Princeton – Flemington Eye Institute

601 Ewing Street Suite C-15 Princeton, NJ 08540

1100 Wescott Drive Suite 305 Flemington, NJ 08822

Patient Information

Today's Date__/___/__

Patient Name: _____

Last Name First Name Middle Initial

Address: _____ Apt#_____

City: _____ State_____ Zip Code_____

Phone # (H) _____ (C) _____ (W) _____

Email Address: _____

Sex: M / F DOB: __/___/____ Social Security #_____

Who referred you? _____

RACE

Caucasian	Asian	African American	Pacific Islander	Hawaiian Native	American Indian	Alaskan Native

ETHNICITY

Hispanic or Latino	Non-Hispanic or Latino

Primary Physician Name: _____

Physician Address/Phone #: _____

Name and Location of Pharmacy: _____

Pharmacy Phone #: _____

Name of Previous Eye Doctor: _____

Reason for Today's Visit/Complaint: _____

_____

Do You Wear Glasses? YES NO

DISTANCE	READING	BIFOCAL	PROGRESSIVE	OTHER

Do You Wear Contact Lenses? YES NO BRAND: _____

Prescription: R: _____ L: _____ Base Curve: _____Diameter: _____

OCULAR HISTORY (List any previous eye surgeries, trauma, diagnosis or conditions):

_____

Do you smoke?

Yes	No	Former

Do you use alcohol?

Yes	No	Former

MEDICATIONS (List and current medications/supplements/eye drops):

NAME	STRENGTH	FREQUENCY	REASON

MEDICAL HISTORY (List any conditions you are being treated for):

_____

_____

FAMILY HISTORY (M=mother, F=father, B=brother, S=sister, GP=grandparent):

Glaucoma:	Cataracts:	Retinal Disease:
Macular Degeneration:	Blindness:	Cancer/ Type:
Diabetes:	Hypertension:	Stroke:
Sickle Cell:	Migraines:	Heart Disease:

Allergies to Medications: _____

Seasonal Allergies: YES / NO: _____

Occupation: _____

Employer / School_____

Employer Address / School Address_____

Insurance Information

Please completely fill out insurance section, any missing or incorrect information may result in denial of insurance payment for today's visit.

Person Responsible for Insurance: _____

Sex: M / F Social Security #_____ DOB:_____

Address if different from patient: _____

Relationship to Patient: SELF SPOUSE/PARTNER PARENT

Insurance Company Name_____

ID#_____ Group# _____

ADDITIONAL/SECONDARY INSURANCE: YES NO

Subscriber Name: _____

DOB: __/____/____ Relationship to Patient: SELF SPOUSE/PARTNER PARENT

Insurance Company Name: _____

ID#_____ Group#_____

I certify that I, and /or my dependent(s), have insurance coverage with the above insurance company(ies) and assign directly to Princeton-Flemington Eye Institute all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not they are paid by insurance.** I authorize the use of my signature on all insurance submissions.

Princeton-Flemington Eye Institute and all doctors involved may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature/Patient Guardian_____Date:_____

Patient Acknowledgement Regarding Refraction Service and Fee

A refraction is necessary to determine the performance of the visual system and is an essential part of the medical eye exam. Although refraction is also used to determine the need for corrective eyeglasses or contact lenses, this practice performs refractions as a necessary part of the medical exam. Refraction is also necessary to evaluate a patient for surgery. Unfortunately, some insurance plans (including Medicare) DO NOT cover the cost of refractions. In these cases, the patient will be responsible for the refraction charge of $45.00.

- Refraction is NOT a covered service by Medicare or some insurance plans.
- Our practice will not file the charge for refraction with a health insurance plan unless we have verification that your insurance plan covers the cost of the refraction.
- If your plan does not cover the refraction you will be responsible for paying the $45.00 refraction fee at the time of service in addition to any copayment your insurance plan may require.

Non-Covered Services

As our patient, we want to provide you with the best care possible. There may be certain services we feel are necessary for the maintenance of good health that will not be covered by your insurance company contract. ***You will be expected to pay for any non-covered services.*** Please be assured we will order only those tests and perform only those services that are necessary for your treatment and care. We will notify and discuss with you as we progress with your treatment any services we feel may not be covered although we may not always know for certain how your insurance company will process your claim. Please note that verifying insurance coverage is your responsibility. If you have a question about your coverage, please contact your insurance provider directly. If we file a claim and it is denied because our services are not covered under your insurance plan, you will be billed directly for all costs associated with your visit.

I have read and understand the above information. I accept full financial responsibility for the cost of any uncovered services if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have is separate from and not included in these fees.

Patient Signature: _____Date_____

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Notice of Privacy Practice Patient Acknowledgement

Patient name _____

Date of birth _____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

The Note Includes:

A statement that this practice is required by law to maintain the privacy of protected health information

- A statement that this practice is required to abide by terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes treatment, payment, and health care operations
- A description of each of uses and disclosures that are prohibited or materially limited by law
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated, and that to no retaliatory actions with be used against me in the effect of such a complaint
    - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction
    - The right to receive confidential communications of protected health information
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature _____ **Date** _____

Relationship to patient (if signed by personal representative of patient) _____