New York Ophthalmology, P.C.

Ophthalmology
Opthalmic Surgery
Optometry

Cornea
External Disease
Laser Vision Correction
Anterior Segment Trauma
Contact Lenses
Low Vision

Website:
www.2020-eye.com

Email:
EYESPORTS@gmail.com

Dear Patient,

**** PLEASE PRINT ON SINGLE SIDED, WHITE PAPER ****

**** PLEASE USE BLACK INK ON ALL FORMS ****

We appreciate your selection of our office for your complete eye care. Please complete the enclosed forms **using black ink only** and arrive 10 minutes early for your appointment. Bring a list of all medications, eye drops and eye glasses with you. Be prepared to spend enough time for all necessary testing, which can be up to approximately 90 minutes. At your initial visit, it is very likely that your eyes will be dilated. This means your vision will be blurry after the examination. Please **bring dark sunglasses** with you as dilation will cause your eyes to be light sensitive. You may wish to bring a driver.

Please be sure to **bring all insurance cards** and information. If your insurance carrier requires a referral or authorization from your primary care physician, you must request authorization prior to your exam and bring it with you to the visit. Your insurance company will not allow us to treat you without proper authorization.

Payment is expected at the time of the visit and may be made by cash, check or credit card.

Your appointment time is being reserved for you. If you must cancel your appointment, kindly notify us no less than 24 hours prior to your appointment so we may offer the time to another patient.

If you have any questions, please do not hesitate to contact us.

We look forward to meeting you.

333 East Shore Road • Manhasset, New York 11030 • Tel. (516) 487-4722 • Fax (516) 487-1067
360 S. Oyster Bay Road • Hicksville, New York 11081 • Tel. (516) 938-6363 • Fax (516) 938-6452

NEW YORK OPHTHALMOLOGY, P.C.

PATIENT INFORMATION

Patient's Name: _____ Marital Status: _____ Sex: _____

Date of Birth: _____ Referred by (Dr's name): _____

Social Security Number: _____

/ Parent's / Guardian Name: _____

*If Patient is a Minor:
(Under age 18) \ Parent's / Guardian's Social Security Number: _____

Patient's Home Address: _____

City / State / Zip Code: _____

Primary Tel Number: (___)_____ Alternate Tel Number: (___)_____

Email Address:_____ Patient's Occupation:_____

Name of Person Insured / Date of Birth: _____

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Secondary Policy Holder's Name / Date of Birth: _____

Policy Number: _____ Group Number: _____

I accept full financial responsibility for payment of fees charged by New York Ophthalmology, P.C., regardless of medical insurance coverage.

I understand that payment is due at the time services are rendered. If I do not remit my co-pay at the time of service, I understand that I am responsible for a billing fee of twenty dollars. I understand that I am responsible for all legal costs and a seventy five dollar administrative fee, if my account is not paid in full within 90 days after service is provided.

I understand that I need to give N.Y. Ophthalmology, P.C. no less than 24 hours notice if I need to change or cancel my appointment.

I hereby give authorization to release any information acquired in the course of my examination and treatment to my insurance company. I authorize that a photocopy of this is to be as valid as the original.

Signature of Patient or Legal Guardian: _____

Print Name: _____ Date: _____

NEW YORK OPHTHALMOLOGY, P.C.

PATIENT MEDICAL HISTORY

Please answer all of the following to the best of your knowledge: check (yes or no)

Do you (the patient) have:

	YES	NO		
1 - Diabetes	_____	_____	How long? _____	Medication _____
2 - High Blood Pressure	_____	_____	How long? _____	Medication _____
3 - Heart Disease	_____	_____	How long? _____	Medication _____
4 - Lung Disease	_____	_____	How long? _____	Medication _____
5 - Arthritis	_____	_____	How long? _____	Medication _____
6 - Cancer	_____	_____	When? _____	Type _____
7 - Glaucoma	_____	_____	How long? _____	Medication _____
8 - Cataracts	_____	_____	When diagnosed?	_____
9 - Retinal Problems	_____	_____	How long? _____	Medication _____

Please answer all of the following questions. If not applicable, write N/A:

Have you ever had surgery on your eye(s): ____yes ____no Type _____

Is there any family history of glaucoma: ____yes ____no Whom _____

*Do you have any allergies to medications: ____yes ____no (if yes, please list allergies):

_____ _____ _____ _____

Do you have any other medical conditions: ____yes ____no (if yes, please list):

_____ _____ _____ _____

What medications do you currently take: _____ _____ _____

What eye drops do you currently use: _____ _____ _____

Signature of Patient or Legal Guardian: _____

Print Name: _____ Date: _____

NEW YORK OPHTHALMOLOGY, P.C.

Pharmacy Information Sheet

Patient Name:_____

Patient's D.O.B.: _____ Patient's Gender: _____ Patient's Zip Code: _____

Pharmacy Name: _____

Address: _____

Town/State: _____

Zip Code_____

Pharmacy Phone #: _____

Mail Away Pharmacy Name:_____

Signature of Patient or Legal Guardian: _____

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NEW YORK OPHTHALMOLOGY, P.C.

REFRACTION SHEET

Dear Medicare Patient,

Under section 1862 (a)(1) of the Medicare law, some office procedures / visits done in the office which Medicare considers "not reasonable and necessary", may not be reimbursed by Medicare. However, we feel that they are a necessary part of your eye care.

Medicare does not cover refractions (the prescribing of, examination for, or check of eyeglasses). If you would like us to check your eyeglass prescription (refraction), you will be charged for this uncovered procedure. The fee for this service will be collected from you along with any copayments at the time of your visit.

1) **Yes, I wish to have a refraction today and assume responsibility for payment.**

Signature / Date	Signature / Date
_____	_____
_____	_____
_____	_____
_____	_____

2) **No, I do not wish to have a refraction (examining, prescribing, or checking my eyeglasses) on my visit today.**

Signature / Date	Signature / Date
_____	_____
_____	_____
_____	_____
_____	_____

NEW YORK OPHTHALMOLOGY, P.C.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for services furnished by New York Ophthalmology, P.C., to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient name printed:_____

Patient (or authorized person) signature: _____

Medicare Insurance Identification (ID) number: _____

Date: _____

NEW YORK OPHTHALMOLOGY, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for New York Ophthalmology, P.C. to use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (New York Ophthalmology, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I acknowledge receipt of the Notice of Privacy Practices prior to signing this consent.

New York Ophthalmology, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to New York Ophthalmology, P.C.'s Office Manager.

With this consent, New York Ophthalmology, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, New York Ophthalmology, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, New York Ophthalmology, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that New York Ophthalmology, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to New York Ophthalmology, P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, New York Ophthalmology, P.C. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name (print) Date

_____

Name of Legal Guardian (print)