PATIENT INFORMATION

Name: ______________________ DOB: ____/____/______ Age: __________

Address: ______________________ City: ______________ ST: _____ Zip: ______

Cell Phone: ______________________ Home Phone: ______________________

SS#: ______________________ Sex: ______ Marital Status: S M W D

Email Address: ______________________ Referred By: ______________________

Primary Physician: ______________________ Primary Physician Phone #: ______________________

Pharmacy Name: ______________________ Pharmacy Phone #: ______________________

How did you hear about us: (*Please circle one*) Family Friend Doctor Mailing or: ______________

Emergency Contact Information

Name: ______________________ Relationship: ______________ Phone #: ______________

Insurance Information

Primary Insurance: ______________________ Policy Number: ______________________

Name of Policy Holder (*if different from the patient*): ______________________

Relationship to Patient: ______________________ DOB: ____/____/______ SS#: _____-____-_____

Secondary Insurance: ______________________ Policy Number: ______________________

Name of Policy Holder (*if different from the patient*): ______________________

Relationship to Patient: ______________________ DOB: ____/____/______ SS#: _____-____-_____

By my signature, I confirm that all information is accurate and correct.
I will be responsible to inform Garden State Eye Center of any an all changes in my address, phone number(s) and insurance information. Any outstanding balances such as co-insurance, non-covered services or lapse of coverage will be the patient's responsibility. Balances that are outstanding will accrue an interest charge of **1.5% per month** until paid in full. Co-payments and yearly deductibles are **due at time of visit.**

I understand that if my insurance requires referrals that it is my responsibility as the patient to obtain that referral and that a referral must be present at the time of visit. If no referral is present at time of visit that appointment will need to be rescheduled due to a non-compliance in this matter.

Patient Signature: ______________________________ Date: ______________

MEDICAL HISTORY INFORMATION

Name: ______________________________ DOB: ____/____/______ Date: ____________

What is the reason for your visit today? Are you experiencing a specific problem? ______________________

____

Do you have or have you had any of the following?

____ High Cholesterol: ____________________ ____ High Blood Pressure: ____________________

____ Heart Disease: ____________________ ____ Emphysema: ____________________

____ Thyroid Disease: ____________________ ____ Tuberculosis: ____________________

____ Arthritis: ____________________ ____ Stroke: ____________________

____ MS: ____________________ ____ HIV Positive: ____________________

____ Hepatitis: ____________________ ____ Birth Control: ____________________

____ Diabetes: ____________________ ____ Other: ____________________

Please list medications you are currently on: ______________________________

____

____

Do you have allergies to any medications? ______________________________

Are you allergic to latex: Yes or No Do you have allergies or sensitivities to anything else? ____________

Do you take eye drops for any of the following conditions?

____ Dry Eyes ____ Glaucoma

____ Allergies ____ Other: ______________________________

Have you or a member of your family been diagnosed with the following?

____ Cataract Relationship: ____________ ____ Cross Eyed Relationship: ____________

____ Glaucoma Relationship: ____________ ____ Lazy Eye Relationship: ____________

Have you ever had any serious illness or injury to your eyes? Yes or No

If yes, please describe what it was, when it occurred and specify right, left or both eyes. ____________________

____

Have you ever worn contact lenses? Yes or No

Patient Signature: ______________________________ Date: ____________

"No Show" and "Cancellation" Policy & Procedure

For Office Visits, Procedures & Surgery

At Garden State Eye Center, our goal is to provide quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients. The following policy is regarding patients who fail to keep their scheduled office visit appointment, procedure appointment or scheduled surgery appointment.

Please be courteous and call Garden State Eye Center promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $25.00 for 1st missed appointment; fee of $50.00 for 2nd missed appointment; fee of $100.00 for 3rd missed appointment.. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- Patients who fail to show for their scheduled office procedure appointment or did not notify the office within 48 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $100.00.
- Patients who fail to show for their scheduled surgery appointment, did not notify the office within 48 hours of their scheduled surgery appointment time, shall be subject to a "No Show/Cancellation" penalty of $500.00. If cancelled by the physician as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.
- These fees are not covered by insurance and is therefore the sole responsibility of the patient.

