NEW JERSEY
EYE CENTER
DELLO RUSSO

1 N Washington Ave. Bergenfield, NJ 07621
177 Prospect St, Passaic, NJ 07055

Tel.: 201-374-8900
FAX: 201-385-3881

www.thenjeye.com

**Welcome to The New Jersey Eye Center PA**
**Patient Information**

**Please print below:**

**Name:** _____ _____ _____ **DOB:** ___/___/____ **Age:**_____
Last First Middle Month Day Year

**Street Address:** _____ **City:** _____ **State:**_____ **Zip:** _____

**Telephone (Home)**_____ **(Cell)**_____ **(Work)**_____ **Email**_____

**Social Security Number:** _____ **Sex:** __ Male __ Female **Marital Status** __ Single __ Married __ Divorced __ Widowed

*In case of Emergency, please contact:* _____ *Phone#* _____

| | | | |
|---|---|---|---|
| **Remind me of my appointment via:** | ☐ **Phone** | ☐ **Text** | ☐ **Email** |

**Who Can we Thank for Referring you to The New Jersey Eye Center? Choose One**

| | | | |
|---|---|---|---|
| **Hospital (name)** | ☐ **Insurance Company** | ☐ **Google** | ☐ **Other** |
| **Physcian (name and number)** | | **Individual (name)** | |

Primary Care Doctor Name and Address: _____ Phone# _____

**Please list your specialist information, cardiologists, rheumatologist, endocrinologist, neurologist etc. This way we can keep all your doctors informed of your care. Thank you**

Specialist: _____ Specialty: _____
Address: _____ Phone: _____ Fax: _____

| | | |
|---|---|---|
| **Pharmacy** | **Pharmacy Address** | **Pharmacy Phone Number** |
| **Mail-Order Pharmacy** | **Mail- Order Pharmacy Address** | **Mail-Order Pharmacy Phone Number** |

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## Health Insurance Coverage

| Primary Insurance Company | | Effective Date | Secondary Insurance Company | | Effective Date |
|---|---|---|---|---|---|
| Claims Mailing Address (Street or PO Box) | | | Claims Mailing Address (Street or PO Box) | | |
| City | State | Zip Code | City | State | Zip Code |
| Policy ID Number | Group ID Number | | Policy ID Number | Group ID Number | |
| Subscriber Name (Policyholder) | Date of Birth | | Subscriber Name (Policyholder) | Date of Birth | |
| Subscriber SS Number | Relationship to Patient | | Subscriber SS Number | Relationship to Patient | |
| Vision Plan Insurance (if applicable) | | | Plan ID # / DOB / Social Security Number | Subscriber Name | |

***Third Party Consent***

***I authorize The New Jersey Eye Center to communicate with my insurance company and coordinate treatment and obtain reimbursement. I understand that insurance is not a guarantee of payment and should my insurance company deny payment, I will be responsible to remit any due balances. I understand that it is my responsibility to know my insurance plan, and what it covers and does not cover, what authorization or referrals are required.***

If you are not familiar with your health insurance coverage please call the number located on the back of the card and speak to a representative.

**Print Name:** _____ **(guardian if patient is a minor)** _____

**Signature:** _____ **(guardian if patient is a minor)** _____

**Date:** _____

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## Medical Questionnaire / Eye History

**What ocular problem brings you in?** _____

**When was your last eye exam?** _____/_____/_____ **Eye Doctor:** _____

| | YES | NO | | |
|---|---|---|---|---|
| Do you wear glasses? | | | | |
| Do you wear contact lenses? | | | | |
| Do you have Glaucoma? | | | If so when were you diagnosed? | |
| Have you had Cataract Surgery? | | | If so, Which Eye? | Date of Surgery |
| Have you had any other ocular surgeries? *Please describe below* | | | | |

| Eyes | YES | NO | COMMENT |
|---|---|---|---|
| Blurred Vision? | | | |
| Double Vision? | | | |
| Redness? | | | |
| Sandy or Gritty Feeling? | | | |
| Blind Spots? | | | |
| Floaters? | | | |
| Flashes? | | | |
| Itching/Burning? | | | |
| Glare/ Light Sensitivity? | | | |
| Eye Pain? | | | |
| Chronic Infection Eye/ Lid? | | | |

