SPECTOR
EYE CARE

_____
PATIENT NAME

PATIENT REGISTRATION

Address: _____ City: _____ State: ____ Zip: _____

Home #: _____ Work #: _____ Cell #:_____ Email: _____

Preferred method of contact for appointment reminders: _____

Date of Birth: _____ Male: ___ Female: ___ Family Physician: _____

Employer: _____ Occupation: _____

Is visit related to a workplace injury? Yes _____ No _____

How did you hear about our practice: _____ Referred by: _____

Reason for today's visit: _____

INSURANCE AND PAYMENT INFORMATION

Insurance: _____ Secondary Insurance: _____

Name of Insured: _____ Name of Insured: _____

Relationship: _____ DOB: _____ Relationship: _____ DOB: _____

If your insurance requires a referral, did you bring it with you? _____

Who is responsible for the payment of your fees?

Name: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

_____ _____
PATIENT SIGNATURE DATE

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PATIENT NAME

FINANCIAL POLICY

COPAYMENTS & DEDUCTIBLES: Your insurance plan determines your co pay/coinsurance/ deductible. Contact your insurance company to obtain co pay, coinsurance/deductible information. All co-payments are due at the time of service.

A $5.00 service fee will be charged if the co-pay is not paid at the time of service.
A $35.00 service charge will be applied for each returned check.

Pt Initials _____

INSURANCE COVERAGE: Understanding you insurance plan is your responsibility. Please contact your insurance company directly with any questions regarding your coverage. It is simply not possible for our staff to know the details of every individual insurance plan.

If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of the services. Please notify our office of any changes to your insurance coverage. If your insurance coverage was not in effect at the time of your visit, you will be responsible for payment in full.

Pt Initials _____

MISSED APPOINTMENTS: We kindly request a 24 hour notice to either cancel or reschedule an appointment. You may be charged a $25 fee if you do not provide 24 hour notice.

Pt Initials _____

PAYMENT POLICY: Just as we make every effort to accommodate you for your eye care, we expect that you will make every effort to pay your bill promptly within 30 days. If you have a financial hardship or if you are unable to pay your bill in its entirely please contact our billing office to discuss payment options.

A $5.00 service fee will be charged for every 45 days an account is past due. If your account is 90 days past due and you have not established a payment arrangement with our billing office, your account will be turned over to a collection agency. A collection agency fee of 36% will be added to your account if turned over to agency.

Pt Initials _____

I have read the financial policy and agree to its terms.

_____ _____

Patient Signature Date

SPECTOR EYE CARE

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PATIENT NAME

PATIENT HISTORY

TODAY'S DATE: _____ DATE OF BIRTH: _____

HOW DID YOUR HEAR ABOUT US?_____

DATE & LOCATION LAST EYE EXAM:_____

MEDICAL HISTORY:

	YES	NO		YES	NO
DIABETES	____	____	ARTHRITIS	____	____
HEART ATTACK	____	____	CANCER/TUMOR	____	____
HIGH BLOOD PRESSURE	____	____	THYROID DISEASE	____	____
STROKE/SHOCK	____	____	SEIZURES	____	____
PACEMAKER/DEFIBRILLATOR	____	____	BLOOD CLOTS	____	____
ASTHMA	____	____	BLEEDING DISORDER	____	____
EMPHYSEMA	____	____	TRANSFUSIONS	____	____
LIVER DISEASE/JAUNDICE	____	____	AIDS/HIV POSITIVE	____	____
STOMACH ULCER	____	____	KIDNEY STONES/DISEASE	____	____
PACEMAKER	____	____	**LATEX ALLERGY**	____	____

OTHER:

_____

FAMILY HISTORY AMONG BLOOD RELATIVES:

	YES	NO		YES	NO
GLAUCOMA	____	____	RETINAL DISEASE	____	____
CATARACTS	____	____	DIABETES	____	____
MACULAR DEGENERATION	____	____	HEART DISEASE	____	____
NIGHT BLINDNESS	____	____	BLEEDING DISORDER	____	____

_____

SOCIAL HISTORY:

