PATIENT REGISTRATION INFORMATION

First Name: _____ Last Name: _____ Social Security Number: _____

Sex: M F Date of Birth: _____ Marital Status: S M D W Domestic Partner

Address: _____ City: _____Zip: _____

Home phone: _____ Cell Phone: _____ Email: _____

How did you hear about the practice?_____ Referred By:_____

Primary Care Physician: _____ Location:_____

Pharmacy: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____ Telephone: _____

PARENT INFORMATION (FOR ADOLESCENTS UNDER 18)

Name: _____ Date of Birth: _____Sex: M F

Address (if different than above): _____

Telephone: _____ Cell Phone: _____

VISION INSURANCE CARRIER

Carrier: _____ID#: _____

Policy Holder: __SELF __OTHER (Name) _____ DOB: _____SSN (policy holder): _____

PRIMARY MEDICAL INSURANCE CARRIER

Carrier: _____ID#: _____

Policy Holder: __SELF __OTHER (Name) _____ DOB: _____Relationship: _____

SECONDARY MEDICAL INSURANCE CARRIER

Carrier: _____ID#: _____

Policy Holder: __SELF __OTHER (Name) _____ DOB: _____Relationship: _____

I hereby grant permission to Manasquan Eye Care (Sushma Patel OD LLC) to employ such medical, surgical and lab/x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency (or its intermediary) any information needed for this or related insurance claim. I agree to pay any charges incurred by me to to Manasquan Eye Care (Sushma Patel OD LLC).

_____ _____

Signature of Patient/Guardian **Date**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION & HIPAA

I authorize the staff and/or practitioners at Manasquan Family Eye Care to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following for the purpose of my treatment or payment of services rendered:

Name of Designated Individual_____

Relationship_____

Phone Number of Designated Individual_____

____ I do NOT wish to designate an individual

Patient Dilation Consent Form

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the Optometrist to get a better view of the inside of your eye. This allows for better examination of the eyes' internal structures.

Without dilation, serious eye diseases such as diabetes, hypertension, retinal detachment, or malignant tumors (which can result in blindness, loss of vision, loss of an eye, or even death) could be present and not seen by the doctor.

Dilating drops blur vision for a length of time which varies from person to person and may make bright lights and near work bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

☐ Yes, I would like my eyes dilated at my appointment.

☐ No, I **DO NOT** want my eyes dilated on the day of my appointment. In refusing to have my eyes dilated, I understand that there is not an alternative procedure that can replace dilation of my pupils. I agree to indemnify, hold harmless, waive and release from any and all claims, legal actions, and attorney fees, which may arise as a result of my failure to comply with the instructions of my Optometrist, Manasquan Eye Care and their employees, officers, directors, and agents.

_____ _____

Patient/Guardian signature Date

Confidential Medical/Ocular History & Review of Systems

Manasquan Care

Reason for visit today: _____

Do **YOU** currently have any problems in the following areas:

Review of Systems

EYES

Blindness	Yes / No
Blurred vision	Yes / No
Crossed or "Lazy" eyes	Yes / No
Cataracts	Yes / No
Glaucoma	Yes / No
Macular degeneration	Yes / No
Retinal detachment	Yes / No
Eye trauma or injury	Yes / No
Distorted vision/ halos	Yes / No
Loss of side vision	Yes / No
Double vision	Yes / No
Dryness	Yes / No
Mucous discharge	Yes / No
Redness	Yes / No
Sandy or gritty feeling	Yes / No
Itching	Yes / No
Burning	Yes / No
Glare / Light sensitivity	Yes / No
Eye pain or soreness	Yes / No
Flashes	Yes / No
Floaters	Yes / No

CONSTITUTIONAL

Fever / Weight changes	Yes / No

INTEGUMENTARY (Skin)

Rosacea	Yes / No
Other _____	Yes / No

OTHER NOT LISTED ABOVE _____

_____

_____

EARS, NOSE, MOUTH, THROAT

Allergies / Hayfever	Yes / No
Sinus congestion	Yes / No
Dry throat/ mouth	Yes / No

RESPIRATORY

Asthma	Yes / No
Emphysema	Yes / No
Chronic bronchitis	Yes / No

VASCULAR / CARDIOVASCULAR

Diabetes	Yes / No
Vascular disease	Yes / No
High cholesterol	Yes / No
High blood pressure	Yes / No

