

OPHTHALMOLOGY ASSOCIATES OF BAY RIDGE

PATIENT INFORMATION

Primary Doctor: _____ Referring Doctor: _____

Referring Doctor Address and Phone: _____

Last Name: _____ First Name: _____ MI: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M F

Marital Status: Single Married Divorced Legally Separated Widowed

Student Status: Full time Part time Not a Student Email address: _____

Occupation: _____ Spouse's Name and DOB: _____

Parents' or Legal Guardian's Names and DOB (if dependent): _____

Name of person to notify in case of emergency: _____

Relationship: _____ Phone: _____ Allergies: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

Address of Insurance Company: _____

Insurance #: _____ Group/Policy #: _____

Insured's Name (if different than patient): _____ Insured's Date of Birth: _____

Insured's SS #: _____ Pharmacy Name/Address: _____

Subscriber relationship to patient: Self Spouse Parent Other _____

SECONDARY INSURANCE COMPANY: _____

Address of Insurance Company: _____

Insurance #: _____ Group/Policy #: _____

Insured's Name (if different than patient): _____ Insured's Date of Birth: _____

Insured's SS#: _____

Subscriber relationship to patient: Self Spouse Parent Other _____

Insured Employer Name: _____ Occupation: _____

Insured Employer Address: _____

I hereby authorize and request my insurance company to pay directly to the doctor the amount(s) due on my claim of service(s) rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

Patient Signature: _____ Date: _____

Insured's Signature: _____ Date: _____

Name: _____ Age: _____ Today's Date: _____

Name of your **Family Physician**: _____ Date of Last Visit: _____

Do you have: **Diabetes**? Yes No, For How Long: _____ Name of Medications: _____

High Blood Pressure? Yes No, For How Long: _____ Name of Medications: _____

Thyroid problems? Yes No, For How Long: _____ Name of Medications: _____

Glaucoma? Yes No, For How Long: _____ Name of Medications: _____

Do you have **any other medical conditions**? Yes No For How Long: _____

Name of Medical condition: _____

Name of Medications you take for it: _____

Have you ever had a: **Stroke**? Yes No When: _____

: **Heart Attack**? Yes No When: _____

: **Cancer**? Yes No What type: _____ When: _____

Did you need **Surgery**? _____ **Radiation**? _____ **Chemotherapy**? _____

Is there a family history of: **Glaucoma**? Yes No Whom: _____

Cataracts? Yes No Whom: _____

Crossed Eyes? Yes No Whom: _____

Retinal Disorders? Yes No Whom: _____

Have you ever had an **eye injury**? Yes No When: _____

Explain: _____

Have you ever had an **eye operation**? Yes No When: _____

Type: _____ Doctor: _____

Do you take any other **eye drops**? Type: _____

Have you ever been diagnosed with: a **Lazy eye**? _____ **Crossed eyes**? _____

Cataracts? _____ **Retinal Disorders**? _____ **Any other Eye Diseases**? _____

Are you **allergic** to any medicines? Yes No To what? _____

Do you **smoke** cigarettes? Yes No Packs per day? 1 2 3

Do you see black **floating spots**? Yes No In which eye? Right Left Both

Do you see **flashes** of light? Yes No In which eye? Right Left Both

Do you wear: **Distance** glasses? _____ **Reading** glasses? _____ **Bifocals**? _____

Contact lenses? _____ : Daily wear _____ Extended wear _____ Disposable _____

What **problems** are you having with your eyes:

Name of your medical **insurance company**: _____

Who should we contact in case of a medical emergency: _____ phone: _____

Relationship: _____

Whom may we thank for this kind referral? _____

For our women patients: Are you **pregnant**? Yes No Are you **nursing**? Yes No

DO YOU WANT TO BE CHECKED FOR A NEW EYE GLASS PRESCRIPTION TODAY?

If you do, we must perform a **REFRACTION**, for which we charge a nominal fee of **\$25**. Refraction is the procedure that a trained Ophthalmic professional performs **to determine a person's exact eye glass prescription.**

Aetna, ElderPlan, HealthNet, HealthPlus, HIP, MagnaCare and United HealthCare **WILL** pay eye care professionals for this service and therefore, there will be NO bill for patients with this insurance.

