Eye Care Associates of New Jersey

PATIENT INFORMATION (please fill form out completely)

Last Name First Name MI Gender

Patients Mailing Address (no PO Box) City State Zip Code

Home Phone Business Phone Cell Phone Email Address

Contact Preference: Phone Mail Email Text Message

Marital Status Date of Birth Age Social Security Number

Occupation/Retired Employer

Employer Address City State/Zip Code Phone Number

The Federal Government requests ethnicity and race information. Providing this information is voluntary.

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unkown Decline to Answer

Race: White African American American Indian/Alaskan Native Asian Native Hawaiian/Other Pacific Islander Other Race Decline to Answer

Preferred Language: ______________________________

Are you an existing patient of the practice? Yes No

New patient referred by: Another Patient Insurance Internet Dr.

Other: ______________________________

Reason for visit: Medical Exam Vision Exam Details:

____

INSURANCE INFORMATION (please give insurance cards to receptionist)

Does your plan require a referral? Yes No

Primary Insurance: ____________________ Policy Holder Name: __________

Secondary Insurance: ____________________ Policy Holder Name: __________

Third Insurance: ____________________ Policy Holder Name: __________

Separate Vision Insurance: ____________________ Policy Holder Name: __________

Spouse's Full Name	Spouse's SSN#	Spouse's DOB	Age	Cell Phone

Spouse's Employer	Spouse's Employer Address	City/State/Zip	Work Phone

IF PATIENT IS UNDER AGE 18 PLEASE COMPLETE: (person responsible for this account)

Mother's Full Name	SSN#	DOB	Phone

Mother's Employer	Work Phone	Address (if different from above)

Father's Full Name	SSN#	DOB	Phone

Father's Employer	Work Phone	Address (if different from above)

DO YOU HAVE AN ADVANCED DIRECTIVE? Yes No Type: __________

EMERGENCY CONTACT: (if unable to reach patient or to speak about eye care with you)

Name	Relationship	Phone

PHARMACY INFORMATION:

Local Pharmacy	Street Address	City/State/Zip	Phone

Mail Order Pharmacy	Street Address	City/State/Zip	Phone

Patient, Parent or Guardian Signature (if child is under 18) **Date**

Eye Care Associates
of New Jersey

FINANCIAL AND OFFICE POLICIES ASSIGNMENT OF BENEFITS

I ______________________________, have requested treatment from **Eye Care Associates of New Jersey, P.A.**

Please read and then sign in the space provided,
Should you have further question our staff will gladly assist you.

We are committed to providing you with the highest level of service and quality care. Our goal at Eye Care Associates of New Jersey, P.A., is to serve your medical needs as well as possible. We want to make billing a non issue from the start.

We require you to bring your insurance card (s) with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information would be due and payable by you.

We require that you update your address, telephone and employer and information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed acceptable if they are returned to us unclaimed, forwarding order expired or otherwise undeliverable.

In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, all financial liability rests with the patient.

We accept Cash, Personal checks, MasterCard, Visa and Discover.

PATIENTS WITH INSURANCE

It is your responsibility to provide your insurance information. Without complete insurance information, this office cannot bill for services. Proof of insurance is required at the time of service. Insurance is a contract between you and your insurance company. As a courtesy to you, we will file your claim but you are ultimately responsible for all charges regardless of what your insurance does or does not pay. Your co-pay and any deductible not satisfied will be collected at the time of service, A $25 service charge will be added to your account if your co-pay, Medicare 20% co- insurance, or refraction fee are not paid at the time of service.

MINOR/DEPENDENT CHILDREN

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth, and social security number. We request that you inform the subscriber that their insurance has been used.

PATIENTS WITHOUT INSURANCE

All charges incurred at the time of service must be paid in full at the time of each appointment. If you are unable to pay in full at the time of service, arrangements must be made in advance with the office manager.

DELINQUENT ACCOUNTS

Outstanding accounts in excess of 90 days will be forwarded to IC Systems, Inc. for collection proceedings. Should circumstances prevent you from paying your account in a timely manner prior to commencement of collection activity please contact our office to make other arrangements for payment. Patients with delinquent accounts may be permanently discharged from our practice. **Returned checks for non-sufficient funds (NSF) will incur a $30.00 NSF fee. Future payments must be made with cash, money order or credit card.**

VISION EXAM

These are examinations for diagnosis of vision problems or correction of vision prescriptions. A vision exam determines if vision can be improved with glasses or contact lenses. It is a basic screening exam, which may include refraction and dilation. These are for measurement purposes only and are not intended to diagnose or treat diseases of the eye.

MEDICAL EXAM

These are examinations for diagnosis of diseases that manifest with ocular symptoms. If glasses or contact lenses cannot improve vision, often the cause is related to an underlying medical condition. This type of exam is a detailed analysis of all parts of the eye including a dilated exam of the peripheral retina and vitreous for pathology causing loss of vision.

REFRACTION FEE

Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is NOT a covered service by most insurance plans. Our office fee for refraction is forty-five dollars ($45), is collected at the time of service, and is in addition to any co-payment.

CONTACT LENS EVALUATION

In order to ensure that the fit and your vision with contact lenses are optimal and that there are no problems developing with your eyes as a result of contact lens wear, we require an annual contact lens evaluation. **The annual fee is twenty-five dollars ($25) and is separate from any copay or refraction fee.**

I have received a copy of the privacy policies for Eye Care Associates of New Jersey, PA.

I assign all insurance benefits (including Medicare, if applicable) directly to Eye Care Associates of New Jersey, PA and authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In Medicare assigned cases, the physician, or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ________________

Patient, Parent or Guardian Signature (if child is under 18) **Date**

The above signatures / authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.

Eye Care Associates of New Jersey

Patient Name ______________________________

REFRACTION

Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is **NOT** a covered service by most insurance plans.

Do you want an eyeglasses and / or contact lens prescription today? Yes No

Do you want a copy of your eyeglasses and / or contact lens prescription today? Yes No

Do you want to change the lens and / or frame of your prescription today? Yes No

If you answered **YES** to any of the above questions, you need a refraction. **Our office fee for refraction is forty-five dollars ($45),** is collected at the time of service, and is in addition to any co-payment.

______________________________ ______________

Patient Signature **Date**

One Broadway | Suite 404 Elwood Park | NJ 07407
(201) 797-5100 | Fax: (201) 797-4160 | www.eyenj.com | facebook.com/eyenj