Negrin MD PLLC

PATIENT INFORMATION				
PATIENT'S LAST NAME	**FIRST**	**MIDDLE**	**SEX**	**BIRTH DATE**
			□ M □ F	

SOCIAL SECURITY #	**HOME PHONE**	**CELL PHONE**	**EMAIL**
	( )	( )	

HOME ADDRESS

P.O. BOX or APARTMENT #	**CITY**	**STATE**	**ZIP CODE**

OCCUPATION	**EMPLOYER**	**EMPLOYER PHONE NUMBER**
		( )

How were you referred to us?	□ Dr.	□ Friend / Family	□ Internet

REFERRING PHYSICIAN NAME, ADDRESS & PHONE NUMBER:

PRIMARY CARE DOCTOR NAME, ADDRESS & PHONE NUMBER:

PHARMACY NAME, ADDRESS & PHONE NUMBER

INSURANCE INFORMATION			
Person responsible for bill:	**Birth date:**	**Address (if different):**	**Phone No:**

Occupation:	Employer:	Employer Address:	Employer Phone No.:

Is this patient covered by insurance? □ Yes □ No

Primary insurance:					
Subscriber's name:	Subscriber's SS No.:			Birth Date:	Policy No.:
				/ /	
Patient's relationship to subscriber:	□ Self	□ Spouse	□ Child	□ Other	

Secondary insurance:					
Subscriber's name:	Subscriber's SS No.:			Birth Date:	Policy No.:
				/ /	
Patient's relationship to subscriber:	□ Self	□ Spouse	□ Child	□ Other	

HIPAA CONSENT FOR EMERGENCY/MEDICAL/FINANCIAL CONTACT
(Who can we speak with on your behalf?)

Name	**Relationship**	**Address**	**Best Phone #**

Negrin MD PLLC

ASSIGNMENT OF INSURANCE

MEDICARE
I request that payment of authorized medical benefits be made on my behalf to Negrin MD PLLC for any Service furnished me. I hereby authorize **Negrin MD PLLC** to release to the Health Care Administration and its agent any medical information needed to determine these benefits to the benefits payable for related services under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE
I hereby authorize the release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS PAYABLE TO ME TO Negrin MD PLLC**. I understand that I am financially responsible for any balance not covered by my insurance carrier.

_____ _____
Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have read and received Negrin MD PLLC **Notice of Privacy Practices** and authorize Negrin MD PLLC to use, access, and disclose my health information in the manner described in the notice.

_____ _____
Patient/Guardian Signature Date

Negrin MD PLLC Financial Policy

Thank you for choosing Negrin MD PLLC, a specialty practice for your eye care needs. We are committed to providing you with excellent service in every area including billing and insurance claims filing. Please read and sign our policy below.

Our practice participates in many medical insurance plans. We do not participate in any vision plans. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, VISA, MasterCard, Discover and American Express.

We will bill your primary insurance company on your behalf for any medical services provided by our office. As a courtesy, we will also bill your secondary insurance company, though ultimately you are responsible for all balances identified by your primary insurance company. It is also your responsibility to provide us with accurate insurance information, referrals or other authorizations necessary for your visit, as well as accurate personal information which will allow us to be reimbursed for your services from your primary insurance company. Your insurance coverage is a contract between you and your insurance company and we cannot always fully anticipate, based on your individual contract, your full financial responsibility for your visit. We do realize that temporary financial difficulty may affect the timely payment of your account. It is your responsibility to contact us promptly if you need to set up a payment plan to satisfy a balance with us.

Our eye examinations typically consist of covered components in which we are assessing the medical health condition of your eye as well as refraction in which we check the quality of your vision. From this, an eyeglass prescription may be given in order to allow you to read more clearly. Most insurance plans, including Medicare, do not pay for refractions. You will be asked to pay for the refraction at the time of your visit. This fee is additional to any co-pay, co-insurance or deductible balances you may have. If you currently wear, or wish to start wearing contact lenses, there is a separate charge for the contact lens fitting which must be paid at the time of service. Pricing information can be provided upon request.

If you are having surgery, we will assist in getting pre-authorization for your procedure. We will inform you in advance of the procedure if there are components which your insurance provider has not approved.

Charges you may be responsible for include but are not limited to:

Any services applied to your deductible or for which you are required to pay co-insurance and/or any co-pays as determined by your primary insurance carrier.

