CONFIDENTIAL- PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name:_____First Name:_____Middle:_____Previous Name:_____

Mailing Address:_____Apt#:_____

City/State/Zip:_____

Home Phone:_____cell:_____work:_____

Please select: Preferred Number: ○ home ○ cell ○ work Email:_____

May we leave a message regarding your medical care and test results? ○Yes ○ No

Family Physician or Pediatrician:_____Date of Birth:_____Sex : ○ Male ○Female

Marital Status:_____Social Security#_____Employer_____

Emergency Contact Name:_____Phone#_____Relationship_____

Pharmacy Name / Location/Phone_____

Race: (check)__White__Hispanic__Black or African American__American Indian __Asian __ Pacific Islander__Other __Decline.

RESPONSIBLE PARTY- If the patient is a minor(under 18 years of age), the parent or guardian

Last Name:_____First Name:_____Date of Birth_____

Social Security#_____Phone#_____Relationship to patient_____

Address of Person Responsible:_____City/State/Zip_____

INS: INFO: PRIMARY MEDICAL INSURANCE SECONDARY MEDICAL INSURANCE VISION INSURANCE

Ins. Co. Name_____

Policy Holder Name:_____

Policy Holder's DOB:_____

Policy Holder's SS#:_____

Patient relationship to policy holder_____

Which of the following influence the patient to choose our office? Please note name of individual

_____Doctor Referral _____Friend/Relative___ Website___ Outside Advertisement

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS OF HEALTH SERVICES AND REIMBURSEMENT AND PAYMENT OF CLAIMS FROM MY INSURANCE COMPANY. IF FOR ANY REASONS THE ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL BILLING CHARGES, INTEREST CHARGES, COLLECTION COSTS AND REASONABLE LEGAL FEES.

SIGNED_____DATE_____

EYESIGHT MEDICAL CENTER

Name:_____ **Chart #**_____ **DOB:** _____

OPHTHALMIC HISTORY

	Pt	Fam	No	Relationship to Patient
Thyroid				
Glaucoma				
Crossed eyes				
Retinal Disorder				
Corneal				
Cataract				
Injury				
Contact Lenses				
Cardiopulmonary				
Diabetes				
High blood pressure				
Cholesterol				

SURGICAL HISTORY:_____

MEDICAL HISTORY:_____

OCULAR HISTORY: _____

PREGNANT OR NURSING? YES NO

Ever been seen by a Retinal Specialist? YES NO Dr. _____ **Date:** _____

CURRENT MEDICATIONS: NONE

ALLERGIES : NKA

PCN _____
SULFA:_____
ASA:_____
CODEINE:_____
LATEX:_____
OTHER:_____

(Office use only) GLAUCOMA MEDICATION HISTORY:

DATE:	IOP OD / OS	MEDICATION:

Reviewed by: _____

_____
Date

Patient Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____

THE ABOVE INFORMATION IS REVIEWED ON A YEARLY BASIS WITH ALL CHANGES NOTED. (3/26/13)

RK025

EyeSight Medical Center
Nicholas A. Stathopoulos, M.D.

4041 Delaware Ave., Suite 100
Tonawanda, NY 14150

CANCELLATION AND NO-SHOW POLICY

Dear Patients:

Our staff is dedicated to helping you. However, we need your assistance. Your treatment is only as effective as your willingness to attend your scheduled appointments. We reserve the time to evaluate and treat your problem and attend to your ophthalmic needs. If you cancel or no-show, not only are you hurting yourself and delaying your treatment, but you are taking up valuable time in your doctor's schedule that could have been used by another patient.

Effective February 1, 2009 if you do not show for your appointment, or fail to cancel within 24 hours of your appointment, you will be subject to a $25.00 fee to be paid prior to being seen in the future.

Sincerely,

N Stathopoulos, MD

Nicholas A. Stathopoulos, M.D.

Please sign and date below:

I have read and fully understand the cancellation and no show policy.

_____ _____
Patient/Guardian's Signature **Date**

_____ _____
Witness **Date**

EYESIGHT MEDICAL CENTER

FINANCIAL POLICY

This statement sets forth Eyesight Medical Center services, policy as to the handling of patient responsibility balances. Patients are responsible for providing Eyesight Medical Center the correct insurance information and eligibility prior to the time services are rendered. Once the insurance is billed out for the visit we cannot retract and bill another insurance.

If you are seeing Nicholas Stathopoulos, M.D. and you have a medical condition your visit will be billed to your medical insurance. (unless we are informed otherwise).

Participating Insurance Plans; Eyesight Medical Center will bill your insurance carrier timely after the date of service. Eyesight Medical Center will post all primary and secondary payments received and apply the contractual adjustments to your account. Upon resolution of all insurance balances, patient will be billed their member responsibility. Patient agrees to remit payment upon receipt. The applicable Government Agencies and insurance companies have determined that except for certain circumstances, the discounting or waiving of a patients co-pay or deductible is unlawful or in violation of their contractual agreement. Patient's assign Eyesight Medical Center the right to receive any monies from said insurances.

