Cornea Consultants of Albany, PLLC

Patient Registration Form

Personal Information

Last Name:	First Name:	Middle Initial:	Suffix:

Email Address:	Date of Birth:	Sex: ☐Male ☐Female

Address:	City:	State:	ZIP Code:

Home Phone:	Work Phone:	Cell Phone:

Occupation:	If Under 18 Parent or Guardian's Name:

Referring Doctor:	Clinic or Location:	Phone:

Primary Care Physician:	Clinic or Location:	Phone:

How did you hear about us?

☐Physician Referral ☐Patient Referral ☐TV ☐Internet ☐Radio ☐Mailing ☐Other____________________

Preferred Method of Contact:

☐Home Phone ☐Work Phone ☐Cell Phone ☐Email ☐Text Message(for appointment reminders)

Notify in Case of Emergency

Name:	Relationship:	Phone Number:

Address:

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Insurance Information

Primary Insurance Name:	
Policy #:	Group #:
Subscriber Name:	Subscriber Date of Birth:
Patient Relationship to Subscriber of Insurance:	
Secondary Insurance Name:	
Policy #:	Group #:
Subscriber Name:	Subscriber Date of Birth:
Patient Relationship to Subscriber of Insurance:	

Assignment of Benefits, Signature on File and Financial Agreement

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Cornea Consultants of Albany for services furnished me by Cornea Consultants of Albany. I authorize any holder of medical information about me to release it 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 indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Cornea Consultants of Albany accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP/SECONDARY INSURANCE:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Cornea Consultants of Albany, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Cornea Consultants of Albany 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 (1) which is or may be liable or under contract to Cornea Consultants of Albany for reimbursement for services rendered, and (2) any health care provider for continued patient care. Please see our Notice of Privacy Practices for information on your rights under the HIPAA Regulations, 45 CFR Parts160 and 164. Cornea Consultants of Albany 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, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. INSURANCE COVERAGE: Cornea Consultants of Albany contracts with most of the major health plan payers; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. Our business office is available for assistance at 518-459-5397. I understand that I am responsible to pay for any health care services for which my health plan denies coverage.

5. NON-COVERED SERVICES: I understand that Cornea Consultants of Albany contracts with health care plans that identify items and services which are "covered services." Accordingly, the undersigned accepts full financial responsibility for all items or services, which are ultimately determined by the health care service plans not to be 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 Cornea Consultants of Albany to obtain necessary health care service plan authorizations. Payment for non-covered services is expected at time of service.

6. NO SHOW POLICY: I understand that Cornea Consultants of Albany reserves the right to bill me for a "No Show Fee" in the event that I miss two consequent scheduled appointments without prior notice.

7. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Cornea Consultants of Albany, I will pay my account at the time service is rendered or will make financial agreements satisfactory to Cornea Consultants of Albany for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my 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 Cornea Consultants of Albany. If copayments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Cornea Consultants of Albany. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

8. EYE DROP ADMINISTRATION: I understand, as a patient, or parent/guardian of a minor child, that my eyes/my child's eyes may be dilated as part of the exam. Dilation and other drops used during my visit can affect vision and function for a period of time. By signing below, permission is granted to dilate and give other drops.

____ Patient/Responsible Party Signature

__________________________ Date

Billing and Insurance Information

We are pleased you have chosen Cornea Consultants of Albany, PLLC for your eye care needs. To help answer some of your billing and insurance questions, we have compiled some information to guide you through the process.

MEDICARE

If you have Medicare, our office will bill Medicare and/or your secondary insurances. You are responsible for the following:

- Any deductibles and co-pays
- 20% co-pay of the allowed charges
- Any non-covered services
- Services ordered by the physician that do not meet Medicare guidelines for medical necessity
- Routine eye examinations or refraction charges

MEDICAID

If you have Medicaid, you are required to present a current Medicaid card at every visit. You are responsible for the following:

- All non-covered services

HMO & PPO PLANS

If you have HMO or PPO coverage, you are required to obtain an insurance referral for most services. It is your responsibility to obtain all insurance referrals before services are rendered. You can do this by calling the referral department of the clinic listed on your insurance card. If you fail to obtain an insurance referral and services are denied, the balance will become your responsibility.

COMMERCIAL PLANS

If you have a commercial plan, we will bill your insurance company as a courtesy. If payment from your insurance company has not been received within 30 days, you are responsible for the balance in full. You are also responsible for the co-pay and/or any non-covered services. **Co-pays are due on the day of service**.

BILLING CYCLE

If your insurance information is verified at registration, you will not receive a bill until:

- Your insurance company has denied the claim
- Your insurance company has paid the claim, leaving a co-insurance, deductible or non-covered service.

OR

- Your insurance company has not responded to the claim.

ROUTINE VISION PLANS

Some employers have separate vision benefit plans specifically for routine eye exams, called “carve out” plans. These plans are separate from your medical insurance coverage and are handled by a different company. We do **NOT** participate with these plans. These include, but are not limited to:

- VSP(Vision Service Plan)
- Davis Vision
- Amerisight
- Spectera

If you have this type of vision plan, you will be responsible for payment in full for your services. If you are scheduled for a routine vision exam, please review your vision benefits carefully. *(This does not pertain to LASIK services and/or Refractive Evaluations)*

ROUTINE EXAMINATION AND REFRACTION CHARGES

Benefit coverage for routine eye examinations and refraction charges vary by health plan and by employer. Specific benefit coverage can also change from year to year.

