New Patient Information

Patient Name: _____ DOB: _____ SS#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____ Sex: O Male / O Female

Primary Care Physician: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Reason for Current Visit:	When did it start?

EYE HEALTH: Check all that apply

Current Issues:	Pain Level			When did it start?	Which Eye is Affected?		
	Mild	Moderate	Severe		Right	Left	Both
Blurry Vision							
Drooping Eyelid							
Eye Turn							
Foreign Body Sensation							
Headaches							
Redness							
Loss of Vision							
Burning Sensation							
Cataracts							
Dry Eyes							
Floaters							
Glaucoma							
Itching							
Retinal Detachment							
Double Vision							
Light Sensitivity							
Infection							
Tearing/ Watery Eyes							
Mucus Discharge							

FAMILY HISTORY: Check all that apply

	Family Member(s)
Cataracts	
Glaucoma	
Macular Degeneration	

Medications	Used for:

Medication Allergies	Other Allergies

GENERAL HEALTH: Check all that apply

Allergies/ Hay Fever	**Asthma/ Respiratory**	**Blood Disorders: Specify-**
Cancer	**Cardiovascular/ High BP**	**Chronic Bronchitis**
Chronic Cough	**Diabeties: Type 1 or Type 2**	**Emphysema**
Gastointestianl Problems: Specify-	**Heart Attach/ Strokes**	**Headaches/ Migranes**
Kidney Disease	**Psychiatric Depression**	**Rheumatoid Arthritis**
Thyroid/ Edocrine Disease	**Skin Disorder: Specify-**	**Pregnant/Nursing**

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to family members you must sign below. Signing below will only give information to the family members indicated below.

I authorize Eye Associates of Monroe County to release my medical, billing, and/or appointment information to the following individual(s):

1. _____ Relation to Patient:_____

2 _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

Patient Information

1. I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
2. I understand that information disclosed to any above recipient is no longer protected by federal or statelaw and may be subject to re-disclosure by the above recipient
3. I have the right to revoke this consent in writing.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations**
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice**
- **The Practice reserves the right to change the Notice of Privacy Practices**
- **The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease**
- **The Practice may condition the receipt of treatment upon execution of this Consent**
- **The patient acknowledges that he/she has received a copy of our HIPAA practices brochure**

Signature: _____ Name(printed):_____

Our Financial Policy

Authorization for Assignment of Benefits – I request that payment of authorized medical benefits be made directly to Dr. Anthony S. Diecidue, P.C. for services furnished to me by Dr. Anthony S. Diecidue, P.C. or his associates. I authorize any holder of medical information about me to release to insurer and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature authorizes releasing the information to the insurer or agency shown. Dr. Anthony S. Diecidue, P.C. or his associates accepts the charge determination of Insurance Carrier(s) as the full charge and I am responsible for any deductible, co-insurance, co-pay or non-covered services. Co-insurance/deductible are based upon the determination of the Insurance Carrier.

Patient Responsibility – Payment is due **IN FULL** when services are rendered or goods are delivered unless prior arrangements have been made. Failure to pay, returned check, or delinquent payments will result in additional charges related to collection of fees to your account up to $30.00 and/or 30% dependent on severity of delinquency.

This office will make any reasonable attempt to obtain payment from your insurance provided we have received accurate coverage information from you. You are required to disclose to us your insurance information PRIOR TO YOUR EXAMINATION. Coverage information disclosed after your examination will not be processed. If we are unable to collect payment from your insurance company, you will be held financially responsible for all remaining outstanding charges incurred at this office.

We are committed to providing you with the highest quality eye examination services. If you have insurance coverage, we are eager to help you receive your MAXIMUM allowable benefit. To achieve these goals, we need your assistance and your understanding of our policy regarding payments on patient accounts. We participate with BlueCross of NEPA, PA BlueShield, Highmark, Geisinger Health Plan, United Healthcare, Medicaid, Medicare, Aetna, Cigna, VSP, VBA, NVA, Davis Vision, Spectera, Eyemed, and most other state and commercial insurance programs. If we participate in your insurance carrier's network, they will send their payment directly to us, however, you are responsible for any non-covered services, copayments, and/or deductibles as determined by the insurance carrier.

PAYMENT FOR YOUR COPAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED. We accept cash, check, MasterCard, VISA, AMEX, Discover, Debit Cards, and Care Credit.

<u>It is important that you understand the following:</u>

1. Your insurance is a contract between you, your employer, and/or the insurance company. (We are not a party to that contract)

2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. We must emphasize that our relationship is with you, the patient, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, *all charges are ultimately your responsibility* from the date the services are rendered.

We realize that temporary financial problems may affect timely payments of your account. If such problems arise we encourage you to notify us promptly for assistance in management of your account. If you have any questions about the above information or uncertainty regarding insurance coverage, PLEASE, do not hesitate to ask us. We are here to help you.

Please sign below indicating you have read and understand the information on this page.

Signature: _____ **Date: _____**

Print Name: _____ **Relationship to Patient: _____**