How to Cancel Your Appointment

To cancel or reschedule appointments call Garden State Eye Center at 732-363-2244. If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Patient Signature: ____ Date: ____________________

Patient Printed Name: ____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your voicemail, home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed including phone number:

Name: ______________ Relationship: ______________ Phone #: ______________

Name: ______________ Relationship: ______________ Phone #: ______________

Name: ______________ Relationship: ______________ Phone #: ______________

This consent was signed by: ______________________________
(PRINT NAME PLEASE)

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

INSURANCE BILLING AUTHORIZATION FORM

This form authorizes Garden State Eye Center to use or disclose your patient health information to bill your insurance plan. If Garden State Eye Center **PARTICIPATES** in your insurance plan, this means that we will accept the payment for the **covered** service as payment in full, less your co-payment and/or deductible. The procedure **MUST** be a covered item under your specific policy. If your insurance does not cover a specific procedure(s) under your plan, it will be necessary for you to pay for this procedure(s) separately (out of pocket).

IN NETWORK means that under your policy, we accept the insurance company's fee schedule, but you will be responsible for any and all CO-PAYS and DEDUCTIBLES.

OUT OF NETWORK means that Garden State Eye Center is not a contracted provider with your insurance plan and all services will need to be paid in full out of pocket. We will supply you with a receipt for you to submit to your insurance carrier.

It is important to read your insurance policy carefully. If you have any questions or concerns regarding your policy, please contact your insurance company directly.

All testing and procedures are to be paid in full **AT TIME OF SERVICE** unless prior arrangements are made.

***** Medicare Patients***** If the doctor advises you to have a REFRACTION performed, please be aware that this is not a covered procedure with your insurance, and you will be responsible for a payment in full at the time of service.

"I request that payment of authorized insurance benefits be made on my behalf to Garden State Eye Center for services provided me by Garden State Eye Center, its agents, and employees. I authorize any holder of medical information about me to release to The Garden State Eye Center, and/or any other insurance company including its agents and employees, any information or documentation needed to determine these benefits or the benefits payable for related services."

"I understand my signature requests that payment be made and authorizes release of medical information necessary to secure payment for the claim. If I have supplemental health insurance coverage, my signature authorizes releasing the medical information to the supplemental insurance company, its agents, and employees. This signature authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original."

BILLING YOUR INSURANCE DOES NOT GUARANTEE PAYMENT. THE AMOUNT PAID BY INSURANCE CANNOT BE GUARANTEED. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR BALANCE.

Please sign below that you have read and understand the information stated above.

Patient's Name (PRINT): ____

Patient's Signature: ____ Date: ____________________

CONTACT LENS CONSENT

A contact lens fitting is not part of a complete eye examination. These are two separate procedures and therefore will be charged per procedure. The fitting fee for contact includes the diagnostic fit, instructions, initial pair of contacts and first follow up visit. For any additional appointments there will be a fee of $25.00 collected at time of visit.

Fee Schedule:

$115.00	Fitting for current wearer of single vision standard contact lenses, new or established patient. *Patient must bring the following information: contact brand, prescription for each eye, base curve and diameter.
$135.00	Fitting for current wearer of single vision standard contact astigmatic or multifocal lenses, new or established patient. *Patient must bring the following information: contact brand, prescription for each eye, base curve and diameter.
$215.00	Fitting for first time wearer of single vision contact lenses, new or established patient.
$235.00	Fitting for first time wearer of astigmatic contact lenses, new or established patient.
$275.00	Fitting for first time wearer of multifocal contact lenses, new or established patient. *If the patient is a current wearer of astigmatic or multifocal contact lenses and has the following information; contact brand, prescription for each eye, base curve and diameter; the price of the fit is $135.00 and up depending on how difficult the fit is.

Before a prescription for contact lenses can be released the patient must pay the fitting fee.

By state law, contact lens prescriptions are valid for 1 year. Contact lens prescriptions and orders for contacts will only be dispensed to those patients whose prescription remains valid and have not surpassed the expiration date.

It is impossible to determine in advance whether or not a patient will have a successful response to contact lens wear. Certain personal, physiologic or environmental factors may adversely affect wearing time or necessitate the discontinuation of wear.

Signature of Patient/Guardian_________________________ Date__________

Patient Signature: ____ Date: ______________________

Patient Printed Name: ____

ATTN: GARDEN STATE EYE CENTER and ACCUVISION PATIENTS

It is highly recommended that you purchase your frame and lenses at

Garden State Eye Center/Accuvision

If you choose to take your prescription and get your frame and lenses made elsewhere, we will **NOT** replace or repair them under any circumstances.

We stand behind all eyeglasses we make!!!

Please print and sign below that you have read and understand the information stated above.

Printed Name: ____

Signature: ____ Date: ____________________