

**WOODCLIFF LAKE OPHTHALMOLOGY, LLP.**

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**577 Chestnut Ridge Road**

**Woodcliff Lake, NJ 07677**

**Tel. (201) 782-1700 Fax (201) 782-1749**

We want to welcome you to our office and thank you for choosing us to provide you with your eye care needs.

Please complete the enclosed forms and bring them with you along with your insurance card(s) and referral form if needed.

Please bring the following:

1. Insurance Cards
2. Referral if needed
3. List all medications that you are currently taking.
4. Current eyeglasses.
5. If you are a contact lens wearer, we will need you to provide any information regarding your lenses; brand, power, base curve, diameter.

A parent or legal guardian must accompany patients under the age of 18. If this is not possible, please provide a letter authorizing medical treatment.

Anyone in a wheelchair must have someone accompany them for the complete visit.

**Thank You!**

**We look forward to meeting you.**

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Woodcliff Lake Ophthalmology  
577 Chestnut Ridge Road  
Woodcliff Lake, NJ 07677

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions. If you agree then you are bound to abide by such restrictions.

**Please give us the name of the person that you would allow us to release confidential information to, such as test results, billing questions or treatment.**

_____	_____	_____
NAME	Telephone Number	RELATIONSHIP
_____	_____	
PLEASE PRINT PATIENT NAME (OR RESPONSIBLE PARTY IF MINOR)	RELATIONSHIP TO PATIENT	
_____	_____	
SIGNATURE	DATE	

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do as documented below:

Date:	Initials:	Reason:
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Give copy to Patient

# WOODCLIFF LAKE OPHTHALMOLOGY, LLP

## FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship.

It is very important that you, the patient, come into our office with all of the required documentation and be fully aware of how your plan works prior to the time of your scheduled appointment. You may be billed for any uncovered services. You, the patient, are the policyholder and it is your responsibility to know your insurance plan.

### **PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.**

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of \$25 may then be added to your account. Cancellation for a Saturday appointment requires 5 days notice. Should you not provide this notice; a \$50 cancellation may then be added to your account.
- **REFERRALS** – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with a referral within 48 hours with the date of by our visit or you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay that co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of \$20 may be added to your account.
- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. If we do not “participate” with your plan we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days. You will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to our office with the Explanation of Benefits, Private Insurance Authorization for Assignment of Benefits/Information Release; I, the undersigned, authorize payment of medical benefits to Woodcliff Lake Ophthalmology, LLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company ( or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating claims of benefits.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.  
Medicare Lifetime Signature on file: I request that payment of authorized Medicare benefits be made on my behalf to Woodcliff Lake Ophthalmology, LLP for any services furnished to me. I authorize any holder of medical information about me to release to CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – the parent who consents to the treatment of a minor child is responsible for payment of services rendered. Woodcliff Lake Ophthalmology, LLP will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. If a balance is unpaid after 30 days, there will be a \$10 billing charge added each 30 day billing cycle until the balance is completely paid. Any balance left unpaid after 90 days, without attempts at resolution, will be considered delinquent, and may be submitted to a collection agency. If you are having financial hardship, please speak with the billing office, and we will make every effort to set up an acceptable payment plan with you. Should it become necessary for us to use an outside agency to collect payment, you will be additionally responsible for whatever charges we incur as a result of this. Until the bill is paid we will be unable to provide any further medical care to you. Submission of your account to a collection agency may adversely affect your credit rating.

PLEASE BE ADVISED THAT WE DO NOT PARTICIPATE IN ANY VISION PLANS.

WE ACCEPT CASH, CHECKS, MASTERCARD, AND VISA.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Give signed copy to patient**

vers. January 2016

**WOODCLIFF LAKE OPHTHALMOLOGY, LLP.**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work No.: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext.: \_\_\_\_\_

Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

**Preferred Method of Contact (circle one):** Home-Tel Work-Tel Cell Email-Address

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status (circle): Single Married Separated Divorced Widowed

**How were you referred to our office?** \_\_\_\_\_

**Employment:** Occupation: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

**If under 18, please complete:** \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Father: \_\_\_\_\_ Employer: \_\_\_\_\_

Are you full time student? Yes No Name of School \_\_\_\_\_ State: \_\_\_\_\_

**If you are married, please complete Spouse Information:**

Spouse Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Spouse Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ Town: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Insurance Information:**

