doctor & associates
GENERAL, MEDICAL AND SURGICAL EYECARE

PLEASE PRINT

Name: _____
LAST FIRST M.I.

Address: _____
Street Apt # City State Zip

Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

Gender: _____ Male _____ Female Home Phone #: (_____)_____-_____

Phone #: (_____)_____-_____ work/cell Email: _____

Emergency Contact: _____ Phone #: (_____)_____-_____

Primary Care Physician: _____ Referred by: _____

Primary Care Physician Address/Phone #_____

INSURANCE

Primary:

Insurance Name: _____ ID #: _____

Group #: _____ Effective Date: _____ Policyholders Name: _____

Policyholders Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

Secondary:

Insurance Name: _____ ID #: _____

Group #: _____ Effective Date: _____ Policyholders Name: _____

Policyholders Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

All Patients: I am responsible for the refraction fee of **$60.00** if applicable. If I am responsible for a co-payment, it is to be paid at the time of service. If my insurance company requires a referral or preauthorization, it is my responsibility to obtain it prior to the visit and provide it at the time of the visit. If I fail to supply a required referral, it is my responsibility to pay in full for the service(s) rendered at the time of service. If I have a deductible on my insurance policy, I agree that I will be responsible for the bill or any portion that is not covered by my policy due to failure to have met my deductible. I authorize payment of medical benefits to Leslie C. Doctor, M.D for services described. I accept full responsibility for total amount of the bill.

Signed: _____ Date: _____

Medicare Patients: Medicare does not cover the refraction fee of **$60.00**. This payment is due at the time of service. If Medicare denies payment, I agree to be fully responsible for payment of services rendered. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or their intermediaries or carriers, or the billing agent of this physician, any information needed for this is a related Medicare claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signed: _____ Date: _____

Patient Name: _____ **Date:** _____

Please circle any medical conditions you are currently or have previously been treated for:

High Blood Pressure

Diabetes

High Cholesterol

Heart Disease

Autoimmune Disease

Cancer

Blood Disorders

Psychiatric Problems (Depression/Anxiety, etc)

Respiratory Problems (Asthma, etc)

Headaches (including migraines)

Neurological Conditions

Arthritis

Thyroid Disease

Allergies

Skin Problems (Acne/Rosacea, etc)

Any Other Disease/Illness; Description:

_____

Please circle any eye conditions you are currently or have previously been treated for:

Glaucoma

Cataracts

Macular Degeneration

Retinal Detachment

Strabismus (Crossed Eyes)

Amblyopic (Lazy Eye)

Other Eye Disease/Condition; Description:

_____

Do any blood relatives have any of the following conditions? Please Circle

Glaucoma

Cataracts

Macular Degeneration

Strabismus (Crossed Eyes)

Amblyopic (Lazy Eye)

High Blood Pressure

Diabetes

Cancer

Heart Disease

Any Other Disease/Condition; Description:

_____

PLEASE SEE BACK OF PAGE TO COMPLETE FORM

Do you take any medications (including over the counter medications/aspirin)? Yes No

If yes, please list medications: _____

_____

_____

Are you allergic to any medications or latex? Yes No If yes, please list: _____

_____

Have you ever been hospitalized? Yes No If yes, please explain: _____

_____

Have you ever had surgery? Yes No If yes, please explain: _____

_____

Do you smoke? Yes No If yes; how much? _____

Do you drink alcohol? Yes No If yes; how much? _____

What is your Occupation? _____

Hobbies/Favorite Activities? _____

Have you ever worn glasses? Yes No

Contacts? Yes No If yes: (please circle) Soft Disposable Gas Permeable

Are you interested in LASER VISION CORRECTION/REFRACTIVE SURGERY? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to provide Doctor & Associates with any changes in my medical status.

Please initial to acknowledge the above statement: _____

Thank you for taking the time to complete this form as it is beneficial to providing you with the best care possible.

Our Financial Policy

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is due at the time of service, unless arrangements have been made in advance by your carrier. We accept Cash, Check, Visa and MasterCard credit cards.
2. Keep in mind that your insurance policy is basically a contract between **you and your insurance company**. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay **co-payment, refraction fee, contact lens fit and evaluation at the time of service.**
4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand Doctor & Associate's Financial Policy. By signing below, I agree to be financially responsible for my Eye Exam. I am aware that I need to check with my insurance company for my policy coverage. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient _____ Date _____

Please print name of the Patient _____

Doctor & Associates, PC

Date:

I, _____, authorize Doctor and Associates, PC to discuss any personal health information (protected health information) with my family, (family members' name), _____ with regards to _____.

Signature of Patient: _____

Witness:_____

In accordance with our contracted agreement with your insurance company it is our responsibility to collect and your obligation to pay all of your out of pocket expense at the time of service. Including but not limited to Co-payment, Co-Insurance, and Deductible. If you have any questions regarding your financial obligations please contact your insurance company directly. Thank you for choosing Doctor & Associates PC.

_____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY
Doctor & Associates, PC

This Notice is Effective as of: 10/1/2013

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Doctor & Associates
Leslie C. Doctor M.D., P.C.

CONTACTS LENS/FITTING POLICY

We want your contact lens experience to be a healthy and pleasurable one.

The goal of contact lens fitting is to find the best lens for your eyes. This goal makes the contact lens exam more intensive then a routine exam. The measurements taken are different than those for eyeglasses. (The contact lens sits directly on the cornea and has to be fitted for shape, size, water content and lens power.)

Contact lenses are medical devices and standard of care requires a one-year expiration on all contact lens prescriptions. The contact lens wearer is required to have an annual exam by an eyecare professional, this is the industry standard, which has been set for your safety and the health of your eyes.

Fitting Fee: A fitting fee is charged in addition to the exam fee. This fee includes evaluation, instruction and follow up care. This fee is not covered by insurance. The fees are structured according to lens type and patient experience. i.e. first time wearers, refitting, etc.

Basic Fee Schedule:				
	Soft Sphere	$110.00	Refit	80.00
	Soft Toric	$135.00	Refit	$105.00
	Hard Lens	$160.00	Refit	$130.00
	Therapeutic Fit	$205.00		
	(i.e.Keratoconus , cornel irregularities)			
	Evaluation	$ 50.00		
	(current fit and eye health)			

Annual Exams: An annual exam is necessary to ensure the health of your eyes and safety as a contact lens wearer.

Contact Lens Prescriptions: You are entitled to a copy of your prescription once both you and your eye care professional are satisfied with your fit and vision. This may require multiple trials, it is our goal to make sure you are happy with your vision and that you are confident in the care and proper use of lenses.

Contact Purchases: We will be happy to supply your lenses and discuss the benefits and options available to you. Payment for all lenses is made upon ordering.

Exchanges: We will be happy to exchange only unopened boxes of lenses that have not expired and were purchased here. Contact Lens manufacturers will not accept expired or open boxes of lenses for exchange.

I by this signature, attest that I have read and understand this policy.

_____ _____

Signature **Date**