EYE CENTERS OF AMERICA
Excellence in Eyecare

Stephen A. Gollance, MD James Kirszrot, MD
Scott W. Silodor, MD Linda L. Hogan, OD
Joel Pakett, MD

PATIENT REGISTRATION FORM

First Name **MI** **Last Name**		**Suffix**	**Sex: M / F**
Home Address		**Date of Birth**	
City	**State**	**Zip Code**	
Preferred Language Ethnicity ☐ Hispanic Origin. ☐ Not of Hispanic Origin	Race ☐ Native American (Indian) ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic or Latino ☐ White		
Home Phone #	Work #	Cell #	
Social Security #	Marital Status ☐ S ☐ M ☐ D ☐ W	E-mail	
Patients' Employer Name, Address / Occupation			
Emergency Contact Name	Phone #	Relationship	
Referring Physician	Phone #	City	
Primary Care Physician	Phone #	City	
Financially responsible person (if different from patient)			
Responsible person's address:		Phone #	
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?		☐ Yes	☐ No
Is this visit related to an automobile accident or Workers' Compensation?		☐ Yes	☐ No

INSURANCE INFORMATION

Primary Insurance:	**Policy Holder Name:**	**DOB:**	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
ID #:			
Vision Service Plan ☐ Yes ☐ No	Policy Holder Name:	DOB:	Policy #:

FINANCIAL POLICY STATEMENT

Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You will be responsible for any balances not covered by your insurance. A return check fee of $35.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, patient will be charged a $25.00 fee. Second occurrence, patient will be charged a $35 fee. Third occurrence, patient will be charged a $50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

If you have any questions regarding billing, please contact our billing office Monday - Friday 8am - 5pm at (973) 707-7057

PATIENT AUTHORIZATION

I hereby authorize Eye Centers of America, LLC to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and/or any other insurance company be made directly to Eye Centers of America, LLC. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare Part B benefits.

I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature______________________________ **Date** ______________

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HIPAA NOTICE OF PRIVACY PRACTICE

Privacy Consent

I understand that Eye Centers of America, LLC, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy. I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Eye Centers of America, LLC, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Eye Centers of America, LLC has already made in reliance prior to my consent. Eye Centers of America, LLC, provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

I acknowledge that by signing this form, I permit Eye Centers of America, LLC, to release any information to the physician(s) involved in my care. I consent that Eye Centers of America, LLC, may call my house or designated locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Eye Centers of America LLC, may mail to my home appointment reminders and patient statements.

I designate the following representative(s) as being legally authorized to communicate with Eye Centers of America, LLC, on my behalf. If you do not designate anyone below, the Doctor/Eye Centers of America, LLC, will not be able to speak with anyone besides the patient regarding your medical condition.

Please let us know if there is anyone else we can speak with on your behalf.

Name________________________________**Relationship**____________________**Phone**____________

Name________________________________**Relationship**____________________**Phone**____________

Signature on file

I request that the payment of authorized benefits be made on my behalf to Eye Centers of America, LLC.
I authorize any holder of medical information about me be release to Novitas Medicare Solutions or any other of my medical carriers and any information needed to determine benefits or benefits payable for related services.

Patient Name:____ **Date of Birth:** _____________

Signature (Patient or Legal Guardian): _________________________________ **Date:** ________________

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The Eye Institute • 968 Hamburg Turnpike Wayne, NJ 07470

CONTACT LENS EVALUATION

You have the option of having your contact lenses evaluation during your complete eye exam today. This service is not included in the exam but is a very important step in maintaining your eye health. One of our doctors will evaluate the fit of the lens, the condition of the lens and the change in the power of the lens, if needed. (the power is usually different than that of your glasses. Improper fit of the lens can cause various problems including damage to your cornea. We will check to see if your lenses have any rips or tears and will check the cleanliness of the lenses.

If you do not have your contact lenses with you, we will be happy to re-schedule this evaluation for you at the check-out desk today.

The cost of this evaluation if $45.00 and is not covered by most insurance companies.

_________ Yes, I do want a contact lens evaluation.

_________ No, I do not want a contact lens evaluation; therefore, I will not receive an updated Contact lens prescription.

_________ I do not wear Contact Lenses

VISION SERVICE PLAN MEMBERS

If you do not advise us of your VSP coverage prior to service, we are not obligated to submit your services after rendered as they require prior authorization.

As a Vision Service Plan (VSP) member, this contact lens evaluation fee is discounted at 15%.

Do you wish to have a contact lens evaluation today? ____ Yes ______ No

____ ____________
Patient Printed Name Date

____
Patient Signature

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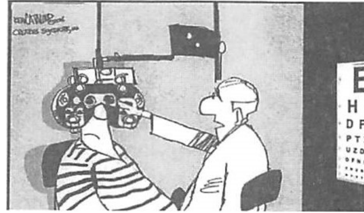

REFRACTION SERVICE AND FEE

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eyes, which is essential medical information for us to have, as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider a refraction a "vision" service, not a "medical" service. Unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Please check your Explanation of Benefits to see if your insurance plan paid for the refraction. If your plan did pay for the refraction, please let us know and we will reimburse you accordingly. Our fee for a refraction is $76.00. If paid on the day of your appointment, the fee is reduced to $55.00.

If you do not have the refraction on the day of your exam, you will not be able to receive your current eye glass prescription.

PATIENT ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

(By signing this you acknowledge that you understand our policy.)

____
Patient Printed Name

____
Date

____
Patient Signature

We now offer an alternative for dilation when having your eye exam.

We have a High Speed Camera (OPTOS) that takes a picture of the back of your eyes in several seconds, that will give the doctors the information they will need to complete your eye exam in half the time. Your vision will not be affected.

Not all patients are a candidate for this procedure. **If you have a medical condition such as cataracts, glaucoma, diabetes, retinal issues, etc, you are NOT a candidate for the Optos.** If you are able to choose this option, there is an out-of-pocket expense of $39.00 (this is not covered under insurance).

___**Yes** ___**No**