Name of Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of the Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Who is responsible for your visit: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Reason for Office Visit:**

- |  |   |
|--|---|
| <input type="checkbox"/> Routine Eye Exam              | <input type="checkbox"/> Need New Glasses             |
| <input type="checkbox"/> Medical or Surgical Problem   | <input type="checkbox"/> Interested in Contact Lenses |
| <input type="checkbox"/> Referred by Medical Physician | <input type="checkbox"/> Other: _____                 |

**Person to contact in case of emergency:**

Name: \_\_\_\_\_ Phone No. (    ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Review of Systems:**

**Please check off if you have:**

- Blurred Vision .....
- Loss of Vision .....
- Reduced Side Vision .....
- Flashes of Light .....
- Floaters.....
- Abnormal Sensitivity to Light .....
- Halos around Lights .....
- Problems with Glare .....
- Foreign Body Sensation .....
- Eye Irritation.....
- Eye Dryness .....
- Eye Itching .....
- Pressure In or Around the Eye .....
- Tearing .....
- Discharge .....
- Crusting or Red Eyelids .....
- Double Vision .....
- Headaches .....
- Sandy or Gritty Eyes.....
- Night Vision Difficulty .....
- Tired Eyes .....
- Swelling .....
- Recurrent Infection.....
- Inability to Wear Contact Lenses.....

**Past Medical History:**

**Please check off if you ever had:**

- Eye surgery .....
- Eye injury .....
- Serious Eye Infection.....
- Lazy Eye.....
- Eye Turning In or Out .....
- Droopy Eyelid .....
- Corneal Disease .....
- Cataract .....
- Retinal Disorder .....
- ENT:** Sinusitis .....
- Ringing in Ears.....
- Neurological Disease:**.....
- Headaches .....
- Migraine .....
- Psychiatric** .....
- Endocrine** .....
- Heart** .....
- Abdominal** .....
- Hematologic** (Bleeding/Clotting Difficulty)....
- Vascular** .....
- Musculoskeletal:** joints or muscles .....
- GYN** .....
- Genitourinary (bladder/kidneys) .....
- Other \_\_\_\_\_

**Social History**

Do you drink?  Yes  No

If yes, how much? \_\_\_\_\_

Do you smoke?  Yes  No

If yes, how much per day? \_\_\_\_\_

**Present Medications: Dosage and Frequency**


**List Allergies to Medications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical History:**

Medical Conditions: **(Please circle any that apply):** Diabetes, Hypothyroidism, Coronary Artery disease, High Blood Pressure, High Cholesterol, Asthma, Allergies, Cancer. \_\_\_\_\_

**Ocular History:**

**Do you drive?**  Yes  No      Do you have difficulty with distance or near vision?  Yes  No

**Do you wear glasses?**  Yes  No      If yes, how old is your current pair? \_\_\_\_\_

If yes, what type?    Distance      Reading      Bifocal      Progressive      Trifocal      Half

**Do you wear contact lenses?**  Yes  No      If yes, how old is your current Pair? \_\_\_\_\_

What type of contacts do you wear?    Soft    Gas Perm.    Toric    Multifocal    Disposable    Extended Wear

Do you sleep in your lenses?  Yes  No      What do you clean your lenses with? \_\_\_\_\_

Brand of contact Lenses: \_\_\_\_\_

	Right Eye	Left Eye
Present Prescription:	_____	_____
Base Curve (B.C.):	_____	_____
Diameter (Dia.):	_____	_____

**Family History**

- Cataracts. Whom: \_\_\_\_\_       Glaucoma. Whom: \_\_\_\_\_
- Macular Degeneration. Whom: \_\_\_\_\_       Retinal Detachment. Whom: \_\_\_\_\_
- Diabetes. Whom:: \_\_\_\_\_       Lazy Eye. Whom: \_\_\_\_\_
- Blindness. Whom: \_\_\_\_\_       Crossed Eye. Whom: \_\_\_\_\_

**Signature Release:**

I have read the office policy and I understand that, regardless of my insurance status, I am responsible for professional services rendered to me or my dependent. I authorize you to release any information to my insurance company for the purpose of processing claims. I understand that it is my responsibility to be familiar with my insurance company policies.

I understand that Medicare and other insurance companies consider a routine eye exam and refraction (procedure done by the doctor to check your prescription) as a **“non-covered”** procedure. I understand that I am responsible for payment in full for these procedures at today’s visit.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_