Associates in Eye Care

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

Review of Systems

Date:_____

Patient's Name:_____ **DOB:**_____

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 ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other_____

Y N Diabetes ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other_____

Y N Blindness ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other_____

Y N Cancer ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other_____

Y N Macular Degeneration ☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other _____

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Review of Systems

Patient's Name:_____ **Date:**_____
(please print)

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

MEDICATION	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

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900 Stuyvesant Avenue
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908-687-0330

MEDICAL VS VISION EXAM

Date: _____

Patient's name: _____ Date of Birth:_____
(please print)

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: _____

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Patient's name: _____ **DOB: _____**
(please print)

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 medical 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 perform 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:_____

*****If you qualify for financial hardship, please call our billing department (973-232-6900 ext. 213) to request a financial hardship packet.*****

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DATE:_____

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

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

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.

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AUTHORIZATION/ASSIGNMENT OF BENEFITS AGREEMENT

Date:_____

Patient's name:_____ DOB:_____
(please print)

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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FINANCIAL POLICY

(PLEASE KEEP FOR YOUR RECORDS)

Thank you for choosing Associate in Eyecare to serve your eye care needs. We are dedicated to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is vital to our professional relationship. Your payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, and your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Insurance Claims

Please bring your insurance cards to every visit. In order to accurately bill your insurance company, we require that you provide accurate and current insurance information including primary and secondary insurance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company possibly will pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. It is your responsibility to check with your insurance company to be sure we participate with your plan. Some insurance companies have coverage that fall into a Tier plan. Please confirm if we are under Tier 1 or Tier 2 under your plan. If we do not participate with your plan, you will be responsible for full payment.

Vision Plans

We participate with several Vision Plans. Please check with your plan to see if we are members of your Vision Plan. If we do not participate, services are payable at the time of service.

Co-payments

Patients are expected to pay AT TIME OF SERVICE all amounts known not to be covered by their insurance company. These amounts include co-payments, co-insurance, and/or deductibles. Payments may be made by cash, check, and/or credit card.

Patients without Insurance coverage

Self-pay accounts are for patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without any insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If you come for an office visit and we do not participate with your insurance company, we assume you decided to see us as an out-of-network provider.

Payment Plan

Extended payment arrangements for established patients are available. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. If you pay cash, please be sure to ask for a receipt so that you will have a record of your payment.

Financing

Care credit is a financing option that is available to our patients. You can apply online **www.carecredit.com**

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FINANCIAL POLICY

(PLEASE KEEP FOR YOUR RECORDS)

Routine vs. Medical Exam

A Routine Vision Exam is a screening exam which is performed as a "healthy" eye visit. It is most frequently requested by patients to determine the need for corrective lenses. Not all insurances cover screening exams or offer a "vision" benefit. It is your responsibility to know if you have this benefit and how often it may be available. You will be responsible for payment if your vision exam is not covered. A medical exam is billed to your medical insurance with the symptom or condition which was examined on the day of the visit.

Glasses and Contact Lens Exam

Examinations for spectacles and contact lenses are SEPARATE exams. If you require both exams on your visit, you will be charged a fee for your contact lens evaluation. The cost of the contact lens exam is payable at the time of service. You may have a vision plan which covers the contact lens exam fee, but it is then deducted from your materials benefit (for glasses or contact lenses). Also, if you decide to use your materials benefit elsewhere, your contact lens exam will NOT be covered. To avoid confusion and future billing issues, it is our office policy to accept payment for the contact lens exam at the time of your visit so you can apply your materials benefit to glasses and/or contact lenses.

Refraction

This is the test to determine if you need a prescription for eyeglasses. Unfortunately, most insurance companies do not pay this fee, it is billed to the patient in addition to the exam charge and is payable at the time of service. Our Refraction fee is $50.00.

Workers' Compensation

In the case of a workers' compensation, you must obtain the claim number, phone number, contact person, name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Returned Checks

The charge for a returned check is $25.00 payable only by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) who accompanies the minor is responsible for full payment and will receive the billing statements.

Outstanding Balances

If your account becomes delinquent and you have not established or met payment options with our billing department, your account will be turned over to a collection agency. Outstanding balances must be resolved prior to any non-emergency appointments. If you have a financial hardship, or if you are unable to pay your bill in its entirety, please contact our billing department to discuss payment options. Our staff is always available to listen and help.

This Financial Policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at 973-232-6900