An examination is considered **routine** when performed for a patient who has no specific illness, symptom, complaint, or injury that needs to be treated or diagnosed.

Refraction is a test that is used to determine any optical defect present in the eye. A refraction is necessary:

- to prescribe the best corrective lenses
- to determine the progression or diagnosis of certain ocular diseases
- to ascertain the basis for your visual complaints.

You may want to check benefit coverage with your insurance carrier to determine if vision care is a covered service. All refraction fees are due on the date of service.

OVERPAYMENTS

In the event that Cornea Consultants of Albany receives a payment that results in an overpayment on your account, this overpayment will be credited to your account. If the overpayment is in excess of $20, Cornea Consultants will reimburse you for this amount.

For questions regarding your account, please call our Billing Department at: **518-459-5397.**

CONTACT LENS REMOVAL POLICY

Refractive or Cataract Surgery Evaluations ONLY

Our physicians and staff at Cornea Consultants of Albany want to make every effort to ensure you have the best visual result following your surgical procedure. Therefore, we ask that you adhere to the recommended protocols regarding the removal of contact lenses. Wearing contact lenses, especially over a long period of time, can temporarily alter the shape of the front surface of the eye (the cornea). This pressure can influence critical measurements that must be taken prior to the treatment. It is essential that contact lenses are removed and your eyes are allowed to rest for a period of time before your measurements are taken for the procedure.

Please adhere to the following guidelines in removing your contact lenses:

For those who have not had an exam to take the necessary measurements:

- ❑ Rigid contact lenses, including gas permeable should be removed for a minimum of 4 weeks prior to your ***refractive or cataract evaluation.***
- ❑ Soft contact lenses should be removed for a minimum of 2 weeks prior to your ***refractive or cataract evaluation.***

Warning: If contact lenses are worn during the required removal period, there is a strong likelihood that the ancillary tests and vision correction procedure will have to be rescheduled for a later date.

Please discuss any specific contact lens issues you might have with our surgical coordinator or your eye doctor.

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: ____
Date of Birth: _____________________________
Date of Visit: _____________________________

Date of Last Eye Exam: ______________________

List Any Eye Medications/Drops You Currently Use: ____
____

List Any Other Medications You Currently Take: ____
____
____
____

List Any Allergies to **Medications**: ____
____

List All Major Illnesses (Glaucoma, Diabetes, High Blood Pressure, etc.) or Injuries (Concussion, etc.): ____________
____
____

List Any Eye Surgeries You Have Had (Cataract, LASIK, etc.) and Approximate Date: _________________________
____

List Any Other Surgeries You Have Had (Tonsillectomy, Appendectomy, etc.): _____________________________
____

Do you ***currently*** have any problems in the following areas? If **YES**, please explain.	**YES**	**NO**	**DETAILS**
EYE HISTORY			
Loss of vision			
Blurred Vision			
Fluctuating vision			
Double Vision			
Distorted Vision (halos)			
Glare or light sensitivity			
Visual difficulty when driving			
Problems with night vision			
Dryness			
Sandy or gritty feeling			
Redness			
Itching			
Burning			
Excess tearing or watering			
Eye pain or soreness			
Mucous Discharge			
Tired Eyes			

MEDICAL HISTORY QUESTIONNAIRE - CONTINUED

GENERAL HISTORY	YES	NO	DETAILS
General/Constitutional (fever, weight loss, etc)			
Ears, Nose, Throat (sinus, ear infection, etc)			
Cardiovascular (high blood pressure, heart, etc)			
Respiratory (congestion, wheezing, etc)			
Gastrointestinal (stomach upset, diarrhea, etc)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, etc)			
Muscles, Bones, Joints (joint pain, stiffness, etc)			
Skin (acne, warts, growths, rash, etc)			
Neurological (numbness, headache, etc)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc)			
Blood/Lymph (cholesterolemia, anemia, etc)			
Allergic/Immunologic (hay fever, etc)			

FAMILY HISTORY			**M=Mother F=Father S=Sibling GP=Grandparent**
DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Age Related Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
Stroke			
High Blood Pressure			
Other			

SOCIAL HISTORY

Current Occupation: ______________________________

Education: ______________________________

Marital Status: ______________________________

Living Arrangements (Nursing Home, Assisted Living, Rehabilitation, etc): ______________________________

Alcohol Consumption: ☐None ☐Occasionally ☐1/Day ☐2-3/Day ☐4+/Day

Smoking Habits: ☐None ☐Occasionally ☐1/2 Pack/Day ☐1 Pack/Day ☐1+Pack/Day

Do You Drive? ☐YES ☐NO

Have You Ever Worn Contact Lenses? ☐YES ☐NO

Do You Currently Wear Contact Lenses? ☐YES ☐NO If Yes, How Long? ______________

Do You Currently Wear Glasses? ☐YES ☐NO If Yes, How Long? ______________

Patient's Signature: ______________________________ *Date:* ______________

Physician's Signature: ______________________________ *Date:* ______________