Patient Information

Date:_____

Last Name_____First Name:_____M.I. _____

Street Address_____Town_____Zip_____

Telephone:Home_____Work_____Cell_____

Is it ok to leave a message? ☐ No ☐ Yes: Home Cell Work (circle)

Birthdate_____/____/_____ ____Male ____Female Social Security Number: _____

- **Ethnicity: Check one**: ____Hispanic/Latino ____Not Hispanic/Latino
- **Race: Check One**: ____ American Indian/Alaska Native ____Asian ____Black/African American ____Native Hawaiian or Pacific Islander ____White
- **Preferred Language**: ____English ____Spanish ___French ____Other: _____

Email _____ Do you want to access the patient portal? Yes ____ No ____

Employer_____Employer's Address_____

Emergency Contact_____
Tele_____Relationship_____

Spouse or Parent/Guardian Information (if patient is a minor)
Last Name_____First Name:_____M.I. _____

Street Address_____Town_____Zip_____

Telephone: Home_____Work_____Cell_____

Birthdate_____/____/_____ ____Male ____Female Social Security Number:_____

Employer_____ Employer's Address_____

Release of Medical Information

May we discuss your medical information with the people listed above? Yes_____ No_____

Name of Medical Doctor?_____May we discuss your medical information with him/her? Yes____ No____

Is there anyone else you would like to authorize to access your medical information? If yes, list names and relationships:

_____

Please check and tell us how you heard of us so that we may thank them.

__Dr or Optometrist Name_____ __Friend/Family Name _____

__DKH Diabetes Clinic __Internet __Diabetic Seminar __Insurance Co. or Listing

__Turnpike Buyer/Shoppers Guide __ Senior Center __Senior Publication __Telephone Book

__ Other _____

*** PLEASE TURN OVER AND CONTINUE ON THE OTHER SIDE***

Office Policies

- It is the goal of Eye Care Northeast to provide excellent service and high quality vision care to meet our patient's ocular needs.
- I understand that the service of checking my vision for glasses or contact lenses, called Refraction, is a separate portion of the eye examination and may not be covered by some insurance companies, such as Medicare, and will be my financial responsibility.
- Dilation drops are given in order for the physician to examine the retina of your eyes. Dilation drops could cause light sensitivity and glare which may make driving difficult. If you feel you need a driver, we'll be happy to reschedule your appointment to another day.
- I understand that if my medical insurance requires a referral from my primary care physician, it is my responsibility to assure that it is obtained prior to services being rendered. Eye Care Northeast, PC has the right to deny or delay non-emergent services until that referral is obtained. Denial of insurance payment due to a lack of the required referral will result in the visit being my financial responsibility.
- **It is each patient's responsibility to know what his or her insurance will cover.**
- If you have a vision plan with your insurance please be advised that Eye Care Northeast does not participate with vision plans.
- I understand that copayments are due at the time of service or a $10.00 billing fee will be added.
- If I cannot attend an appointment, and I do not cancel within 24 hours, a $50 Service Fee will be added to my account.
- Three no-shows/same day cancellations will result in withdrawal from the practice
- I understand that patient balances must be paid within 60 days of a billing statement to avoid late fees and collection activity.
- Bank checks returned for insufficient funds will accrue a $25 Service fee.

Authorizations:

I authorize the release of my medical information to the above-named parties, insurance company/companies and to receive payment from the above named insurance company/companies on my behalf, to Eye Care Northeast for any services they have provided to me. I understand that I will be financially responsible for any deductible/coinsurance/copayment and/or any denied claim as outlined in my insurance contract. This is a lifetime authorization, unless revoked in writing.

For Medicare patients, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of Carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to the Medicare assignment of benefits apply. This is a lifetime authorization, unless revoked in writing.

By reading and signing this document, I, the undersigned patient (or authorized representative) have read and understand the above, and consent to and authorize the performance of any treatments, examinations, eye drops, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s).

_____ _____

Patient's Signature **Date**