Welcome! Please complete this form and return it to the receptionist so we may prepare your chart.

PATIENT INFORMATION				
Last Name:	First Name:		M.I.:	DOB:
SS #:	Bill to same name: Y N	Sex: M F	Age:	Today's Date:
Street Address:				
City:			State:	Zip:
E-mail Address (to receive our newsletter):			Home Phone:	
Employer:				
Occupation:			Employer Phone:	
Name of Nearest Relative:			Phone:	
Whom may we thank for referring you to us (Name & Address):				

INSURANCE INFORMATION	
Medicare #:	Medicaid #:
Is Medicare your secondary payer as a result of TEFRA? Y N	
Are you currently a member of an HMO, HIP or other managed care plan? Y N	

PRIMARY INSURANCE		
Private Insurance Name:		Insured's Name:
Insured's Date of Birth:	Insured's SS #:	Relationship to Insured: Self Spouse Child Other
ID #:		Group:

SECONDARY INSURANCE		
Private Insurance Name:		Insured's Name:
Insured's Date of Birth:	Insured's SS #:	Relationship to Insured: Self Spouse Child Other
ID #:		Group:

PAYMENT OF BENEFITS DIRECTLY TO THE PHYSICIAN

I request that payment of authorized benefits be made directly to Stahl Eyecare Experts on my behalf for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or agent any information needed to determine these benefits or the benefits payable for related services.

Signature: ____ Date: ____

Please turn over and fill out the other side of this form →

PATIENT INFORMATION

Diabetes	N Y	For ______ Years	Last Blood Sugar _________	Taken When? ________
			Last Hemoglobin A1C ______	Taken When? ________
Asthma	N Y	For ______ Years	Well controlled on medication?	N Y
High Blood Pressure	N Y	For ______ Years	Well controlled on medication?	N Y
Glaucoma	N Y	For ______ Years	Well controlled on medication?	N Y
Heart Attack	N Y	Number of attacks: _____	What year was the last one:	___________________
Stroke	N Y	Number of strokes: _____	What year was the last one:	___________________
High Cholesterol	N Y		Arthritis N Y	
Heart Disease	N Y		Cancer N Y	Of what? ___________
Bronchitis	N Y		Emphysema N Y	

Other (Please list):

MEDICATIONS

List any medications you are allergic to:

Eye medications you are taking:

Other medications that you are taking:

EYE HISTORY

How many years ago was your last eye examination: ____	Have you ever had any surgery performed on your eyes? N Y If yes, for ______________________________
Do you wear glasses? N Y	Glasses are __________ years old
If yes, for Distance Reading Only	Bifocals Progressive Bifocals
Do you wear contact lenses? N Y	Wearing for __________ years
If yes, Hard Soft	

What is the main problem that you are having with you eyes that you are here for today?

PRIMARY CARE PHYSICIAN / FAMILY DOCTOR

Name:

Address:

Do you want us to send a letter of your findings to this doctor? N Y

T.J. Hufnagel, M.D.
Marc S. Werner, M.D.
Benjamin Chang, M.D.
K. Buol Heslin, M.D.
Harry Briffel, O.D.
Brian Lewy, O.D.
www.stahlny.com

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Refractive Surgery • Cataract Surgery • Glaucoma • Cornea and External Disease • Medical & Surgical Retina • Diabetic Retinopathy • Age Related Macular Degeneration • Ophthalmic Plastic & Reconstructive Surgery • Neuro-ophthalmology • Optometry • Contact Lens

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Stahl Eyecare Experts may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Stahl Eyecare Experts 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. Stahl Eyecare Experts 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 Thomas Bartolomeo, Stahl Eyecare Experts, 450 Endo Blvd, Garden City, NY 11530.

With my consent, Stahl Eyecare Experts may call my home, or other designated location, and leave a message on voicemail, 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 consent, Stahl Eyecare Experts 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 confidential. I have the right to request that Stahl Eyecare Experts 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 form, I am consenting to Stahl Eyecare Experts use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures, and reliance upon my prior consent. If I do not sign this consent, Stahl Eyecare Experts may decline to provide treatment to me.

____________________________________ ________________________
Signature of Patient or Legal Guardian Date

____
Print of Patient or Legal Guardian

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IAA 2012

Patient: ______________________________

- I hereby assign, transfer and set over to the above named physician group and facility sufficient monies and or benefits to which I may be entitled from government agencies, insurance carriers and/or others who are financially liable for the cost of care and treatment rendered to the patient.
- I authorize the above named physician group and facility to release any and all records, medical history, services rendered, or treatment given to the patient for the purpose of review, investigation or evaluation of any claim submitted to my insurer(s).
- I authorize the transferring of any and all necessary personal medical or demographics information required by the pharmacy in order to fill or refill medication prescriptions. I understand that this information may be transferred electronically, verbally or in writing.
- I agree that I am financially responsible for any balance that my insurance does not cover for services or treatment rendered to the patient. I agree that if the patient is not covered by medical insurance, then I am responsible for all charges for services or treatment rendered to the patient.
- I am aware of the conditions and limitations of my insurance plan benefits and will provide the above named physician group and facility with all necessary information that is required to be examined by an ophthalmology specialist. I agree that I am financially responsible for all charges, if the patient is examined by the physician without a referral that is required by my insurance, and/or if my insurance was terminated at the time of services and I failed to update the physician with my current information.

Vision Plans: If you have a vision plan, it is your responsibility to let the front office staff, the technician and the doctor that you are here for a routine vision exam under your vision plan or vision benefit which is part of your medical insurance. Please understand that vision exams are for routine vision problems (i.e. checking prescription for glasses/contact lenses) and not for medical conditions. If you have a medical eye condition known or discovered at this “routine vision” exam, you may be asked to make another appointment to be examined for this medical condition.

We cannot file claims to both your Vision Insurance and your Medical insurance on the same day. If you do not notify prior to the visit that this exam is for a “routine vision exam” and there is a medical condition and medical insurance has been filed we will not go back and file this visit under your vision plan even if your medical insurance paid nothing or applied to your deductible. You must let us know prior to the exam which plan this claim is to be filed.

Remember that we do not participate in all vision plans so please make sure that your doctor is listed as a provider prior to your making an appointment.

______________________ ______________________________
Date Signature of Patient/Guarantor

____
Printed Name of Signee