Patient Name: _____ Date of Birth: _____

Patient E-Mail Address: _____

Do you have, or have you ever had, any of the following medical issues?

	YES	NO		YES	NO
Cataracts ……	___	___	Cancer ……	___	___
Glaucoma ……	___	___	Migraine headaches ……	___	___
Macular Degeneration ……	___	___	Seasonal allergies ……	___	___
Strabismus "Lazy Eye" ..……	___	___	Wear contact lenses ……	___	___
Corneal disease ……..…	___	___	Retina Problems ..……	___	___
Heart disease ……..……	___	___	Thyroid disease .....……	___	___
Diabetes (**Type 1 or Type 2**) ..……	___	___	Asthma ……...……	___	___
Arthritis ……..…	___	___	Stroke ……	___	___
Hypertension ……___		___	Pacemaker/Defibrillator……____		___
Hearing Aids……..	___	____	Other_____		
Dentures/Caps/Bridges …….____		____			

Family history of:

Glaucoma ……	___	___
Cancer ……	___	___
Heart disease ……..……	___	___
Diabetes ……	___	___

Please **circle** the appropriate response below:

Tobacco Use: **None/Past Smoker/Current Smoker**

Alcohol Use: **None/Socially/Weekly/Daily**

Please answer all five (5) questions below and continue onto the back.

1. Reason for today's visit: _____
2. Occupation _____
3. Marital Status **CIRCLE ONE** Single – Married – Divorced – Widowed
4. Have you ever had an injury to your eye(s)? **Circle** YES or NO
    a. If yes, please explain briefly

    _____
5. Have you ever had eye surgery? **Circle** YES or NO
    a. If yes, please explain briefly

    _____

    _____

PLEASE FINISH BOTH SIDES ENTIRELY

Please list all prescription medications below (write none if no meds):

_____
_____
_____
_____
_____
_____
_____

Please list all allergies below (write none if no allergies):

_____
_____
_____
_____
_____
_____
_____

PLEASE FINISH BOTH SIDES ENTIRELY

Signature on File, Assignment of Benefits, Financial Agreement

_____

Patient Name (Print)

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Bronxville Eye Associates for services furnished me by Bronxville Eye Associates. I authorized 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 or the 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 added in item 9 of the CMS-1500 form or elsewhere on other approved claim forms my signature authorizes releasing the information to the insurer or agency shown. Bronxville Eye Associates accepts the determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MediGap:** I understand that if a MediGap policy or health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. Request that payment of authorized secondary insurance benefits be made on my behalf to Bronxville Eye Associates, if possible, or otherwise to me.

3. **Release of Information:** Bronxville Eye Associates may disclose all or any part of my medical record and/or financial ledger including information regarding alcohol or drug abuse, psychiatric illness, communicable disease or HIV, to any person or corporation which is or may be liable or under contract to Bronxville Eye Associates for reimbursement for services rendered, and (2) any health care provider for my continued care. Bronxville Eye Associates may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education and/or medical research, for the collection of statistical data or pursuant to State or Federal Law, statue or regulation. A copy of this authorization may be used in place of the original.

4. **Other Insurance:** I understand that Bronxville Eye Associates maintains a list of healthcare service plans with which it contracts. A list of such plans is available from the business office and that Bronxville Eye Associates has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Bronxville Eye Associates if I belong to a plan that does not appear on the above mentioned list or if I do not follow the guidelines of my insurance by getting a referral if required to.

5. **Non-Covered services:** I understand that Bronxville Eye Associates' contracts with health care service plans relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans to be not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Bronxville Eye Associates to obtain necessary health care service plan authorizations.

6. **Financial Agreement:** I agree that in return for the services provided to the patients by Bronxville Eye Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Bronxville Eye Associates for payment. If an account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Bronxville Eye Associates. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Bronxville Eye Associates. However it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Patient Signature or Authorized Party **Date**

PLEASE FINISH BOTH SIDES ENTIRELY

Bronxville Eye Associates LLC.
Office Policies: Effective 10/01/2022
Please note changes in bold and underlined

Insurance Billing:

- It is your responsibility to confirm with your insurance company that the doctor is participating and if a referral is required
- It is your responsibility to provide us with your CURRENT/VALID insurance
- We are not responsible to know the requirements of your insurance company

Referrals:

- If your insurance company requires a referral from your Primary Care Physician (PCP) for your specialist visit, you are required to contact your physician to obtain this referral. Failure to obtain this referral will result in rescheduling your appointment until it is obtained or payment in full by the patient at the time of your visit.

Refractions:

- **Refraction is the process of determining your eyeglass or contact lens prescription. It is not possible to provide you with an accurate eyeglass or contact lens prescription without performing refraction. Please be advised, Medicare and most other insurance companies DO NOT PAY for this service. Medical insurance does not cover this service as it is considered a vision service. As a courtesy to our patients, we will provide this vision testing if you request a prescription for a $50 fee payable at the time of service.**

Co-payments:

- Co-payments are due at the time of service. THERE ARE NO EXCEPTIONS. We cannot bill patients for these fees. If you leave the office without paying your co-payment, THERE WILL BE AN ADDITIONAL FEE OF $50.00 to cover this expense.

NO-SHOW/LATE CANCELLATION:

- To cancel appointments please call 914-337-8844 **24 hours in advance**. If you do not reach the office you may leave a detailed message on the voice mail. Not showing for your appointment or cancelling in advance denies another patient the opportunity to have an appointment at that time. Failure to be present at the time of a scheduled appointment will result in a $50.00 No-show/Late cancellation fee being assessed to your account without advance notice and MUST be paid before any future appointments.

Billing Policy:

- In the event that a collection agency is used to collect any delinquent balances the additional collection fees of 30% will be assessed to the patients account. You agree reimburse the fees we incur in collection of such debt.

By signing below I confirm that I have reviewed these office policies including information regarding additional fees that may be charged to my account.

_____ _____

Patient Name (please print) Date

_____ _____

Patient/Parent Signature Date

PLEASE FINISH BOTH SIDES ENTIRELY

NEW PATIENT INFORMATION

LAST NAME_____ FIRST NAME _____ MI ____

ADDRESS_____ CITY _____

STATE _____ ZIP _____ SEX _____ SS# ____-_____-____ DOB___/___/___

HOMEPHONE ( ) _____ CELLPHONE ( ) _____

EMERGENCY CONTACT _____ PHONE ( ) _____ RELATIONSHIP

TO PATIENT_____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

PLEASE FINISH BOTH SIDES ENTIRELY

PATIENT HIPAA AWARENESS

With my permission, Bronxville Eye may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Bronxville Eye's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bronxville Eye reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Bronxville Eye may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Bronxville Eye may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Bronxville Eye may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Bronxville Eye restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Bronxville Eye to use and disclosure of my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of patient or legal guardian Date

Patient Name

Print Name of legal guardian if applicable

PLEASE FINISH BOTH SIDES ENTIRELY

CONSENT FOR REFRACTION

Refraction (92015- billing code) is the procedure which allows the doctor to produce an eyeglass (or contact lens) prescription for you. This is **NOT** part of a medical eye exam and is a separate fee.

Many Insurances, including Medicare do **NOT,** reimburse the doctor for this service. Our fee for a refraction is $50.00 which is due on the date of service.

By signing below, you agree to pay the $50 fee for refraction.

_____ _____

Patient Signature Date

PLEASE FINISH BOTH SIDES ENTIRELY