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| Do you Smoke? | Do you Drink? | Allergies to Medications? |
|---|---|---|

Do you have any problems in the following areas? Please check all applicable

| | YES | NO |
|---|---|---|
| **General** | | |
| Fever | | |
| Fatigue | | |
| Weight Loss/Gain | | |
| **ENT: Ears, Nose, & Throat** | | |
| Sinus Infection | | |
| Cough | | |
| Trouble Walking | | |
| Hoarseness | | |
| Loss of Hearing | | |
| Nose Bleeds | | |
| **Heart** | | |
| Chest Pain | | |
| Irregular Heartbeat | | |
| Pacemaker | | |
| Heart Murmur | | |
| Swollen Feet/ Ankles | | |
| Leg Cramps when Walking | | |

| | YES | NO |
|---|---|---|
| **Lungs** | | |
| Wheezing, Shortness of Breath | | |
| Coughing up Blood/ Phlegm | | |
| **GI/ GU** | | |
| Vomiting | | |
| Bloody Bowel Movement | | |
| Heartburn | | |
| Loss of Appetite | | |
| Difficulty with Urination | | |
| **Musculoskeletal** | | |
| Muscle Pain | | |
| Joint Pain, Arthritis | | |
| **Neurological** | | |
| Fainting, Frequent Headaches | | |
| Seizures | | |
| **Other** | | |
| Pregnant | | |
| Menopausal | | |

Please list all Medications including any Eye Drops

| | | | |
|---|---|---|---|
| 1. | 4. | 7. | 10. |
| 2. | 5. | 8. | 11. |
| 3. | 6. | 9. | 12. |

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## Acknowledgement of Financial Responsibility
## The New Jersey Eye Center PA

**Insurance Coverage**

Insurance is a contract between you and your insurance company. We are not party to this contract in most cases. We will bill your primary insurance company for 60 days as a courtesy to you. Although, we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your health coverage. This may include any co-pays, co-insurance and deductibles. It is the responsibility of the patient to be aware of your insurance coverage, policy provisions, exclusions, referrals and authorizations required. If your insurance company requires a referral and/or any pre- authorization, you are responsible for obtaining it and presenting it at the time of service. If you do not bring a referral, you will be expected to pay for services rendered. We collect copies of your insurance assuming the coverage is active, and in good faith that coverage is active during the time of your visit. If you do not have coverage, or it is inactive at the time of your visit you will be responsible for payment in full. ***If you have any changes in your insurance coverage, it is your responsibility to inform the office(s). Failure to do so may result in a denial of your claim and will be the patient's responsibility.***

**Monthly Statements**

If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges, the service fee (if any) and payments and credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due payable when the statement is issued and is past due if not paid within (30) days.

**Past Due Accounts**

If your account becomes past due, we will take the necessary steps to collect the debt. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred

**Admin Fee**

An Admin Fee of $20 will be imposed for any co-pays or out-of-pocket tests not paid within 24 hours of visit.

**Insurance Payments**

If by error an insurance check is mailed to you, it should immediately be forwarded to our billing office with a copy of the Explanation of Benefits (EOB) **Address: 1N Washington Ave. Bergenfield, NJ 07621 Attention: Billing Department**

**Self Pay Patients**

Self Pay Patients must pay in full for services before they are rendered. If additional appointments, procedures or surgeries are required additional fees will apply. Pricing will be discussed prior to any additional appointments.

**Cancellations/No-Show/Rescheduled Appointments**

No-Show, Cancellation and/or Reschedule without 24 hours advance notice will be an automatic charge of $25

**Bounced Checks**

Please be advised that we will charge an additional fee of $40.00 for any checks due to insufficient funds and/or closed accounts.

| Print Name of Patient | Signature of Patient | Date |
|---|---|---|

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## Notice of Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is provided in two layers: The first layer briefly summarized how we handle your health information; second layer is full copy in greater detail of our privacy policies and procedures which are on our webpage, and copies of which are available to you at our front desk upon request.

