf. In some cases, there may be a remaining balance on your account. You will be responsible for the remaining balance or any non-covered service(s).

CONTACT LENS EXAMS: Examinations for eyeglasses and contact lenses are separate exams. If you require both exams on your visit you will be charged a fee for your contact lens evaluation. The cost of the contact lens exam is payable at the time of service. Our office fee for this exam is $90.00. You may have a vision plan which covers the contact lens exam fee, but it is then deducted from your materials benefit (for glasses or contact lenses). Also, if you decide to use your material

benefit elsewhere, your contact lens exam will NOT be covered. To avoid confusion and future billing issues, it is our office policy to accept payment for the contact lens exam at the time of your visit so you can apply your material benefit to glasses and/or contact lenses.

PATIENT NO-SHOW/CANCELLATION POLICY/LATE POLICY: We make every attempt to see our patients at the time of their scheduled appointment. We require 24-hour notice if an appointment must be cancelled. In the event you wake up ill or have an emergency, if you call to cancel your appointment you will not be charged a no-show fee. The offices no-show fee is $35.00. Lastly, if you are more than 15 minutes late for your appointment you will be asked to reschedule.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient at Branchburg Eye Physicians, I will pay my account at the time services are rendered or will make financial agreements satisfactory to Branchburg Eye Physicians for payment.

PATIENT DUES: We gladly accept checks, FSA, Apple Pay, and all other credit cards. Insurance copayments, deductibles, and co-insurance will be collected at the time of service if real time eligibility and cost estimation are available from your insurance company. If we do not participate in your insurance plan, you are to provide payment in full at the time of the service. We shall provide you with receipt for the amounts paid which you may submit to your insurer. The insurer is then responsible for reimbursing you.

MEDICAL RECORDS: If you request copies of your medical records from our office, a charge of $1.00/per page will be charged. Under HIPAA regulations, healthcare providers generally have 30 calendar days to respond to a patient's request for access to their medical records.

REFERRALS: Our office is always happy to serve you. If you need a written referral from your primary care physician, please have it available at the time of service (TOS). If you do not have the insurance referral in-hand, we require payment in-full at TOS. Our staff will then provide you with a receipt you can submit for reimbursement; however, without required referrals, they may not reimburse you.

NOTICE OF PRIVACY PRACTICES: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. HIPAA provides you, the patient, with significant rights to understand and control how your health insurance information is being used. Additionally, HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, Branchburg Eye Physicians has prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information. Branchburg Eye Physicians may use and disclose your medical records only for each of the following purposes: **Treatment**: providing, coordination, or managing health care or related services by one or more healthcare providers. An example would include a physical examination. **Payment**: such activities as obtaining reimbursement for services confirming coverage, billing, collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment**. Healthcare Options**: includes the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, and cost-management analysis and customer service. An example would be an internal quality assessment review. Branchburg Eye Physicians may create and distribute de-identified health information by removing references to individually identifiable information. Branchburg Eye Physicians reserves the right to change the terms of our Notice of Privacy Procedure and make the new notice provisions effective for all protected health information we maintain. Branchburg Eye Physicians will post, and you may request a written copy of the Notice of Privacy Practices form. You have resources if you feel your privacy protections have been violated. You have the right to file a written complaint to Branchburg Eye Physicians or to the U.S. Department of Health and Human Services.

CONSENT TO RELEASE INFORMATION: I acknowledge that by signing this form, I permit Branchburg Eye Physicians to release any information to the physician(s) involved in my care. I consent that Branchburg Eye Physicians may call my house or designated locations and leave a message or voicemail or in person in reference to my appointment reminders and insurance items. In addition, Branchburg Eye Physicians may mail my home appointment reminders and patient statements.

I designate the following representative(s) as being legally authorized to communicate with Branchburg Eye Physicians on my behalf. If you do not designate anyone below, Branchburg Eye Physicians will not be able to speak with anyone besides the patient regarding your medical condition.

I acknowledge and give my consent to Branchburg Eye Physicians to use the standard of care images taken of my eyes. These images will be used for submission to a 3rd party imaging vendor for certification purposes only. All personal identifiers will be removed prior to images being used.

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Signing this form acknowledges that you have read our policy, accept full financial responsibility for payment and give us permission to bill your claim electronically and/or by mail.

_____	_____	_____
Patient or Responsible Party	**Signature**	**Date**