SPECIALIZED EYE CARE
BRETT LEVINSON, MD
1 VILLAGE SQUARE, SUITE 190, BALTIMORE, MD 21210
PHONE: 410.435.8881 • **FAX:** 410.435.8886

PATIENT REGISTRATION FORM

To Our Patients: Certain information requested is mandated by the government.

PATIENT NAME (*Last, First, MI*): _____NICKNAME_____

SOCIAL SECURITY # _____-_____-_____ **DATE OF BIRTH** _____/_____/____SEX_____

ADDRESS_____ZIP CODE_____

HOME # _____**WORK #** _____**CELL #** _____

EMAIL ADDRESS _____ **MARITAL STATUS**_____

EMPLOYER _____

RACE ____**CAUCASIAN/WHITE**____**BLACK/AFRICAN AMERICAN** ____**ASIAN** ____**MULTI-RACIAL**

____**AMERICAN INDIAN** ___**ALASKAN NATIVE** ___**NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER**

ETHNICITY ____**SPANISH/LATINO** ____**NON HISPANIC** ____**OTHER** (*Please Specify*) _____

HOW DID YOU HEAR ABOUT SPECIALIZED EYE CARE?_____

REFERRING PHYSICIAN_____**TELEPHONE**_____

PRIMARY PHYSICIAN_____**TELEPHONE**_____

EMERGENCY CONTACT _____**TELEPHONE**_____

(*Please provide number other than patient's number*)

RELATIONSHIP TO PATIENT_____

PHARMACY NAME/LOCATION_____**TELEPHONE**_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____**POLICY HOLDER DOB** _____

POLICY HOLDER_____**RELATIONSHIP TO PATIENT** _____

POLICY NUMBER_____**GROUP NUMBER**_____

SECONDARY INSURANCE_____**POLICY HOLDER DOB**_____

POLICY HOLDER_____**RELATIONSHIP TO PATIENT** _____

POLICY NUMBER_____**GROUP NUMBER**_____

GUARANTOR'S NAME AND ADDRESS IF OTHER THAN PATIENT_____

_____

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I herby authorize treatment and authorize Specialized Eye Care to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance. I certify that all the information I have reported above is correct.

SIGNATURE_____**DATE**_____

SPECIALIZED EYE CARE

PATIENT HISTORY RECORD

Name _____ Referring Doctor _____ Today's Date _____

Date of Birth _____ Age _____ Sex (M/F) _____

Please answer the following questions about your medical history.

1. List any medical conditions for which you have been treated (i.e., diabetes, high blood pressure, arthritis).

   _____

2. Have you ever had any eye disease (i.e., glaucoma, cataract, "lazy" eye, retinal detachment)?

   _____

3. List any past surgeries, including any eye surgery.

   _____

4. List any medications, including eye drops.

   _____

5. Do you have any prescription drug or food allergies? If yes, please describe.

   _____

6. Do your currently have any of the following problems? If yes, please circle.

Fatigue	Hearing Loss	Sinus Problems	Sore Throat	Irregular Heart Beat
Chest Pain	Shortness of Breath	Wheezing	Coughing	Heartburn
Diarrhea	Vomiting	Urinary Discomfort	Bloody Urine	Abdominal Pain
Skin Rashes	Excessive Dry Skin	Muscle Aches	Joint Pain	Swollen Joints
Headaches	Weakness	Depression	Numbness	Paralysis
Anxiety	Weight loss/gain	Others: (Please Specify)		

7. Do any medical or eye diseases run in your family (i.e., diabetes, glaucoma, macular degeneration)?

   _____

8. Do you smoke? _____ If yes, how much? _____

9. Do you drink alcohol? _____ If yes, how much? _____

_____

Comments

_____

Doctor's Signature Date

SPECIALIZED EYE CARE

PATIENT CONSENT FORM

Specialized Eye Care's ("SPEC") Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. YOUR HAVE A RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have a right to revoke this Consent in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. SPEC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

You understand that:

- Protected health information may be disclosed for treatment, payment or health care operations.
- SPEC has a Notice of Privacy Practices and that you have the opportunity to receive a copy of such Notice.
- SPEC reserves the right to change the Notice of Privacy Practices.
- You have a right to restrict the use of your information but SPEC does not have to agree to those restrictions.
- You may revoke this Consent, in writing, at any time and all future disclosures will then cease.
- SPEC may not condition treatment upon the execution of this Consent.

Patient Name_____ Account No._____

_____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative If Representative, Relationship to Patient

If you would like us to share your private health information with anyone, please list the name(s) of the person(s) and their relationship to you.

_____

Name Relationship to Patient

_____

Name Relationship to Patient

SPECIALIZED EYE CARE

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Specialized Eye Care ("SPEC") for your eye care. Please read and sign this agreement to acknowledge our financial policies.

Patient Financial Responsibilities

- We are pleased to assist you by billing our contracted insurers. You are responsible for providing us the most correct and updated insurance information in a timely manner.
- We will assist you, but ultimately, you are responsible for determining if we accept your insurance provider and obtaining any necessary physician referrals or authorizations prior to treatment.
- You are responsible for any charges that your insurance does not pay and for any services and products not covered by insurance. This includes any charges applied to your insurance deducible. (Your deducible is the amount for which you are personally responsible before your insurance covers your medical expenses. For example, if your deductible is $250 and has not been met, and your medical charge is $400, then you will owe $250.) We are happy to check the amount of your deductible, and how much of the deductible has been met. If you would like us to do this for you, please ask our front desk.
- Payments for co-payments, co-insurance, deductibles, refraction fees, payments for services not covered by insurance and self-pay payments are due at the time of service.
- We accept cash, check, and most credit cards. There is a $25.00 returned check fee.

Contact Lenses Policies

- Contact lenses are generally not covered by medical insurance. If you have a vision plan that covers contact lenses, you can submit a receipt for your charges, and may be reimbursed. We are an out-of-network provider with vision plans, as we cannot accept vision plans. There will be separate charge for the professional contact lens fitting service. This charge ranges between $40-100.
- Some medical insurance plans will reimburse for medically necessary contact lenses. We have forms to assist you to request reimbursement for medically necessary contact lenses. (The cost of the professional fitting service for medically necessary contact lenses may be covered by your medical insurance.)
- Upon receipt of contact lenses, you are responsible for full cost of the contact lenses.
- **Signature of this form serves as an Advanced Beneficiary Notice (ABN)**
  If your insurance company reimburses you for a portion of your lenses, you are still responsible for the full cost of the lenses. For example, if you are reimbursed $100 for your contact lenses, and cost from SPEC is $250, we cannot refund the remaining $150.

Patient Authorizations

- I authorize SPEC to release and send any necessary information, including medical information regarding my case to the insurance company and any other consulting and/or referring physicians.
- I consent to the use and disclosure of PHI (Private Health Information) for any treatment, payment, and health care operations. I authorize SPEC to access my medication history through e-prescribing and to use e-prescribing as a form of generating my prescriptions or renewing my medications.

I have read, understand and agree to this Patient Financial Responsibility Agreement.

_____

Printed Name of Patient or Representative If Representative, Relationship to Patient

_____

Signature of Patient or Representative Date