Princeton Eye Group

PLEASE PRINT ALL INFORMATION

Full Legal Name (last, first, middle initial)_____Prefix/Suffix _____/_____
Address _____Apt #_____ City, State, Zip _____
Email _____ Home # _____ Cell # _____
SS # _____ Birthdate _____ Sex M / F Marital Status (please circle) S M D W
Employer _____ Occupation _____ Telephone # _____
Address _____ City, State, Zip _____
Emergency Contact _____ Relationship _____ Telephone # _____

Please List ALL Pertinent Medical History: _____

_____

Family Medical History: _____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

PLEASE LIST ALL ALLERGIES: _____

_____

Referring Physician _____ Telephone # _____
Address _____ City, State, Zip _____
Primary Care Physician_____ Telephone # _____
Address _____ City, State, Zip _____
Pharmacy Name _____ Telephone # _____
Address _____ City, State, Zip Code _____

Responsible Party (if different than patient)
Name _____ Relationship _____ Social Security # _____
Address _____ City, State, Zip _____
Email _____ Telephone # _____ Birthdate _____

DO YOU HAVE ROUTINE EYE EXAM (VISION) COVERAGE? Yes _____ No _____
If so, Insurance Company _____ Policy Number _____

Primary Insurance Company _____ Telephone Number _____
Policy # _____ Group # _____
Address _____ City, State, Zip _____
Co-Pay Amount $_____ Deductible Amount $_____ Effective Date _____ Expiration Date _____
Name of Insured _____ Relationship _____
Secondary Insurance Company _____ Telephone Number _____
Policy # _____ Group # _____
Address _____ City, State, Zip _____
Co-Pay Amount $_____ Deductible Amount $_____ Effective Date _____ Expiration Date _____
Name of Insured _____ Relationship _____ Birthdate_____

I have completed this form and certify that I am the patient, or duly authorized agent of the patient. I understand that it is my responsibility to pay any deductible amounts and co-insurance. There are certain services, which are not covered by any insurance such as cosmetic procedures and routine eye exams (unless I have vision coverage). I understand that I will be responsible for payment for such non-covered services. **Medicare does not pay for routine eye exams or refraction (a necessary part of an eye exam to determine the need for glasses) to be medically necessary, therefore they do not cover these services.** I am expected to pay for these services at the time of checkout. I authorize release of medical information as may be required to substantiate or explain insurance claims filed. I authorize my insurance company to assign benefits to Princeton Eye Group. **I understand that if I have not provided Princeton Eye Group the correct insurance information, listed above, that I will be solely responsible for ALL services provided.** I permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. Under HIPAA Payment, Treatment and Options (TPO) I give permission to Princeton Eye Group to access Pharmacy Benefit Manager Information for management of prescriptions.

_____ _____
SIGNATURE OF PATIENT/GUARDIAN DATE

Princeton Eye Group

Standardization for Health Care Quality Improvement:

Under the Affordable Care Act we are compelled to collect the specific information listed below to ensure that all patients throughout the country are treated fairly. **This is required by the US Government not Princeton Eye Group**.

Please review and provide the answers. Use the "Unknown/Not Reported" option if you prefer not to give this information.

What is your race? _____ White _____ African American _____ Asian

_____ American Indian _____ Native Hawaiian

_____ Unknown/Not Reported

What is your ethnicity? _____ Hispanic or Latino _____ Non-Hispanic or Non-Latino

_____ Unknown/Not Reported

What is your preferred language? _____ English _____Spanish

_____ Other _____

If you are 13 years of age or older, what is your smoking history?

_____Never _____ Former- year started _____, year quit _____

Current Smokers:

_____Somedays- year started_____ _____ Everyday- year started _____

If you are a patient on Medicare:

Have you had the Pneumonia Vaccine within the last 5 years? _____ Yes _____ No

_____ _____

Name Date

Print Name _____ D.O.B. _____

Princeton Eye Group

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
AND
PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVATE PRACTICES (NPP)

1. I understand that as part of my health care, Princeton Eye Group originates records and maintains protected health information (PHI) about me describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this PHI may be used or disclosed by Princeton Eye Group for treatment, payment and health care operations. For example, my health information serves as:
    - A basis for planning my care and treatment;
    - A means of communication among many health professionals who contribute to my care;
    - A source of information for applying my diagnosis and surgical information to my bill;
    - A means by which a third party payor can verify that services billed were actually provided; and
    - A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.
2. I acknowledge that I have been provided with Princeton Eye Group, Notice of Privacy Practices that provides a more complete description of the potential uses and disclosures of my PHI. I understand that I have the right to review the Notices of Privacy Practices prior to signing this consent. I understand that Princeton Eye Group reserves the right to change its Notice of Privacy Practices.
3. I understand that I have the right to request restrictions as to how my PHI may be used or disclosed to carry out treatment, payment or health care operations.
4. I understand that I may revoke this authorization in writing, except to the extent that Princeton Eye Group has already taken action in reliance on this consent. I will submit any revisions or revocation of this authorization in writing to Princeton Eye Group.
5. By signing this form, I consent Princeton Eye Group for the use and disclosure of my PHI for treatment, payment and health care operations.

_____ I give permission to discuss my medical record with:

_____
_____

_____ I give permission to leave detailed messages on my voicemail at the following number:

_____-_____-_____

_____ _____
Name of Patient, Patient Representative or Legal Representative Date

_____ _____
Signature of Patient, Patient Representative or Legal Representative Signature of Witness