Non-Participating Insurance Plans: Eyesight Medical Center does not participate with all insurance plans. Your payment for services rendered is at the Customary Charge that is billed to all insurance carriers and patients applicable for the service rendered. Eyesight Medical Center will courtesy bill your insurance claim on your behalf and the patient invoice will be sent at the time the insurance claim is filed. The Guarantor or patient is responsible for this balance. **We do not participate with NY Medicaid and we can not see you if you have this insurance.**

PLEASE ALSO NOTE THAT THE REFRACTION PORTION OF EXAM (CPT Code 92015 30.00) IS NOT ALWAYS COVERED BY ALL INSURANCES AND WILL BE YOUR RESPONSIBILITY.

PRINT NAME_____**D.O.B**_____

SIGNATURE_____**DATE**_____

Disclosure of PHI: I consent to the use or disclosure of my Protected Health Information (PHI) by EyeSight Medical Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of EyeSight Medical Center.

I understand I have the right to request restrictions as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. EyeSight Medical Center is not required to agree to the restrictions that I may request.

I have the right to revoke this consent, in writing, at any time, except to the extent that EyeSight Medical Center has taken action in reliance on this consent.

My "*Protected Health Information (PHI)*" means health information, including demographic information, collected from me and created or received by EyeSight Medical Center, another health care provider, a health care plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review EyeSight Medical Center's Notice of Privacy Practices prior to signing to signing this document. The EyeSight Medical Center's Notice of Privacy Practices are posted in accessible area in the office and have been provided to me in writing. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills or in the performance of health care operations of EyeSight Medical Center. This Notice of Privacy Practices also describes my rights and EyeSight Medical Center's duties with respect to my PHI.

EyeSight Medical Center reserves the right to change the privacy practices that are described in the Notice of Privacy practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Medicare Number

Date

EyeSight Medical Center
Financial Agreement/Disclosure of Protected Health Information (PHI)
Medicare Lifetime Signature on File

Medicare Agreement: **I request that payment of authorized Medicare benefits be made on my behalf to EyeSight Medical Center for services provided me by** Dr. Nicholas A. Stathopoulos. **I authorize any holder of Protected Health Information about me to release to CMS (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable to related services.**

I understand my signature requests that payments be made and authorizes release of Protected Health Information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 forms or elsewhere on other approved claim forms, my signature authorizes the release of information to the insurer or agency shown.

EyeSight Medical Center accepts the charge determination of the Medicare carrier as the full payment. The patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

MediGap: **I understand that if a MediGap policy or other health insurance policy is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to EyeSight Medical Center.**

***Third Party Payors*:** **I understand that EyeSight Medical Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that EyeSight Medical Center has no contract, expressed or implied, with any plan that does not appear on the list. I agree that I am obligated to pay the full charges of all services rendered to me by EyeSight Medical Center if I belong to a plan that does not appear on the above-mentioned list.**

***Non-Covered Services*:** **I understand EyeSight Medical Center contracts with health insurance plans (i.e. HMO's, PPO's) which state items that are deemed to be "covered" by the health plan. Accordingly, I accept full financial responsibility for all items or services or tests, which are determined by the health plan not to be covered. I agree to cooperate with EyeSight Medical Center to obtain necessary health care insurance plan authorizations.**

Financial Agreement*:** **I agree that in return for services provided to the patient by EyeSight Medical Center I will pay my account at the time service is rendered or will make financial arrangements, which are satisfactory with EyeSight Medical Center for payment. If the account is sent to an attorney or collection agency for collection purposes, I agree to pay collection expenses and reasonable attorney's 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, is herby assigned to EyeSight Medical Center. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them.** ***However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

EYESIGHT MEDICAL CENTER
NICHOLAS A. STATHOPOULOS, M.D.
4041 DELAWARE AVE, SUITE 100
TONAWANDA, NY 14150

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Persons Authorized to Receive Information:
Health information **EyeSight Medical Center** collects or receives about you may be disclosed to the following persons:

1) Name:_____Relationship:_____
   Telephone#_____Mobile#_____

2) Name:_____ Relationship:_____
   Telephone#_____ Mobile#_____

Use and Disclosure of information:

_____I authorize the person(s) listed above to receive all health information about my appointments, treatment and/or other information pertinent to my healthcare and /or payment for my healthcare provided at EyeSight Medical Center.

_____I do **not** authorize the following information to be disclosed to any other parties except to me as the patient (please specify):_____

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to EyeSight Medical Center.

Potential for Re-disclosure
The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient_____Date of Birth_____

Signature of Patient_____Date_____