Date________________________________

Patient Information (PLEASE PRINT LEGIBLY)

Name____ Date of Birth_________________ [ ] Male [ ] Female

Address____
Street Apt # City State Zip Code

Home # (_____) ______________________________ Work # (_____) ____

Cell # (_____) ______________________________ Email Address ____

Marital Status [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated

Employment Status [ ] Full Time [ ] Part Time [ ] Retired [ ] Student [ ] Self-Employed [ ] Unemployed

Occupation________________________________ Employer's Name______________________________________

How did you hear about our office? ____

Person Responsible for Payment if Other Than Yourself

Name____ Phone # (______) ________________________

Address____
Street Apt# City State Zip Code

Relationship [ ] Spouse [ ] Parent [ ] Other_________________________________

Insurance Information

Subscriber's Name____________________________________ Subscriber's Date of Birth________________________

Primary Insurance Card (TO BE PHOTOCOPIED)

Secondary/Vision Insurance Card (TO BE PHOTOCOPIED)

Patient Name: ____ **Date**: ___________________________________

Primary Care Physician: _____________________________________ **Phone #:** ________________________________

Family History:Check all that apply

[ ] Blindness [ ] Cataract [ ] Glaucoma [ ] Macular Degeneration [ ] Retinal Detachment

[ ] Arthritis [ ] Cancer [ ] Diabetes [ ] Heart Disease [ ] High Blood Pressure

[ ] Lupus [ ] Sjogren's [ ] Stroke [ ] Thyroid Disease [ ]Other: _________________________

Social History:

Do you smoke? [ ] No [ ] Yes [ ] Socially Do you drink alcohol? [ ] No [ ] Yes [ ] Socially

Medical History: Check all that apply

[ ] Diabetes [ ] Heart Disease [ ] High Blood Pressure [ ] Rheumatoid Arthritis [ ] Glaucoma [ ] Keratoconus

[ ] Cataract [ ] Macular Degeneration [ ] Cancer (Explain below) [ ] Auto Immune Disorder (Specify/Explain below)

Review of Current Symptoms:

YES/NO			YES/NO			YES/NO		
___	___	Loss vision	___	___	Scratched Cornea	___	___	HIV/AIDS
___	___	Fluctuation of vision	___	___	Infection of eye or lid	___	___	Uveitis
___	___	Blurred vision/"halos"	___	___	Common headache	___	___	Lupus
___	___	Double vision	___	___	Migraine headache	___	___	Multiple sclerosis
___	___	Dryness	___	___	Sinus congestion	___	___	Sjogren's syndrome
___	___	Excess tearing/watering	___	___	Dry throat/mouth	___	___	Behcet disease
___	___	Redness	___	___	Runny nose/nasal drip	___	___	Psoriasis
___	___	Itchy eyes	___	___	Shortness of breath/cough	___	___	Reiter's syndrome
___	___	Burning	___	___	Asthma/emphysema	___	___	Thyroid diseases
___	___	Foreign body sensation	___	___	Allergy symptoms	___	___	Crohn's disease
___	___	Sandy/gritty feeling	___	___	Skin rashes/dryness	___	___	Ulcerative colitis
___	___	Mucous discharge	___	___	Muscle/joint pain	___	___	Stroke/Paralysis
___	___	Flashes/floaters in vision	___	___	Numbness/weakness	___	___	Cancer
___	___	Eye pain/soreness	___	___	Urinary problems	___	___	Psychiatric problems
___	___	Stye/chalazion	___	___	Stomach ulcers	___	___	Bleeding disorder
___	___	Glare/light sensitivity	___	___	Diarrhea/vomiting	___	___	Irregular heart beat

If YES, please explanation or list any other conditions not specified: ____

____

____

List all medications / supplements / eye drops: ____

____

____

List any allergies to medications: ____

____

List any major injuries, surgeries, and/or hospitalizations you have had: _____________________________________

____

Are you pregnant and/or nursing? Yes No

Patient Signature____ Date__________________

Doctor Signature____ Date__________________

Eye to Eye Contact
Financial Policy
Important – Please Read Thoroughly

We at Eye to Eye Contact are committed to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy as is written below.

As a patient/guardian, it is in your best interest to know and understand ***your*** insurance plan benefits and your financial responsibilities. We must emphasize that as medical providers, **our relationship is with you, not your insurance company**. It is often necessary for **you** to inquire and explore your benefits with your insurance carrier. Due to the fact that we do accept a variety of insurances, it is not possible for us to know all of your plan provisions. Please check with your insurance company to see if we participate with your plan.

If we do participate with your insurance company, all services performed in our office will be submitted to **your PRIMARY carrier only**, unless we have received prior notification of non-covered services. In regards to SECONDARY insurance carriers, ***you*** will be responsible for payment of any charges that are not automatically forwarded by your PRIMARY insurance carrier. **All copays and deductibles are the patient/guardian's responsibility and will be due at the time of service.** ***We highly recommend you contact your insurance companies for details of your coverage prior to your scheduled appointment in order to avoid any additional charges.*** *ELIGIBILITY VERIFICATION* ***DOES NOT*** *GUARANTEE COVERAGE ONCE A CLAIM IS FILED.* If, for any reason, we are asked to reprocess a claim there will be a **reprocessing fee of $25**.

If we DO NOT participate with your insurance company, this means that we will not bill your insurance carrier AND we will not accept payment from them as payment in full for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all charges. You are responsible to notify us of your insurance and to provide the necessary information about your insurance plan; therefore, please have your **MOST CURRENT** insurance card with you at all times, as well as a photo ID such as a driver's license, military ID, or government issued ID.

Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. Benefit and coverage rules and policies differ among insurers and even between different plans of the same insurer.

To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card) prior to your scheduled appointment. Your employer's human resources department may also be a source of information and assistance.

If your insurance company requires a referral and/or prior authorization, contact your primary care physician prior to visiting our office. Failure to obtain such may result in refusal of being seen for your appointment and/or additional charges.

It is your responsibility to know your insurance company's patient responsibilities and procedures. If proper procedures are not followed, you may be liable for full payment of the bill.

____ ___________________________

Signature of Patient/Guardian Date

Your signature acknowledges that you have read and agree with the above statements.

Receipt of Notice of Privacy Policies & Consent Form

Steven M. Berger, OD
Eye To Eye Contact
1404 West Chester Pike
Havertown, PA 19083
610 853-2001

Patient Name: ____

Patient Number: ____________________ Patient Phone Number: ____________________

Patient Address: ____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Eye To Eye Contact.

____ ____________________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________________ ______________________________
Relationship to Patient Print Name

Source of Authority: ____

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