

**New Patient Information****PERSONAL INFORMATION (Please Print Clearly)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ M / F Soc Security #: \_\_\_\_\_

LOCAL Address: \_\_\_\_\_  
Street City State Zip

Phone: Home: \_\_\_\_\_ Cell / Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

OTHER Address: \_\_\_\_\_  
Street City State Zip

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  DivorcedReferred by:  Doctor \_\_\_\_\_  Friend/Relative: \_\_\_\_\_ Internet \_\_\_\_\_  Yellow Pages  Other: \_\_\_\_\_

Insurance: \_\_\_\_\_

Who to notify in emergency (nearest relative or friend)?

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

Home Phone: \_\_\_\_\_ Cell / Work Phone: \_\_\_\_\_

**FINANCIAL ASSIGNMENT AND AGREEMENT:**

1. Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, co-pay, or any other balance not paid for by your insurance.
2. In order to control your cost of billings, we request that your charges, co-pays, co-insurance, etc. be paid at the conclusion of each visit.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the health care financing administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all Information necessary to secure the payment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## EYE HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing V.I.P. Laser Eye Center & Dr. Salinger for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses?            \_\_\_ Yes        \_\_\_ No
2. Do you wear contact lenses?    \_\_\_ Yes        \_\_\_ No
3. Do you have problems reading? \_\_\_ Yes        \_\_\_ No

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye pain      Blurred Vision      Eyelid Crusting      Flashes of Light      Halos  
Discharge      Light Sensitivity      Double Vision      Decreased Vision      Floaters

5. Have you ever had an eye injury? Please describe:

Type: \_\_\_\_\_ Right / Left    Date: \_\_\_\_\_  
Type: \_\_\_\_\_ Right / Left    Date: \_\_\_\_\_

6. Have you ever had eye surgery? Please list type, which eye, and approximate dates:

Type: \_\_\_\_\_ Right / Left    Date: \_\_\_\_\_  
Type: \_\_\_\_\_ Right / Left    Date: \_\_\_\_\_

7. Have YOU ever had any eye conditions (ie: glaucoma, cataract, wandering or "lazy" eye, herpes keratitis, retinal detachment, etc.) \_\_\_\_\_  
\_\_\_\_\_

8. Are you currently using any EYE medications? Please list names and how often used:  
\_\_\_\_\_  
\_\_\_\_\_

9. What medications other than the above are you taking? Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are you being treated for any medical conditions? Please circle all that apply:

Diabetes            Heart Disease            High Blood Pressure            Stroke  
Arthritis            Other: \_\_\_\_\_

11. Are you allergic to any medications? Please list: \_\_\_\_\_  
\_\_\_\_\_

12. Do you have any food allergies? Please list: \_\_\_\_\_  
\_\_\_\_\_

13. Do you have any family history of eye problems? Please check and list relationship:

Glaucoma                      Relationship: \_\_\_\_\_  
 Cataract                         Relationship: \_\_\_\_\_  
 Retinal Disease                Relationship: \_\_\_\_\_

14. Please mark any of the following that you would like more information about:

LASIK             Cornea Transplant             Dry Eye Syndrome  
Other: \_\_\_\_\_

### MEDICAL HISTORY

Please answer the following questions about your Medical Status and History:

1. Have you ever had any surgery?    Yes     No    If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Have you ever been hospitalized?    Yes     No    If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Review of Systems:

Yes    No    If Yes, please explain:

Do you currently have any of the following problems?