GASTROINTESTINAL

Chronic diarrhea	Yes / No

GENITOURINARY

Kidney / bladder	Yes / No

BONES / JOINTS / MUSCLES

Rheumatoid arthritis	Yes / No

LYMPHATIC / HEMATOLOGIC

Anemia	Yes / No
Bleeding problems	Yes / No

ENDOCRINE

Thyroid	Yes / No

PSYCHIATRIC

Depression	Yes / No

NEUROLOGICAL

Headaches (chronic)	Yes / No
Migraines	Yes / No
Seizures	Yes / No

Family History- Please answer below regarding immediate family (**parents, siblings, children**) and specify family relation after yes

Blindness/ Vision Loss	No / Yes _____	Diabetes	No / Yes _____
Crossed or "Lazy" eyes	No / Yes _____	High blood pressure	No / Yes _____
Cataracts	No / Yes _____	Heart disease	No / Yes _____
Glaucoma	No / Yes _____	Thyroid disease	No / Yes _____
Macular degeneration	No / Yes _____	Cancer	No / Yes _____
Retinal detachment	No / Yes _____	Lupus	No / Yes _____
Other eye disease _____	No / Yes _____	Other _____	No / Yes _____

Please list all major injuries, surgeries or hospitalizations_____

_____

Please list any prescription or non-prescription medications_____

_____

_____

Allergies to medication _____

Are you pregnant and/or nursing? Yes / No If pregnant, how many weeks?_____

Are you Diabetic? Yes / No If yes, how many years?_____ Last fasting blood sugar and when

Social History

Do you smoke? Yes / No / Quit

Do you drink alcohol? Never / Occasionally / Daily

Do you use recreational drugs? Yes / No / Quit

History of STD: None / Gonorrhea / Hepatitis / Syphillis / HIV / Herpes / Chlamydia / Other

Ocular History

When was your last eye exam? _____

Have you ever had any injuries or surgeries to your eyes? If yes, explain _____

_____

Do you wear glasses? Yes / No If yes, how old are your current glasses?_____ Type: Distance / Reading / Bifocal / Progressive

Do you wear contact lenses? Yes / No If yes, how old is current pair?_____ Are they comfortable? Yes / No

Type of contact lenses: Soft / Hard / Ortho-K

What brand of contact lenses do you wear? _____

How often do you dispose of your contact lenses? _____

Patient/Guardian Signature_____ Date_____

Manasquan Care
2516 Highway 35, Ste 104,
Manasquan, NJ 08736-1927

Contact Lens Prescription Signed Acknowledgment Form

Contact lens fitting/evaluation is not part of a routine eye exam. It is a separate exam and evaluation service that is performed by the Optometrist in addition to the routine eye exam. The cost of the fitting depends on the type of contact lens, insurance plan if applicable, and is not refundable. In order to get a new contact lens prescription, a fitting/evaluation must be completed. You have 90 days to finalize the contact lens prescription from the day of the evaluation. Failure to do so will result in paying for another evaluation/fitting if you are unhappy with the lenses. A contact lens prescription is valid for 1 year. When the prescription expires, you will not be able to order contact lenses until the fitting/evaluation is completed again. If you have never worn contact lenses, a class is required to show that you are able to insert and remove contact lenses safely on your own. **Contact lens fitting and evaluation fees are NON-REFUNDABLE.** You are paying for the services rendered by the Optometrist and staff. This included measuring and assessing the eye for contact lens wear and providing the necessary care and handling instructions for new wearers. If you choose not to continue with the fitting process once it has started, or you choose not to wear contact lenses once the prescription is finalized, you are still responsible for the fitting and evaluation fees, as the services have already been provided to you.

The CDC recommends the following for contact lens wearers:

1. Schedule a visit with your eye doctor at least once a year.
2. Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.
3. Understand that eye infections secondary to contact lens wear can lead to eye damage or even blindness. Increased risk of eye infections occur due to overwearing contact lenses.

