

New Patient Form

Date ___/___/___

Name _____ Birth date ___/___/_____

Address _____ SS# _____

City _____ State _____ ZIP _____

Primary Phone # _____ Cell or Land Line

Employer _____ Work Phone _____

Emergency Contact Name _____

Phone _____

Relationship _____

Chief Complaint: Why are you here today for:

Emergency _____

Routine vision exam. To confirm good visual health or update a spectacle or CL prescription.

Pathology check, cataracts, glaucoma, age related macular degeneration check.

Previously diagnosed.

Second opinion.

Payment Information

Name of responsible payer _____ SS# _____

Vision Insurance Carrier _____

ID # _____

Medical Insurance/Medicare Carrier _____

ID/Plan #

Do you have multiple plans? Y N

If yes, who is the alternative carrier? _____

Personal Health Questions

Who is your primary care physician? _____

Last visit to PCP _____

Specialists involved with your care _____

Flu Shot Y or N

Pneumonia Shot Y or N

Shingles Vaccine Y or N

COVID Vaccine Y or N

COVID Boosters Y or N

List current prescription medications that you have been directed to take

Are you taking them as directed? Y or N. If not, why? _____

Have you ever had an adverse/bad reaction to prescription or non-prescription (OTC), medications? Include latex, tapes or dyes.

Do you utilize tobacco products? Y or N How often? _____

Do you utilize alcoholic beverages? Y or N How often? _____

Is there a family history of:

Blindness, Glaucoma, Macular degeneration, Diabetes (Type 1 or 2), Early onset cataracts, Retinal tear or detachment, Crossed eye, Amblyopia/Lazy eye, rheumatoid arthritis, Thyroid disease (high or low), cancer

Ophthalmic/Eye History

Last eye exam (approximate) _____ Previous eye doctor _____

Do you wear glasses? Y or N Constant wear Driving only Near only OTC readers

Do you wear contact lenses? Y or N

Type _____ Brand (if known) _____

How many years have you worn them? _____

Special type (Toric/Astigmatic, Mono vision, Multifocal, Daily Disposable)

Do you remove them to sleep? Y or N

How often do you dispose/replace your lenses? _____

What disinfection system do you use? _____

Have you had cataract surgery? Y or N

Have you had Intraocular (eye) injections? Y or N

Have you had any previous ophthalmic (eye) surgery? Y or N

Are you currently taking any prescription **or non-prescription EYE** medications or nutritional supplements? Example: Glaucoma meds, Restasis/Xiidra, Latisse/Lash extenders, Artificial tears, whitening drops, Ocuville AREDS 2. Y or N

List _____

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (*print*) _____

Identification Number _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Glaucoma-Cataract Consultants, Inc. (hereafter "JFE"), for services furnished me by JFE. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. JFE accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to JFE, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** JFE may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to JFE for reimbursement for services rendered, and (2) any health care provider for continued patient care. JFE may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that JFE maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that JFE has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by JFE if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that JFE's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with JFE to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by JFE, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to JFE for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to JFE. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to JFE. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party

Date