LEHIGH EYE SPECIALISTS

PAGES ARE DOUBLE SIDED

Prefix: Dr. Mr. Mrs. Miss

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ ☐ Home ☐ Cell

Date of Birth _____ SSN _____ ☐ Male ☐ Female

Preferred Email _____@_____

Race: ☐ White/Caucasian ☐ African American ☐ Hispanic ☐ Other _____

Preferred Language _____

Occupation _____

Medicare ID (if applicable) _____

Primary/Secondary Insurance _____ Policy Number _____

Emergency Contact Name _____ Phone _____

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Optometrist/Ophthalmologist _____ Phone _____

Cardiologist _____ Phone _____

Endocrinologist _____ Phone _____

Rheumatologist _____ Phone _____

Neurologist _____ Phone _____

Additional Provider(s) _____ Phone _____

_____ Phone _____

Pharmacy Name _____ Phone _____

Pharmacy Address _____

LIFETIME INSURANCE AUTHORIZATION

MEDICARE LIFETIME SIGNATURE ON FILE:

i request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished to me by Lehigh Eye Specialists. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature _____ Date _____

PRIMARY/SECONDARY INSURANCE:

I request that payment of authorized Medigap/Private Insurance benefits be made on my behalf to Lehigh Eye Specialists for any services furnished to me. I authorize any holder of medical information about me to release to my Medigap/Private insurer any information needed to determine these benefits payable for related services. The patient is responsible for the deductible, coinsurance, and non-covered services.

Patient's Signature _____ Date _____

PAYMENT AGREEMENT

It is the policy of Lehigh Eye Specialists that charges for services rendered by our physicians and staff be paid for at the time of service unless other formal arrangements have been made with our business office.

Arrangements for monthly payments may be made with our business staff. A minimum payment is required each month to keep an account active. You are responsible for making the monthly payment whether or not a statement has been sent to you. Any patient account which becomes delinquent (payment not made within 30 days of the last payment) will begin to be processed in the collection department, and the complete balance will be due immediately.

I agree to the above financial agreement for any services provided to me by Lehigh Eye Specialists.

Responsible Party Signature _____ Date _____

COMMUNICATION CONSENT

It is the office policy of Lehigh Eye Specialists and staff not to release confidential and/or unauthorized information by telephone or voicemail. Information will not be left with an unauthorized person who may answer the telephone.

I authorize Lehigh Eye Specialists and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Phone _____ ☐ Yes ☐ No
Cell Phone _____ ☐ Yes ☐ No
Email _____ ☐ Yes ☐ No
Voicemail _____ ☐ Yes ☐ No
Fax Medical Records to Other Physician(s):
_____ ☐ Yes ☐ No
_____ ☐ Yes ☐ No
_____ ☐ Yes ☐ No
_____ ☐ Yes ☐ No

If you would like to have information released to someone other than yourself please complete the following:

List names of authorized People:

Spouse: _____ ☐ Yes ☐ No
Parent: _____ ☐ Yes ☐ No

Other (please specify relationship):
_____ ☐ Yes ☐ No
_____ ☐ Yes ☐ No
_____ ☐ Yes ☐ No

Printed Name _____

Patient/Guardian Signature _____

Date _____

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality of care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial responsibility rests with you.

Payment for all services provided by our practice is due at the time services are rendered. Exclusions to this policy are made for patients who are covered by an insurance company/organization with which we have a participating agreement. Our office does participate with most major insurance plans. If we do not participate with your insurance plan, we will not submit your claim and you will be responsible for payment in full. If you have managed a care plan that requires a referral to see a specialist, you must obtain a referral from your primary care physician in order for your visit to be covered under your medical insurance. If you do not have a valid referral, we reserve the right to reschedule your appointment, In accordance with your insurance contract, you must be prepared to pay your co-payment, deductible, or any non-covered services at the time of your visit.

We accept cash, checks, and Visa, Master Card, and Discover. A banking fee will be applied for any checks returned for insufficient funds. If you do have a check returned, you will be expected to use another form of payment at your next visit.

Patients will receive a statement itemizing the services rendered for any unpaid balances, which may result after billing your insurance company. We appreciate prompt payment in full for any outstanding balance. If you are unable to pay the balance in full, please notify our billing department immediately and we will try to work out a payment arrangement with you.

Lehigh Eye Specialists reserves the right to turn a patient's account over to a collection agency if it is deemed that the account has been in default of payment obligations or compliance of this policy.

Please sign below to acknowledge that you have read and understand the above financial policy.

Printed Name of Patient: _____

Signature of Patient/Guardian: _____

COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgment of notice and consent authorizes Lehigh Eye Specialists to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. Lehigh Eye Specialists has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: Lehigh Eye Specialists
1251 S. Cedar Crest Blvds, Suite 307
Allentown, PA 18103
Attention: Privacy Officer
Telephone: 610-820-6320
Fax: 610-820-8376

Acknowledgment and Consent

Print or type all information except signature.

I have received the Notice of Privacy Practices for Lehigh Eye Specialists and authorize them to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of patient (or patient's personal representative) Date

_____

Personal representative information (if applicable)

Patient's Name _____ **Date of Birth** _____

☐ Check box if you are **not** taking any medications, vitamins, or using any eye drops

Medications, Vitamins, Eye drops	**Dosage**	**Indication**

☐ Check box if you do **not** have any known drug allergies

Please list **all** drug allergies.	Reaction

Tobacco use: ☐ current ☐ former ☐ never

Type: Units per day: Years used:

Relevant **family** history: ☐ glaucoma _____
(please include relation) ☐ macular degeneration _____
☐ blindness _____
☐ retinal tears / detachments _____
☐ other _____ , _____