Symptoms of Eye Infection include:

- Irritated, red eyes
- Worsening pain in or around the eyes—even after contact lens removal
- Light sensitivity
- Sudden blurry vision
- Unusually watery eyes or discharge

Your contact lens prescription can be obtained by text message, email, written prescription, or the patient portal. If you would like access to the patient portal, please let any staff member or Dr. Sushma Patel know so they can give you access and a user name.

I _____ give Manasquan Eye Care permission to email or text my contact lens prescription to me upon completion of my contact lens fitting. I understand that text messaging/email is not secure and could be viewed by third parties and that my contact lens prescription is available through the patient portal. By my signature, I also acknowledge that I wish to have a contact lens exam performed at my appointment. I have read this document and I agree to pay the appropriate fitting fees for the contact lens exam.

Signature:_____ Date:_____

Manasquan Care
2516 Highway 35, Ste 104,
Manasquan, NJ 08736-1927

Financial Policy

(1) **Comprehensive eye exams** include all professional services related to the evaluation and treatment of your eye and visual health. In particular, **routine eye exams** (i.e., presenting only with symptoms of blurred vision, without any acute/chronic eye health conditions/diseases) and **refractions** (i.e., the determination of your eyeglass prescription) are usually covered by ***vision insurances***, but NOT ***primary health insurances***. (MEDICARE, for example, does NOT cover either, and they are considered out-of-pocket expenses.) A referral is not a guarantee of payment. Our fee for the refraction is $60.00, which we will collect at the time of service for those patients. If we receive payment on the refraction from your insurance company, we will reimburse you in a timely manner.

(2) **Treatment of eye diseases**, either upon initial presentation or otherwise following the initial comprehensive eye exam, is a **separate billable service**. While treatment of eye diseases is **not covered** by ***vision insurances***, it is usually covered by ***primary health insurances***, including MEDICARE.

Ultimately, patients are responsible to know their coverage/insurance carriers. If you have both types of insurance plans, it may be necessary for us to do a medical eye exam to address the any medical complaints or condition, and a vision exam to address blurred vision complaints on two separate days/visits. We will follow a procedure called ***coordination of benefits*** to do this properly, in order to minimize your out-of-pocket expense.

(3) **Contact lens fittings are a separate billable service from comprehensive eye exams** (although they may be rendered on the same day. They may or may not be covered by your ***vision insurance*** and usually are not covered by your ***primary health insurance***, including MEDICARE. You have 90 days from the time of your comprehensive eye exam to return for a contact lens fitting. Any subsequent follow-ups to refine the contact lens prescription are included at no charge for 90 days, or up to four follow-up visits, unless otherwise stated at the time of examination.

I assign all of my medical/vision benefits, including all benefits to which I am entitled through Medicare, private insurances, and any other health plans, to **Manasquan Eye Care/Sushma Patel OD LLC**. A photocopy of this assignment is to be considered as valid as an original. I authorize said assignee to release all information necessary to secure payment of benefits paid and not paid by my insurance company.

Benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. For example, as a Medicare Participating Provider, we agree to accept the charge determination of the Medicare carrier as the full charge for services rendered, but the patient is still responsible for the **co-insurance**, **deductible**, and any **non-covered services**. The co-insurance and deductible are based upon the charge determination of the Medicare carrier, which can only be confirmed after the insurance claim has been submitted.

On my behalf for any services provided to me, I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly. All known co-payments, deductibles, and charges for non-covered services are **due at the time** that they are rendered. In the event that my insurance company sends payment by check directly to me, I agree to endorse and forward such a check to Manasquan Eye Care/Sushma Patel OD LLC. If I deposit such a check in to my personal account, I agree to send Sushma Patel OD LLC payment for the equivalent amount promptly. Accounts 90 days old are subject to collections. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. It is my responsibility to know my own coverage. I understand that if I require a referral or pre-authorization for Manasquan Eye Care's services or any additional services recommended by Manasquan Eye Care (including but not limited to lab work and radiology); I am responsible for obtaining the correct referral. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits.

I hereby request that payment of insurance benefits be made directly to: Sushma Patel OD, LLC/Manasquan Eye Care

Patient/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Manasquan Eye Care
2516 Highway 35, Ste 104,
Manasquan, NJ 08736-1927
Phone: (732) 223-8000
Fax (732) 223-4010

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient/Guardian Signature _____

Date _____