NewView EYE CENTER
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Jacqueline D. Griffiths, M.D., P.C.

Patient Registration

Date___/____/_____

Name _____ _____ ___ **DOB ___/___/_____ Age____**
Last First MI

Address_____ _____ _____ _____
Street City State Zip

Phone: (Home) ____-____-_____ (Work) ____-____-_____ (Cell) ____-____-_____ SS#: ____-___-____

Employer: _____ Occupation: _____ Marital Status: S/M/D/W

Gender: M/F Emergency Contact _____ Phone _____-_____-_____

Email: _____ Referred By: _____

Do you have a Flexible Benefits Plan? **YES NO Pharmacy Name/City: _____**

(If patient is a child or COLLEGE STUDENT please complete this section)

Parent/Guardian_____ _____ ___ **DOB ___/___/_____ Age____**
Last First MI

Address_____ _____ _____ _____
Street City State Zip

Home _____-_____-_____ Work _____-_____-_____ SSN: _____-____-_____

Employer_____ Child's School or University_____

Insurance Information (Please give your insurance card to the receptionists with this form)

Primary_____ Effective Date _____/_____/_____

Address_____ Phone _____-_____-_____

ID# _____ Group/Plan _____ SSN ____-___-_____

Policy Holder's Name _____ **DOB ___/___/_____ Age____**

Employer _____

Patient's Relationship to Policy Holder: Self / Spouse / Child / Other: _____

Secondary_____ Effective Date _____/_____/_____

Address_____ Phone _____-_____-_____

ID# _____ Group/Plan _____

Policy Holder's Name _____ SSN ___-___-_____ **DOB ___/___/_____ Age____**

Employer _____

Patient's Relationship to Policy Holder: Self / Spouse / Child / Other:_____

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MEDICAL HISTORY QUESTIONNAIRE

Name_____ **Date**_____

Date of **Birth**_____ Date of **Last Eye Exam**_____
List any **Medications** you currently take (Rx and over-the-counter**):**_____
_____

Do you have **Allergies** to any medications**?** **YES** **NO**
If YES, list the medications:_____

LATEX ALLERGY: **YES** **NO** **Iodine Allergy:** **YES** **NO**

List all **Major Illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (Concussion, etc.):
_____

List any **Surgeries** you have had (cataract, appendectomy, etc.): _____

Do you ***currently*** have any problems in the following areas? If YES, provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES - Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other Heritable Disease:_____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**
Have you ever had a blood transfusion? **YES** **NO**
Do you drink alcohol? **YES** **NO** If YES, how much?_____
Do you currently smoke? **YES** **NO** If YES, how much?_____ How many years?_____
Have you ever smoked? **YES** **NO** If YES, How many years?_____

Patient's Signature_____

Physician's Signature_____ ***Date***_____

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Initials

Patient Billing Agreement

_____ 1. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is the patient's responsibility to pay any deductible, co-insurance and/or any other balance** not paid by their insurance carrier. Insurance carriers decide what it considers to be medically necessary or routine based on their own criteria. Most insurance carriers do not cover routine eye exams. Therefore we will not bill routine eye exams and patient will be responsible for payment that day. Please check your plan carefully for covered and non – covered services or benefits.

_____ 2. In order to control billing costs, we request that patients pay for all known non-covered services at the time of service. **Patients who have an insurance carrier, with which we do not participate,** are required to pay in full at the time of service.

_____ 3. **FOR MEDICARE PATIENTS ONLY:** Patients with secondary health plans must present proof of insurance on the day of service. If you do not provide proof, you will be responsible to file a claim with your secondary insurance.

Refraction Policy

_____ 1. **Refraction** is a measurement of the lens power necessary to prescribe or change your glasses and/or other corrective lenses. **Refractions** may also be done for diagnostic purposes.

_____ 2. Most medical insurance plans, including MEDICARE, **DO NOT COVER A REFRACTION FEE**. If your examination includes refraction, there will be a minimum **$80** charge **DUE THE DAY OF SERVICE** in addition to your co-payment.

Contact Lens Agreement

_____ 1. We are happy to assist you with any contact lens issues you may have. All contact lens wearers are required to sign our **Contact Lens Agreement** before services are rendered.

Financial Assignment

_____ 1. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information as needed to determine these benefits payable for related services.

_____ 2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

_____ _____

Signature of Patient, Parent or Guardian **Date**

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Patient Financial Responsibilities

It is our goal to provide you the best ophthalmic care we possibly can. Part of your care includes the billing of your services provided we've received the correct and complete information from you. **If complete information is not provided at the time of your visit, you will be responsible to pay on the day services are provided.** Please read the following information as it will answer many of your questions regarding our billing policies.

All Patients: Are expected to have their current insurance card, valid picture ID, **Co-pay**, **Deductible**, **Co-insurance** and any **Balance** that is **due at the time of service**.

HMO/Managed Care Plans: It is **your responsibility** to make sure a **current referral** has been obtained prior to your appointment with our office. If no referral has been obtained, your appointment will be rescheduled. It is the patient's responsibility to make sure the correct referral is in place, **at the time of the visit**.

Co-pays: Primary and secondary insurance co-pays must be **paid at time of check in**. Patients will be asked to re-schedule if they do not have their co-pay at the time of visit.

Late Fees & Collections: Balances greater than 30 days due will accrue a monthly 1.5% late fee. Patients with balances greater than 90 days due will be sent to Collections. **Collection fees are an additional 30% of the balance**. We do not permit patients to carry long term balances so a patient may be discharged from the practice for this reason.

No Shows Fees:

- Failure to cancel an appointment within 24 hours of appointment: **$75.00**
- Failure to cancel any surgery within 10 days of procedure: **$350.00**

Please remember a confirmation call is a courtesy done by this office and not an obligation, therefore it will not be a reason to waive a No-Show fee.

Miscellaneous Charges: There may be charges for the following request

- Rx Processing request outside of office visit
- Processing Forms i.e. DMV, employment, etc.
- Letters

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I understand that it is my responsibility to contact my insurance carrier(s) if they do not respond to payment request made on my behalf.

_____ _____

Signature (Guarantor if patient is a minor) Date

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PATIENT CONSENT FORM

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 Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Please list the names of anyone you authorize to have access to your medical records:

_____

Patient Signature_____

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient):_____

In front of _____ Date_____
Printed name – Practice representative