	YES	NO	
DO YOU DRINK ALCOHOL?	____	____	HOW MUCH PER DAY? _____
DO YOU SMOKE?	____	____	HOW MUCH PER DAY? _____

LIST ALL ALLERGIES: _____

PLEASE LIST ALL **EYE** MEDICATIONS YOU ARE CURRENTLY USING:

_____

PLEASE LIST ANY PREVIOUS EYE SURGERY:

1. _____
2. _____
3. _____

OTHER SURGICAL PROCEDURES:

1. _____
2. _____
3. _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND THE DOSE:

1._____ 2._____

3._____ 4._____

5._____ 6._____

PHARMACY NAME AND ADDRESS: _____

WOMEN ONLY: I AM PREGNANT ____ I AM NOT PREGNANT ____

SPECTOR
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SUMMARY OF NOTICE OF PRIVACY PRACTICE

Privacy Official: (203) 853-9900

This is a brief summary of your rights as detailed in the Notice of Privacy (The "Notice"). The entire Notice can be found at www.spectoreye.com/privacy-procedures.pdf

1. **Uses and Disclosures of your Health Information**. We may use the information we develop and collect for treatment by our practice or disclose the information to others whom we refer you for treatment, for payment for the services and for certain health care "operations", such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptions, billing services and other who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition, or death. If you are available and able, we will ask for your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.

2. **Other Uses and Disclosures**. Except as described in the Notice, we will not use or disclose your medical information without your written consent. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. **Your Health Information Rights**. You have a number of rights under state and/or federal law, which are subject to the terms and conditions specified in the Notice.

a. You may request restrictions on certain uses and disclosures of your information
b. You may request that you receive your information from us in a certain way.
c. You may obtain a copy and inspect your medical records.
d. You may request an amendment to any record you believe is inaccurate.
e. You may request an accounting of disclosures made of your records.

4. **Changes in the Notice.** We reserve the right to change the Notice. If we do so, we will post it on our website and provide a copy upon request.

5. **Complaints.** You may file a complaint with our Privacy Official whose contact information is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Privacy Official: (203) 853-9900

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

If not signed by the patient, please print your name and relationship to the:

Name: _____ Relationship:_____

For Office Use Only:

Signed form received by:

_____

Acknowledgement refused:

Efforts to obtain acknowledgement:

_____

_____

Reason for refusal:

_____

_____

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EYE EXAM POLICY

ROUTINE EYE EXAMINATIONS: A general screening of the overall health of your eyes with no medical problems or complaints.

MEDICAL EYE EXAMINATIONS: An eye examination where you are being evaluated for and/or treated for a medical condition or symptom that you describe to our staff, or a condition that the doctor finds during the examination. Examples include the following: *headache, diabetes, eye irritation, dry eyes, allergies, floaters, contact lens intolerance, glaucoma, cataract, macular degeneration, etc.*

VISION PLANS/VISION BENEFIT: Typical coverage includes an eye examination and a pair of eyeglasses or contact lenses once every 12-24 months. The exam benefit is only used to update your eyeglass or contact lens prescription and not to treat any medical eye issue. If during your visit, the doctor identifies an eye problem, disease, or injury; your visit will be billed to your medical insurance. You will be able to use your routine benefit at a later date.

REFRACTION: The refraction test provides the doctors information about the function of your eyes and may alert the doctors of any problems that may be related to a decrease in your vision. This test is also necessary if you wish to get an updated eyeglass or contact lens prescription. If you do not have routine exam coverage or a separate vision plan, there is a **$50.00** fee for this service, in addition to your copayment or other fees your insurance policy dictates. The fee is not covered under most insurance plans. If your insurance pays the fee, we will reimburse you accordingly.

Please check one:

- ☐ I do NOT have a separate Vision Plan or vision coverage through my medical insurance.
- ☐ I do have a separate vision plan
- ☐ I do have routine vision coverage through my medical plan

If I determine that I have vision coverage plan after my exam has been completed, the exam will not be able to be resubmitted to my vision coverage. _____ (INITIALS)

I understand that my symptoms and the doctor's findings during my exam will determine how my exam is billed to my insurance. I am responsible for any fees that my insurance does not cover. It is my responsibility to know the details of my plan, including deductibles, copayments, and routine vision coverage.

_____ _____

Patient Signature Date