**How we may use and disclose your health information** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to who you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information If you sign an authorization to disclose information you can later revoke it to stop any future uses and disclosures.

**Your Rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decision about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect, or information is missing, you have the right to request that we correct the existing information or add the missing information.

**Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in out policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

**Privacy complaints:** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about the access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

**If you have any questions or complaints, please contact: NJEC Practice Administrator**

***Acknowledgement of receipt of Notice of Privacy Practices: Please sign and date below to acknowledge that you have received this Notice of Privacy Policies. The return this acknowledgement of receipt to Front Desk at The New Jersey Eye Center.***

**Printed Patient Name:** _____

**Signature:** _____

**Date:** _____

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**Welcome to The New Jersey Eye Center PA**
**Explanation of Refraction Fee**

**Patient Name:** _____ **Date:** _____

**A refraction is the test preformed to determine your eyeglass prescription. The patient is presented with a series of lenses in graded powers to determine which gives the clearest vision. A refraction may be performed by either the doctor or a technician. Eyeglasses and/or Contact Lens prescriptions cannot be written or dispensed without a proper refraction.** If you would like a prescription for contact lenses there may be additional fees that may or may not be covered by your insurance.

If you would like to know if your insurance company covers the refraction fee, please call your carrier for more information. If you DECLINE the refraction, you will not receive a prescription.

Unfortunately, Medicare and many other insurances do not pay for refractions and is considered an out of pocket expense to the patient. For that reason, patients will be charged for refractions. The refraction fee is $40.00 and will be collected at the time of service. If the fee is not collected, and we are not paid by the insurance carrier you will receive a bill for $40.00 plus an additional administrative fee of $25.00.

Routine eye exams will only be billed to your vision carrier. If you have a medical policy that covers a routine eye exam once yearly, we can submit the fee to the carrier. If your visit is billed and denied for non- routine coverage, or an uncovered service you will be billed for the full visit as well as an administrative charge of an additional $25.00.

_____ **Accept** _____ **Decline**

**Patient Name:** _____ **Date:** _____

**Patient Signature:** _____

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**About your Insurance**

We value our relationship with you and the fact that you have selected The New Jersey Eye Center (NJEC) as your eye care provider. This memo addressed a difficult issue that affects all of us: What do insurance policies cover and not cover?
There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both.

**- Vision Care Plans**
**- Medical Insurances**

Vision care plans only cover routine eye exam and may cover some materials (such as glasses or contacts) They do not cover diagnosis, management or treatment of eye disease.

Medical Insurance much be used if you have eye health problems, or systemic health problem that has ocular complications.
If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to another. We will collect all types of insurances at the Front Desk. We will coordinate the use of these benefits to minimize your out of pocket expenses.

Health Care Coverage is constantly changing especially for a specialty like Ophthalmology. We deal not only with hundreds of different insurance plans and their variations, but also with stringent requirements regarding visits that must be authorized and categorized as either a medical problem, or routine vision care.

We cannot be expected to know the particulars of every existing policy let alone keep up with the frequent policy changes.
It is your obligation to know your insurance plan, what it covers and does not cover, and what authorization is required for treatment. IF you are not familiar with your benefits regarding eye care coverage, it is your responsibility to find out. Please call the customer service number on the back of your insurance care.

One of the most common issue we deal with is a patient who arrives at our office with no referral or authorization. Your plan with its benefits and restriction should have been described to you at enrollment. Any questions about your insurance coverage should be directed to your employer or to the insurance plan itself.

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to The New Jersey Eye Center PA, and The New Jersey Eye Surgical Center LLC
My signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above

*By signing below, I certify that I have read and understand all the above.*

Print Name: _____

Signature: _____ Date: _____