Welcome

PATIENT REGISTRATION INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Long Term Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Name:_____

Please answer **YES** or **NO** to the following questions. Any comments/explanations may be made in the area next to the question.

Do you currently have or have had any of the following?

1.____ Seasonal Allergies
2.____ Allergies or reactions to any Medications or LATEX (ex: Penicillin → RASH)
3.____ Fever or Weight Loss
4.____ Asthma, COPD, Sleep Apnea, Respiratory Issues
5.____ Arthritis or Rheumatoid Arthritis
6.____ Autoimmune Diseases (Lupus, Rheum, Sarcoid, Sjogrens)
7.____ Insulin Dependent Diabetes
8.____ Non-Insulin Dependent Diabetes
9.____ Thyroid Disease or any other Endocrine Diseases
10.____ Headaches or Migraines
11.____ Irritable Bowel Syndrome, Crohn's Disease, Ulcerative Colitis
12.____ High Blood pressure
13.____ Blood or clotting disorders
14.____Infectious Diseases (ex: HIV, Hepatitis)
15.____ Heart Disease or Stroke

Eye History (Please circle all that apply):

Cataracts Glaucoma Macular Degeneration Lazy Eye/Amblyopia Eye Surgery

Eye Trauma Dry Eyes Diabetic Retinopathy Retinal hole/tear/detachment

Family History (Please circle all the apply):

Cataracts Glaucoma Macular Degeneration Diabetes

Social History (Please circle all the apply):

Current Smoker Former Smoker Drug or Alcohol Dependence Drives a Vehicle

Medications (dose and frequency):

_____

_____

Race: Black/African American White Asian Native Hawaiian American Indian Alaskan Native

Language: English Spanish Other:_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Signature _____ **Date**_____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT & AUTHORIZATION. IN REFUSING WE MAY NOT BE ALLOWED TO PROCESS YOUR INSURANCE CLAIMS.

DATE:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please PRINT your name **Please SIGN your name**

_____ _____

Legal Representative **Description of Authority**

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

___ First Name Only ___Proper Surname ___Other_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ **Relationship:_____**

Name:_____ **Relationship:_____**

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENT, TREATMENT & BILLING INFORMATION VIA:

- **___Cell Phone Confirmation**
- **___Home Phone Confirmation**
- **___Work Phone Confirmation**
- **___Text Message to my Cell Phone**
- **___Email Confirmation**
- **___Any of the Above**

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- **___Cell Phone Confirmation**
- **___Home Phone Confirmation**
- **___Work Phone Confirmation**
- **___Text Message to my Cell Phone**
- **___Email Confirmation**
- **___Any of the Above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

- **___Phone Message**
- **___Text Message**
- **___Any of the Above**
- **___None of the Above (opt out)**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Beyer Eye Associates

I _____ understand that I am expected to know my insurance coverage at the time of service. If a referral is required with my insurance and I do not have one, I will be responsible for the charges incurred during my visit.

I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment is expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time my billing statement is received.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

If you have a vision plan (VSP, EYEMED, DAVIS, VBA) it is imperative that you notify the front desk staff upon arrival to alleviate any errors that could occur with billing. Beyer Eye Associates will not alter or be responsible for any billing information after the date of service.

Some insurance plans such as Medicare do not pay for refractive services. This is the part of your eye exam that determines your eyeglass prescription and best corrected vision. The AMA (American Medical Association) mandates separate billing code (92015) is used for this portion. If it is not payable/covered you are responsible for payment. Any questions may be directed to our staff.

We have taken necessary safety precautions for each patient's visit for COVID 19. Due to the additional time to implement these safety precautions and reduced patient volume to ensure your safety it's important to keep your scheduled appointment. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.
If an appointment is not cancelled at least 24 hours in advance a $50 no show fee will be charged to your account. This will not be covered by your insurance

_____ Date:_____

Responsible party signature

_____ _____

Printed Name of Patient **Printed Name of Parent/Guardian**

Mercerville
395 Route 33
Mercerville NJ 08619

Millstone
498 Monmouth Rd
Clarksburg,NJ 08510

Newtown
11 Friends Lane
Newtown PA

OPTOMAP Digital Retinal Scan
Please note: OPTOMAP not available in Newtown

During COVID 19 we recommend an Optos exam to decrease wait time, exam time, congregation in waiting rooms and less close interaction during the exam to maximize social distancing

Beyer Eye Associates offers state of the art digital scanning technology that allows our doctors to view the inside of your eye *without* the use of dilation drops. The OPTOMAP allows our doctors to evaluate your retina for problems such as macular degeneration, glaucoma, retinal holes, retinal detachments, hypertensive and diabetic retinopathy and much more. The scanning system is completely safe for both kids and adults and allows you the opportunity to see the inside of your eyes just as the doctor sees it.

Dilated Exam	**VS**	**Optomap Exam**
***exam time 30-60 mins** **Drops take 20-30 mins to work**		***exam time typically under 15 mins**
1. Blurred near vision for 4 to 6 hours 2. Light sensitivity for 4 to 6 hours 3. Longer office visit to wait for drops to take effect 4. Only the doctor can see the retina		1. No blurred vision 2. No light sensitivity 3. Scan takes less than 1 minute 4. Digital images are reviewed and Compared each year. 5. YOU CAN SEE YOUR RETINA

Our doctors recommend that all patients have a thorough examination of their retina each year. There is an additional fee of ***$39.00*** for the OPTOMAP scan due on the date of service. In most cases, this scan is not covered by insurance. Dilation may still be required on occasions.

_____ I elect to have a digital scan of my retina today ($39.00)

_____ I prefer a dilated exam of my retina. (no additional fee)

_____ _____

Patient/Guardian Signature Date

_____

Patient Name Printed

Contact Lens Examination

_____ I do not wear contact lenses and I am not interested in contacts at this time.

A routine eye exam is not the same as a contact lens exam. A contact lens examination is necessary if you need a renewal of your contact lens prescription for ordering more replacement lenses.

A contact lens prescription is valid for one year per NJ State guidelines 13:33-4.1

_____ I would like to renew my contacts for standard distance, astigmatism, multifocal and monovision (a discounted fee starting at $60.00)

***Existing contact lens wearers needing a REFIT for astigmatism (toric) will be $130 and up depending on complexity. Doctor will discuss the fee with the patient.**

***Existing contact lens wearers needing a REFIT for a multifocal or monovision (distance and near vision) lens will be $130 and up depending on complexity. Doctor will discuss the fee with the patient.**

_____ I am a CRT patient and would like to have a CRT contact lens examination ($130 and up depending on complexity)

_____ I am a contact lens patient and I do not want my prescription updated today. I understand I will **NOT** be able to order more contact lenses and my current contacts will not be evaluated

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_____ **New fit contact lens wearer :** includes initial fit, training for insertion/removal of contacts and follow up(s) per Doctor's discretion). Doctor will discuss the fee with the patient.

Distance only $150 and up
Astigmatism/Toric distance only $175 and up
Monovision/Multifocal (correction of distance and near vision) $200 and up
Specialty Contact lens and medically necessary $300 and up

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Above fees do not include the cost of contact lenses.

Patient's Name _____ Date _____

Patient's Signature_____
(signature of parent/guardian if minor)