AmeriChoice, BlueCross/Blue Shield, Cigna and Oxford will **SOMETIMES** pay eye care professionals for this service and therefore, we will bill the insurance company first. If they do send us a payment, there will be NO bill sent to you. If they refuse to pay for this service, then a bill for \$25 will be sent to you.

Medicare, AARP, 1199 National, AmeriGroup, Empire Plan, GHI and HealthFirst say this service is the patient's responsibility and they will **NOT** pay for this service. **For patients with these insurance plans, there will be a \$25 refraction charge due on the day of your visit, if this service is performed.**

The refraction service and charge are completely separate from your medical eye examination. Your insurance company **WILL** pay us for the eye examination.

PLEASE indicate if you want our Technician to refract you today to determine your new eye glass prescription.

YES, I ***AGREE*** to have a refraction today: _____

NO, I choose ***NOT*** to have a refraction today: _____

Patient, parent or guardian's signature: _____

Relation to patient: _____

Date: _____

Dear Patient:

Ophthalmology Associates of Bay Ridge ("OABR") respects the privacy of your health information.

In order to provide you with quality health care, we may try to call you on the phone before or after your visit, as well as speak with you in person, while you are here. Sometimes, these face to face conversations may occur when a member of your family, a friend or another escort is with you. Sometimes you may not be home when we call and we will want to either leave a message for you to call us back or we may want to speak with someone else.

The purpose of this notice is to **give you the opportunity to let us know about any restrictions you want us to follow in our communicating with you as part of our providing you with health care.** *Please check the appropriate boxes below* (and provide us with specific guidance as to how to communicate with you privately, if appropriate):

No restrictions:

_____ OABR staff can speak with me in the presence of my family member(s), friend(s) or other individual(s) who accompany me.

_____ OABR staff may leave messages for me or speak with someone else at the phone number(s) I have provided if I am not available to come to the phone myself.

Restictions:

_____ When I am in the doctor's office, please speak to me about my care **ONLY** when my family member(s) or other escort(s) **CANNOT** overhear the conversation.

_____ OABR staff may **NOT** leave call back messages for me at the number(s) I have provided.

_____ OABR staff may **NOT** speak with anyone else at the phone number(s) I have provided.

_____ OABR staff may speak **ONLY** with the following person(s) regarding my care:

Name/Relationship _____ Name/Relationship _____

_____ Other comments or requests regarding the privacy of my health information:

_____.

patient signature

date

OPHTHALMOLOGY ASSOCIATES OF BAY RIDGE, P.C.

PRIVACY NOTICE SUMMARY

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

WE ARE LEGALLY OBLIGATED TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION, TO PROVIDE THIS NOTICE OF PRIVACY PRACTICES AND TO ABIDE BY THE TERMS OF THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES. THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003. YOU CAN REVIEW THE FULL VERSION OF THIS NOTICE BY ASKING THE RECEPTIONIST FOR A COPY OF IT.

- 1. Protected health information (“PHI”) is information relating to your health status or treatment as well as information relating to your health insurance, billing or payment for your health care.**
- 2. We will only use or disclose your PHI for purposes of our treating you, verifying your insurance, billing your insurance company, processing payments from that insurance company or in our performance of other necessary business functions. We will only use or disclose the minimum information necessary in order to accomplish the intended purpose. We will not use nor disclose you PHI for any other reason without your specific authorization to do so.**
- 3. You have the right to inspect and receive a copy of your PHI, for as long as we maintain it.**
- 4. You have the right to request restrictions on how we use or disclose your PHI.**
- 5. You have the right to request that we amend your PHI, if you believe that it is inaccurate.**
- 6. You have the right to request that we communicate with you by non-routine means or at an alternative location.**
- 7. If we even ask you to authorize us to use your PHI for any reason other than treatment, insurance verification, billing payment or other necessary business functions and you give that authorization, you have the right to revoke that authorization at a later date, as well as to receive an accounting of any disclosures or uses we have made, pursuant to your authorization.**
- 8. Any questions or complaints you may have regarding this notice or our privacy practices should be addressed to Dr. Stephen Conrad, who can be reached at: 718-680-1500.**

I HAVE RECEIVED A COPY OF THIS PRIVACY NOTICE:

patient signature

date