COREY M. NOTIS, M.D., P.A.

Registration Form

Last Name:________________________________First Name__________________________________

Address:____

City:_______________________________State:______________________Zip Code:______________

Home Phone:__________________Work Phone_________________Cell Phone:__________________

Date of Birth:_______________________Social Security #___________________________________

Occupation:________________________Emergency Contact:__________________________________

Race/Ethnicity: ______________________ Language Spoken:_______________________________

Male( ) Female( ) Marital Status: Single( ) Married( ) Divorced ( ) Widowed ( )

Email:____ Referred By___________________

Primary Care Physician_______________________Phone #_________________________________

Primary Insurance:_________________________Policy #_____________________________________

Subscriber Name:_____________________________Subscriber Date of Birth:____________________

Address:____

Secondary Insurance:_______________________Policy #____________________________________

Subscriber Name:_____________________________Subscriber Date of Birth______________________

Address:____

*Do you need a referral? YES ( ) NO ( ) *Do you have a referral? YES ( ) NO ( )

*Do you have a vision Plan: YES ( ) NO ( ) Name of Vision Plan____________________________

*Do you have Medicare YES ( ) NO ( ) Medicare ID #____________________________________

*Do you have Medicaid YES ( ) NO ( ) Medicaid ID #_____________________________________

Consent for release of information:

Occasionally, insurance companies require additional information from your file in order to pay claims. To ensure that claims are paid in a timely manner, please read and sign the following:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize Corey M. Notis, M.D., PA to release to the Health Care Financing Administration, and its agents, or any other insurance carrier I may have, any information needed to determine these benefits payables for related services.

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 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 the payment.

Signed:____Date:___________________________________

*****I acknowledge receipt of the Medical Records Privacy Policy*****

Review of Systems

Patient's Name:____ Date:_____________________

Circle Yes (Y) or NO (N). **For any Yes responses, please describe.**

Y N Glaucoma ____

Y N Cataracts ____

Y N Diabetic Retinopathy ____

Y N Macular Degeneration ____

Y N Eye Surgery____

Y N Constitutional Symptoms (e.g., fever, weight loss)_____________________________

Y N Problems with Ears, Nose, Throat, Sinus Disease_______________________________

Y N Cardiovascular (hypertension, heart attack, coronary bypass, stents, etc.)_____________
____

Y N Do You Take Blood Pressure Medications?___________________________________

Y N Respiratory (emphysema, asthma, etc.)_______________________________________

Y N Gastrointestinal (ulcer, inflammatory bowel disease, etc.)_________________________

Y N Musculoskeletal (arthritis, osteoporosis, etc.)__________________________________

Y N Skin (dermatitis, basal cell carcinoma, etc.)____________________________________

Y N Neurological (headache, multiple sclerosis, etc.)_________________________________

Y N Endocrine (diabetes, thyroid disease, etc.)______________________________________

Y N Hematologic (anemia, lymphoma, leukemia, etc.)_________________________________

Y N Immunologic (lupus, rheumatoid arthritis. Polymyalgia, etc.)_______________________

Y N Allergies____

Y N Past Surgical History____

Family History **Relation to Patient**

Y N Glaucoma____

Y N Diabetes____

Y N Blindness____

Y N Macular Degeneration____

Y N Cancer____

Review of Systems

Patient's Name:_______________________________________Date:_____________________________

Social History

Y N Do You Smoke If yes how much/often_____________________________

Y N Do you use Drugs ____

Y N Do you drink Alcohol If yes how much?_________________________________

List of Current Medications & Dosage

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

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PATRICIA SKRAPARIS, O.D.

155 Morris Avenue
Springfield, NJ 07081
973-232-6900

900 Stuyvesant Avenue
Union, NJ 07083
908-687-0330

Authorization for Disclosure of Protective Health Information

Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues, if our attempts to speak with you personally have failed.

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

_____ Myself only
_____ My spouse, significant other, or parent (specify name)____
_____ Other (specify name) ____

Please check your choice on information to be disclosed

_____ Yes, I give my permission for medical information to be left on my answering system.

_____ No, I do not want medical information left on my answering system.

I, ____, have received a copy of the Notice of Privacy Practice
(Please Print Patient's Name)

I understand that I have the right to revoke this authorization in writing to the office manager at the address listed above

Patient's Name: ____

Signature: ____ Date: _________________

Relationship to patient (if not signed by the patient):____

INTERNAL USE ONLY
If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below:

Presented on (date & time):____

Presented by (name & date): ____

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(PLEASE KEEP FOR YOUR RECORDS)

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you or to check you out at the reception desk. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorizations. These situations include: as Required By Law, Public Health issues; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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AUTHORIZATION OF BENEFITS AGREEMENT

Date:_________________________

I request that payment of all authorized Medicare/other Insurance Company benefits may be made on my behalf to this office for any services provided by the physician to me. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents, if I have Medicare and/or my insurance company, any information needed to determine these benefits or the benefits payable for related services.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entry, this authorization also permits disclosure to them for purposes of utilization review or audit.

I understand that I am responsible for my yearly deductible to be paid directly to the physician.

I also have been informed that Medicare/other Insurance Company may or may not pay for certain services (including, but not limited to, refractions, topographies, contact lenses, contact lens fitting, punctal plugs, etc.) , and I am responsible for direct payment to the physician for these non-covered services.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage.

____

Patient's name (please print) **Date of Birth**

____

Authorized Signature