Chronic fever, unexpected weight loss/gain, fatigue.....☹.....☹ \_\_\_\_\_

Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat) .....☹.....☹ \_\_\_\_\_

Heart Problems (e.g. chest pain, irregular heart beat) .....☹.....☹ \_\_\_\_\_

Respiratory problems (e.g. shortness of breath, wheezing, coughing).....☹.....☹ \_\_\_\_\_

Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)..☹....☹ \_\_\_\_\_

Urinary problems (e.g. pain or discomfort, blood in urine).....☹.....☹ \_\_\_\_\_

Skin problems (e.g. rashes, excessive dryness).....☹.....☹ \_\_\_\_\_

Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints).....☹.....☹ \_\_\_\_\_

Neurologic problems (e.g. numbness, weakness, headaches, paralysis).....☹.....☹ \_\_\_\_\_

Psychiatric problems (e.g. depression, anxiety).....☹.....☹ \_\_\_\_\_

#### Family and Social History:

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)?    Yes             No            If Yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Do you smoke?    \_\_\_ No    \_\_\_ Yes, how much \_\_\_\_\_

Do you drink alcohol?    \_\_\_ No    \_\_\_ Yes, how much \_\_\_\_\_

If employed, how many hours per week do you work? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

# Multiple Authorization Agreements

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**1. RELEASE OF INFORMATION:** Cornea & Refractive Consultants (VIP Laser Eye Center) 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 & Refractive Consultants (VIP Laser Eye Center) for reimbursement for services rendered, and (2) any health care provider for continued patient care. Cornea & Refractive Consultants (VIP Laser Eye Center) 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.

**2. NON-COVERED SERVICES:** I understand that Cornea & Refractive Consultants (VIP Laser Eye Center) contracts with health care service plans (i.e., HMOs, PPOs) state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all Items or services, which are 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 & Refractive Consultants (VIP Laser Eye Center) to obtain necessary health care service plan authorizations.

**3. MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Cornea & Refractive Consultants (VIP Laser Eye Center), for services furnished me by Cornea & Refractive Consultants (VIP Laser Eye Center). I authorize any holder of medical information about me to, release to the Health Care Financing Administration 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 & Refractive Consultants (VIP Laser Eye Center) 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.

**4. MEDIGAP:** 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 & Refractive Consultants (VIP Laser Eye Center), if possible or otherwise to me.

**5. OTHER INSURANCE:** I understand that Cornea & Refractive Consultants (VIP Laser Eye Center) maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Cornea & Refractive Consultants (VIP Laser Eye Center) has no contract, expressed or Implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Cornea & Refractive Consultants (VIP Laser Eye Center) if I belong to a plan that does not appear on the above mentioned list.

**6. FINANCIAL AGREEMENT:** I agree that In return for the services provided to the patient by Cornea & Refractive Consultants (VIP Laser Eye Center), I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Cornea & Refractive Consultants (VIP Laser Eye Center) for payment. If an account is sent to an attorney or collection agency 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, is hereby assigned to Cornea & Refractive Consultants (VIP Laser Eye Center). If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Cornea & Refractive' Consultants (VIP Laser Eye Center). However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Consent Form

By signing this form, you are granting consent to Cornea & Refractive Consultants (V.I.P. Laser Eye Center) to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Cancellation Policy

Here at Cornea & Refractive Consultants (V.I.P. Laser Eye Center), we strive to schedule our patients in a timely manner. Dr. Salinger gives every one of our patients his generous time and attention. We ask that you carefully consider your schedule when making your appointments to avoid last minute cancellations or no shows. Please call our office at least 24 hours prior to your scheduled appointment time to avoid a \$20.00 fee.

I agree that there will be a \$20.00 fee charged to me for missed appointments or appointments cancelled within less than 24 hours notice.

Signature: \_\_\_\_\_

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

Date: \_\_\_\_\_



## Exception to the Release of Protected Health Information (PHI)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Exception for Disclosure:** (Individuals or means whereby PHI may be released)  
I authorize the following people to be involved in my care that may require a disclosure of PHI.

Individual's Name (Please Print)	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient \_\_\_\_\_ Date of Request \_\_\_\_\_

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**For Practice Use Only:**

Signature of Employee Receiving Request \_\_\_\_\_ Date Received \_\_\_\_\_

Request for exception has been:  Approved  Denied - Reason for denial: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_