



**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 # \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

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

Email: \_\_\_\_\_ Referred By \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone# \_\_\_\_\_

Pharmacy address: \_\_\_\_\_

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 & Financial Policy\*\*\***



Associates in Eye Care

COREY M. NOTIS, M.D., F.A.A.O  
E. LILLIAN CHENG, M.D.  
JODIE LUCIA-RICCI, M.D.  
JONATHAN M. FREILICH, M.D., FA.C.S.  
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155 Morris Avenue  
Springfield, NJ 07081  
973-232-6900

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

**MEDICAL VS VISION EXAM**

Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_  
(please print)

Date of Birth: \_\_\_\_\_

**MEDICAL EXAM VS ROUTINE VISION EXAM**

What is the difference between a Medical Eye Exam and a Routine Vision Exam? Insurance coverage for eye exams varies. Some plans only cover routine, well eye exams. Other plans will not pay for your exam unless you have a medical eye condition or disease. Some plans require a referral from your primary care physician. Be sure to check your policy(s) to determine your coverage prior to your appointment. For insurance purposes, eye examinations are divided into two categories:

**Routine Vision Exam**

A Routine eye exam is defined by insurance companies as an office visit for the purpose of checking vision, screening for eye disease, and/or updating eyeglass (refraction) or contact lens prescriptions. If all screening appears normal, a dilated eye exam can be performed under your vision plan. If your doctor finds anything abnormal during your vision exam, dilation may be deferred so it can be completed with medical diagnostic testing at a follow up visit. In that case, at follow up, your medical insurance would be billed. Please call your insurance and verify your Routine vision coverage. A Medical and Routine Exam will not be performed on the same day. **This exam is only covered by a Vision plan.**

**Medical Exam**

This is a medically necessary comprehensive examination for the diagnosis and treatment of diseases and conditions of the eye performed by an eye doctor. This exam evaluates the reasons for the symptoms and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, diabetic retinopathy, macular degeneration and many other potentially sight-threatening diseases. **This exam is Not covered by a vision plan.**

**Please check one of the boxes below:**

**Patient requests to have MEDICAL EXAM on this visit**   
(covered by your medical plan ex: Medicare, Horizon, Aetna, UHC, Cigna, etc)

**Patient requests to have ROUTINE VISION EXAM on this visit**   
(covered by your vision plan ex: VSP, Spectera, Eyemed, March, Davis, etc)

Patient/Guardian Signature: \_\_\_\_\_

Date \_\_\_\_\_



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Patient's name: \_\_\_\_\_  
(please print)

DOB: \_\_\_\_\_

Please be advised that **effective June 1, 2018**, Associates in Eyecare will begin to charge a fee for refractions. A refraction is the part of the exam by which we determine whether you need a new or updated eyeglass prescription. Refractions are **NOT** a covered service by Medicare and most other medical insurance plans. All insurance plans consider a refraction a "vision" service not a "medical" service.

Is this new? Refraction (CPT code 92015) has been a "non-covered" service since Medicare was created in 1965. Since about 2007, Medicare has been enforcing the policy of requiring eye doctors to charge separately for refractions. As many private and commercial medical insurance carriers adopt the policies of the federal government, most of our contracts with private/commercial insurance carriers require us collect the money from you, as well.

Refractions are covered by Vision plans (VSP, Eyemed, Davis, March, Spectera, etc). Please call your insurance plan and verify your Routine Vision Benefits. **A Medical and Routine Vision Exam will not be performed on the same day.**

Our office fee for a refraction is **\$50.00** and will be collected at the time of service in addition to any co-payment your plan may require. Should your medical plan pay us for the refraction, we will reimburse you accordingly.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**AUTHORIZATION/ASSIGNMENT OF BENEFITS AGREEMENT**

Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_  
(please print)

Date of Birth: \_\_\_\_\_

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, contact lenses, contact lens fitting, 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.

---

Authorized Signature

Date



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DATE: \_\_\_\_\_

Patient's name: \_\_\_\_\_  
(please print)

Date of Birth: \_\_\_\_\_

**RE: COPAYMENTS/INSURANCE AND REFERRALS**

Please be aware that copayments are collected at the time of your visit. You can pay by cash, debit or credit card.

Please be advised that it is YOUR responsibility to know your insurance and whether you require referrals to see a specialist. Our office cannot keep track of every patient's referral requirements. Please make sure your referral is valid (including number of visits and expiration date), BEFORE coming to see the doctor.

\*\*If you have a follow up appointment scheduled with the office, please call us 4 days prior to your appointment and we will gladly check the status of your referral.

\*\*In the event that you do not have a referral, or it is expired, you have the option of rescheduling your appointment or to leave a deposit for the visit, which we will hold for 1 week. Once you provide us with a properly dated referral, we will return your deposit (minus the copay).

\*\*We will not be held responsible if you come in without a valid or properly dated referral. If you have any questions regarding what your insurance company requires, please call the member services number on your insurance card.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date



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**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, \_\_\_\_\_, \_\_\_\_\_,  
 (Please Print Patient's Name) (Patient's date of birth)

have received a copy of the Notice of Privacy Practice. 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**

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**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. Our practice will never use your Protected Health Information (PHI) for marketing purposes without your authorization.

**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.