Druger Eye Care

PATIENT INFORMATION

Today's Date: _____ SS # _____

Name: First _____ M.I. _____ Last _____

Address: _____ D.O.B. _____

City: _____ State: _____ Zip: _____

Sex: M or F Legal Status: Annulled Divorced DomesticPartner LegallySeparated Married Single Widowed

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Family Doctor: _____ Pharmacy: _____ Location: _____

Occupation: _____ Employer: _____

Language Preference: _____ Need Interpreter? Type? _____

Emergency Contact: _____ Contact Number: _____
Relationship: _____

How did you hear about our office? (please circle) Insurance Friend Relative Phonebook Newspaper Radio Website Other Referred by Dr. _____

Primary Insurance Company: _____ ID # _____

Insured Name: _____ D.O.B. _____
Relationship to Patient: _____

Is your visit with our office accident related? _____ If yes, please explain:

_____

_____

I understand that I am responsible for all financial obligations of health services and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all billing charges, interest charges, collection costs, and reasonable legal fees.

_____

Signature of Patient or Authorized Party Date

Druger Eye Care

Signature on File, Assignment of Benefits, Financial Agreement

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Beneficiary Name (Please Print) **D.O.B.**

This form is a financial agreement that pertains to **ALL insurance companies and people without any insurance**. By having your signature on file you are giving us permission to bill your insurance directly.

Medicare, Medigap:

I request that payment of authorized Medicare benefits be made on my behalf to Druger Eye Care, for services furnished me by Druger Eye Care. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Medigap or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved forms, my signature authorizes releasing the information to the insurer or agency shown. Druger Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. I request the payment of authorized secondary insurance benefits be made on my behalf to Druger Eye Care or to me.

Release of Information:

Druger Eye Care may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to (1) Any person or corporation which is or may be liable or under contract to Druger Eye Care for reimbursement for services rendered, and (2) any health care provider for continued patient care. Druger Eye Care may also disclose on an anonymous basis any information concerning my case which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statue or regulation. A copy of this authorization may be used in place of the original.

Other Insurance:

Druger Eye Care maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office.

Non-Covered Services:

I understand that Druger Eye Care's contracts with health care service plans (HMOs, PPOs) relate only to items and services which are "covered" by the health care service plan. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by your health care service plan not to be covered.

Financial Agreement:

I agree that in return for the services provided to me or the patient by Druger Eye Care, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Druger Eye Care for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits, of any type, under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Druger Eye Care. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Druger Eye Care. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party Date

Druger Eye Care

Patient Consent For Use And Disclosure Of Protected Health Information For

Druger Eye Care, 5700 W Genesee Street Suite 112, Camillus, NY 13031

With this consent, I give you permission to contact me or my alternate representative(s) regarding personal health care information (such as appointments, test results, surgery, medications, etc.) via my home, work or cellular telephone, by postal mail, or E-mail. I authorize the office to leave a detailed message on any or all of my answering machines, voicemails, or with my alternate contact person listed below.

Alternate contact person(s) For example–family members, friends, neighbors, Health Care Proxy, etc.

1. _____ Relationship_____

   Telephone number _____

2. _____ Relationship_____

   Telephone number _____

3. _____ Relationship_____

   Telephone number _____

List other means of communicating with you if you do not agree to the above:

_____

_____

Patient Signature Date

_____

Witness Date

Medical History Questionnaire for Druger Eye Care

Today's Date _____ Patient name _____ Date of Birth _____

OCULAR HISTORY

When was your last eye exam? _____ Name of last provider _____

Do you wear glasses? YES NO How old are they? _____

Do you wear contact lenses? YES NO - If yes, SOFT HARD GAS PERMEABLE?

Have you ever had any eye surgery? _____

Are you allergic to any medications? _____

Please list any medications you are currently taking (prescription and over the counter)

_____

_____

_____

_____

Primary Medical Problems: Please circle: ALS ADHD AIDS ANEMIA ANEURYSM ANGINA ANXIETY ARTERIOSCLEROSIS ARTHRITIS ASTHMA AUTISM BRAIN INJURY BRONCHITIS COPD CANCER _____ CIRRHOSIS COLITIS CONCUSSION CROHN'S DEMENTIA DEPRESSION DIABETES DIALYSIS DOWN'S DRUG ADDICTION EMPHYSEMA EPILEPSY FIBROMYALGIA GERD GOUT GRAVES HIV HEARING LOSS HEADACHES HEART DISEASE HEPATITIS HERNIA HERPES HODGKIN'S CHOLESTEROL HYPERTENSION KIDNEY LIVER LUNG LUPUS MRSA MS MYASTHENIA GRAVIS PARKINSIN'S POLYMYALGIA RHEUMATICA PROSTATE SARCOID SEIZURES SINUS STROKE TIA THYROID TUBERCULOSIS ULCERS

Does anyone in your family have any of the above conditions? Please explain:

_____

_____

Please list any surgical procedures you have had:

_____

Do you smoke? YES NO

Do you drink alcohol? YES NO

Recreational drugs? YES NO

Education level _____

Occupation: _____

Marital Status _____