1. Care not covered because you have not obtained a referral from your primary care physician in advance of your appointment.
2. Care provided and not covered because of termination of your insurance.
3. Care provided and not covered because you did not provide accurate insurance information.
4. Care provided and not covered because the provider is considered out-of-network.
5. Care which is not covered by your insurance company. This includes but is not limited to: refraction services in which an eyeglass prescription is obtained, contact lens fitting exams, contact lenses, and various cosmetic services.

In case of non-payment by you, all reasonable costs of collection, including legal and out of pocket costs will be added to your balance.

I have reviewed a copy of the financial policy provided by Negrin MD PLLC.

Patient's Initials: _____ Date: _____

Negrin MD PLLC MEDICAL HISTORY

Patient Name: _____ Date: _____

Patient Date of Birth: _____

Please answer the following questions to the best of your ability.

Reason for visit: _____

_____

Medications

Please list all medication(s) including eye drops, which you are currently taking

Family History (if yes, please indicate relationship of family member. i.e. mother, father, etc.):

□ Yes □ No Blindness _____
□ Yes □ No Cataract _____
□ Yes □ No Glaucoma_____
□ Yes □ No Macular Degeneration _____
□ Yes □ No Strabismus (Lazy Eye) _____
□ Yes □ No Diabetes _____
□ Yes □ No Heart Attacks_____
□ Yes □ No High Blood Pressure_____
□ Yes □ No Thyroid Disease _____

Your Eye/Ocular History (have you ever had any of the following?):

□ Yes □ No Glaucoma: _____
□ Yes □ No Cataracts: _____
□ Yes □ No Corneal Disease: _____
□ Yes □ No Iritis: _____
□ Yes □ No Crossed Eyes: _____
□ Yes □ No Retinal Disease: _____
□ Yes □ No Injury: _____
□ Yes □ No Other Eye Disorders: _____
□ Yes □ No Cataract Surgery (Date of Surgery)
□ Yes □ No Left Eye _____
□ Yes □ No Right Eye _____

Does your vision make it difficult for you to:

□ Yes □ No Write?
□ Yes □ No Drive?
□ Yes □ No Cook?
□ Yes □ No Sew?
□ Yes □ No Watch TV?
□ Yes □ No Work?

Your Medical History

Have you ever had major surgery or been hospitalized for any reason? □ **Yes** □ **No**
If yes, please describe: _____

_____

Have you ever had any complications from anesthesia? □ **Yes** □ **No**
If yes, please describe: _____

_____

Do you have any **DRUG** or **ENVIRONMENTAL** allergies? □ **Yes** □ **No**
If yes, please list the name of the drug or describe allergy (dust, pollen, etc.) _____

_____

_____

What kind of reactions have you experienced? _____

_____

Do you have any problem in the following areas?

□ Yes □ No Lung Disease
□ Yes □ No Kidney Disease
□ Yes □ No Arthritis
□ Yes □ No Diabetes _____# of Years
□ Yes □ No Neurological Disease
□ Yes □ No Migraines
□ Yes □ No Psychiatric Disorder / Nervous Disorder
□ Yes □ No Heart Disease
□ Yes □ No Gastrointestinal. Type: _____
□ Yes □ No High Blood Pressure. _____# of Years.
□ Yes □ No Scarring Keloids
□ Yes □ No Head or Spinal Injuries _____
□ Yes □ No Seizures, Convulsions or Fainting
□ Yes □ No Temporal Arteritis
□ Yes □ No Carotid Artery Disease
□ Yes □ No (Women) Are you pregnant or nursing?
□ Yes □ No Stroke: _____
□ Yes □ No HIV/AIDs: _____
□ Yes □ No Extensive Confinement from illness or injury
□ Yes □ No Permanent defect from illness, disease or injury
□ Yes □ No Suffering from any other disease: _____
_____

□ Yes □ No Smoke/ chew tobacco?
□ Yes □ No Drink alcohol?
□ Yes □ No Use illegal drugs?

□ Yes □ No Have concerns about bags under your eyes?
□ Yes □ No wrinkles on the face?
□ Yes □ No droopy eyelids or eyebrows?
□ Yes □ No your eyes appearing tired?

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Signature: _____ Date: _____
Reviewed by: _____ Date: _____