

LEHIGH EYE SPECIALISTS
MR#

_____ **2012**

DR./MR./MRS./MS.

LAST NAME FIRST NAME M.I.

ADDRESS _____

PHONE _____ CELL PHONE _____

BIRTHDATE ____/____/____ AGE _____ SEX _____ M _____ F

SOCIAL SECURITY _____ - _____ - _____ MARITAL STATUS ___ S ___ M ___ D ___ W

OCCUPATION _____ WORK PHONE _____

POLICY HOLDER'S NAME _____

(IF OTHER THAN YOURSELF) BIRTHDATE ____/____/____

SPOUSE'S NAME _____ SPOUSE'S BIRTHDATE ____/____/____

RESPONSIBLE PARTY

GUARANTOR/PARENT _____

EMERGENCY CONTACT _____

PHONE NUMBER _____ CELL PHONE _____

Referring Physician _____ PHONE _____

Family Physician _____ PHONE _____

Eye Physician _____ PHONE _____

Cardiologist _____ PHONE _____

Endocrinologist _____ PHONE _____

COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Lehigh Eye Specialists to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. Lehigh Eye Specialists has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: Lehigh Eye Specialists
1251 S. Cedar Crest Blvd., Suite 307
Allentown, PA 18103
Attention: Privacy Officer

Telephone: 610-820-6320
Facsimile: 610-820-8376

Acknowledgement and Consent

Print or type all information except signature.

I have received the Notice of Privacy Practices for Lehigh Eye Specialists and authorize them to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

Signature of patient (or patient's personal representative)

Date

Personal representative information (if applicable):

Name of personal representative

Relationship to patient (or other authority)

COMMUNICATION CONSENT

It is the office policy of Lehigh Eye Specialists and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Information will not be left with an unauthorized person who may answer the telephone.

I authorize Lehigh Eye Specialists and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone _____	_____yes	_____no
Answering Machine _____	_____yes	_____no
Work Telephone _____	_____yes	_____no
Voice Mail _____	_____yes	_____no
Cell Phone and/or Voice Mail _____	_____yes	_____no
Fax medical records for referrals to another entity _____	_____yes	_____no

If you would like to have information released to someone other than yourself please complete the following:

Please list names of authorized people:

Spouse: _____ yes _____ no

Parent: _____ yes _____ no

Other names (please list relationship such as
boyfriend, fiancé, girlfriend, sister, etc.) _____ yes _____ no

Printed Name _____

Patient/Guardian Signature: _____

Date: _____

Patient's Name: _____ D.O.B.: _____

Pharmacy Name & Address:

Phone: _____

CHECK BOX IF YOU ARE **NOT** TAKING ANY MEDICATIONS

Medication	Dosage	Times Per Day

CHECK BOX IF YOU HAVE NO KNOWN DRUG ALLERGIES

Please List **ALL** Drug Allergies

For Office Use Only

Technician: _____

M.D.: _____

Date: _____

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality of care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial responsibility rests with you.

Payment for all services provided by our practice is due at the time services are rendered. Exclusions to this policy are made for patients who are covered by an insurance company/organization with which we have a participating agreement. Our office does participate with most major insurance plans. If we do not participate with your insurance plan, we will not submit your claim and you will be responsible for payment in full. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral from your primary care physician in order for your visit to be covered under your medical insurance. If you do not have a valid referral, we reserve the right to reschedule your appointment. In accordance with your insurance contract, you must be prepared to pay your co-payment, deductible or any non-covered services at the time of your visit.

We accept cash, checks and Visa, Master Card and Discover. A banking fee will be applied for any checks returned for insufficient funds. If you do have a check returned, you will be expected to use another form of payment at your next visit.

Patients will receive a statement itemizing the services rendered for any unpaid balances, which may result after billing your insurance company. We appreciate prompt payment in full for any outstanding balance. If you are unable to pay the balance in full, please notify our billing department immediately and we will try to work out a payment arrangement with you.

Lehigh Eye Specialists reserves the right to turn a patient's account over to a collection agency if it is deemed that the account has been in default of payment obligations or compliance of this policy.

Please sign below to acknowledge that you have read and understand the above financial policy.

Printed name of patient

Date

Signature of Patient/Guardian/Parent

Date

LIFETIME INSURANCE AUTHORIZATION

MEDICARE LIFETIME SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished to me by Lehigh Eye Specialists. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA- 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature _____ Date _____

PRIMARY/SECONDARY INSURANCE:

I request that payment of authorized Medigap/Private Insurance benefits be made on my behalf to Lehigh Eye Specialists for any services furnished to me. I authorize any holder or medical information about me to release to my Medigap/Private insurer any information needed to determine these benefits payable for related services. The patient is responsible for the deductible, coinsurance, and non-covered services.

Patient's Signature _____ Date _____

PAYMENT AGREEMENT

It is the policy of Lehigh Eye Specialists that charges for services rendered by our physicians and staff be paid for at the time of service unless other formal arrangements have been made with our business office.

Arrangements for monthly payments may be made with our business staff. A minimum payment is required each month to keep an account active. You are responsible for making the monthly payment whether or not a statement has been sent to you. Any patient account which becomes delinquent (payment not made within 30 days of the last payment), will begin to be processed in the collection department, and the complete balance will become due immediately.

I agree to the above financial agreement for any services provided to me by Lehigh Eye Specialists.

_____ Date _____
Responsible Party Signature

Name: _____ D.O.B. _____

Briefly describe the problem(s) that you are having (i.e. the reason for your visit):

Do **YOU** have the following? Please circle **YES** or **NO**:

Weight Loss / Gain	YES	NO
Hearing Loss	YES	NO
Chest Pain	YES	NO
Shortness of Breath	YES	NO
Stomach Problems	YES	NO
Urinary / Kidney Problems	YES	NO
Joint Pain / Stiffness	YES	NO
Skin Rashes	YES	NO
Headaches	YES	NO
Anxiety / Depression	YES	NO
Thyroid Problems	YES	NO
Bleeding	YES	NO
Hay Fever / Seasonal Allergies	YES	NO
Diabetes	YES	NO
High Blood Pressure	YES	NO
Heart Disease	YES	NO
Stroke (or history of)	YES	NO
Cancer (or history of)	YES	NO
High Cholesterol	YES	NO
Do You Drive?	YES	NO
Do You Drink Alcohol?	YES	NO
Do You Smoke?	YES	NO
Have You Ever Smoked?	YES	NO

Please **CIRCLE** the following conditions that apply to **FAMILY** members (i.e. blood relatives.)

Diabetes	Heart Disease	Stroke	Cancer
Blindness	Retinal Detachment	Glaucoma	Macular Degeneration

For Office Use Only

Reviewed by: Technician _____ MD _____ Date _____