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: □ English □ Spanish □ other: _____

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 Hamilton Eye Institute. 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 Hamilton Eye Institute 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 Hamilton Eye Institute 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 Hamilton Eye Institute

Patient's Signature _____ **Date** _____

COMMUNICATION CONSENT

It is the office policy of Hamilton Eye Institute 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 Hamilton Eye Institute 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.

Hamilton Eye Institute 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 Hamilton Eye Institute to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. Hamilton Eye Institute 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: Hamilton Eye Institute
5201 Hamilton Boulevard
Allentown, PA 18106
Attention: Privacy Officer
Telephone: 610-530-4444
Fax: 610-366-1343

Acknowledgment and Consent

Print or type all information except signature.

I have received the Notice of Privacy Practices for Hamilton Eye Institute 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: _____

Alcohol use: □ current □ former □ never

How often: _____

Recreational drugs: □ current □ former □ never

Type: _____ Units per day: _____ Years used: _____

Do you wear Contact Lenses? No _____ Yes _____

What Brand _____

Do you use eye Drops/Ointment? No _____ Yes _____

Do you have any allergies to any medications or substances? No_____ Yes_____

Do you have any reaction to Anesthesia? No_____ Yes_____

If YES, list the medications or substances and your reaction:

_____

_____

Have you ever had an allergic reaction or any sensitivity to latex? No _____ Yes _____

List any surgeries you have had in the last 10 years (appendectomy, hysterectomy, gallbladder removal, etc.) and the year(s) they were performed:

SURGERY **YEAR** **SURGERY** **YEAR**

_____

_____

Have any members of your **FAMILY** been diagnosed with any eye disease?

____ NONE ____ Diabetic Eye Disease ____ Glaucoma ____ Cataract ____ Macular Degeneration ____ Retinal Detachment ____ Crossed Eyes/Lazy Eye ____ Blindness ____ Serious Eye Injury ____ Others _____

Have **YOU** ever been diagnosed with any eye disease?

____ NONE ____ Diabetic Eye Disease ____ Glaucoma ____ Lazy eye ____ Cataract ____ Macular Degeneration ____ Retinal Detachment ____ Iritis ____ Crossed Eyes ____ Blindness ____ Serious Eye Injury ____ Others _____

List any EYE SURGERIES or EYE INJURIES you have had and the year(s) they were performed. □ NONE

Type of Surgery	Eye	Year	Physicians Notes
_____	___R / L___	_____	_____
_____	___R / L___	_____	_____
_____	___R / L___	_____	_____

Have you ever been diagnosed with or treated for any of the following. □ No known conditions

	Yes	No
High Blood Pressure		
Heart Problems		
Arthritis		
Lung Problems		
Stroke		
Thyroid Problems		
Diabetes □ Type 1 □ Type 2 □ Diet □ NIDDM □ IDDM		
Cholesterol		
Ulcers		
Cancer		
Other:		

Review of Symptoms

□ No known conditions

Allergic/Immunologic □ Hay Fever □ Seasonal Allergies	**Cardiovascular** □ Chest Pain □ Congestive Heart Failure □ Irregular Heart Beat □ Low Blood Pressure □ Pacemaker/Defibrillator
Constitutional □ Fatigue □ Fever □ Rash □ Weight Loss	**Ear, Nose, Throat** □ Deafness □ Dry Mouth □ Post Nasal Drip □ Runny Nose □ Sinus Infection
Endocrine □ Hyperthyroidism □ Hypothyroidism □ Polydipsia □ Mood Swings	**Eyes** □ Double Vision □ Eye Pain □ Vision Loss
Gastrointestinal □ Bloody Stool □ Constipation □ Diarrhea □ Hepatitis □ Jaundice □ Vomiting	**Genitourinary** □ Blood in Urine □ Discharge □ Genital Ulcers □ Kidney Stones
Hemotologic/Lymphatic □Anemia □ Blood Transfusion □ Excessive Bleeding □ Infection □ Purpura	**Integumentary** □ Breast Lumps □ Dermatitis □ Eczema □ Rash □ Wounds
Musculoskeletal □ Joint Ache □ Pain □ Paralysis Fever □ Stiffness □ Swelling	**Neurological** □ Alzheimer's Disease □ Dementia □ Faints □ Headaches □ Migraines □ Multiple Sclerosis □ Numbness □ Parkinson's Disease □ Seizures □ Stroke
Psychiatry □ Anxiety □ Depression □ Paranoia □ Memory Loss □ Mental and/or emotional factors □ Sleep Patterns	**Respiratory** □ Asthma □ Bronchitis □ COPD □ Cough □ Emphysema □ Shortness of Breath □ TB