WYCKOFF OPHTHALMOLOGY

Financial Responsibility & Non-Covered Services Agreement

To prevent any misunderstanding about payment for medical and surgical care, please read the information below prior to being seen by the physician.

Some services may not be covered by insurance. Your doctor may recommend these services because they are medically appropriate.

FINANCIAL RESPONSIBILITY

- Copays are due at the time of service
- Returned checks incur a $25 fee
- Payment is expected once insurance determines patient responsibility
- Medicare patients are responsible for deductibles, 20% coinsurance and any copays that your secondary insurance does NOT cover.

NON-COVERED SERVICES

Service	ACCEPT	DECLINE
Refraction – $85	☐ ACCEPT	☐ DECLINE
Contact Lens Refraction – $50 (+ refraction)	☐ ACCEPT	☐ DECLINE
Non-Dilation Imaging (Clarus 500) – $70	☐ ACCEPT	☐ DECLINE

I understand that I am ultimately responsible for the balance on my account.

Patient Name: ______________________________

Signature: ________________________________ Date: __________

Wyckoff Ophthalmology
Disease and Surgery of the Eye

Melanie Sinatra, M.D., F.A.C.S.
Diplomate of the
American Board of Ophthalmology

Tyler D'Agostino O.D

Patient Information

Name: ______________________________ Marital Status: _____ Gender: _____

Address: ______________________ City: __________ State: _____ ZIP: ______

DOB: ______ SS#: _____-______-_____ Race: ________ Ethnicity: _________ Language: ________

Home #: ____________ Cell #: ______________ Email: ____________________

Employer: ____________ Occupation: _________ Emergency Contact: ____________

Emergency Contact # ____________

Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center? If so, please list name and phone number. Facility: ______________ Phone: ____________

Primary Care Physician

Dr. ______________ Phone: ______________

Referring doctor (if not primary care): Dr. ____________ Phone: ___________

Pharmacy

Pharmacy Name: ______________ Location: __________ Phone #: __________

Responsible Party (Please complete this section if patient is a minor or has a legal guardian)

Name: ______________________________ DOB: ______ Relation: ________

Address: ______________________ City: __________ State: _____ ZIP: ______

Phone #: ________________ Email: ______________

Past Medical History - *Please check all that apply and provide a brief explanation*

- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Bone Marrow Transplant
- [ ] BPH
- [ ] Cancer: __________
- [ ] COPD
- [ ] Coronary Artery Disease
- [ ] Depression
- [ ] Diabetes 1 or 2
- [ ] End Stage Renal Disease
- [ ] GERD
- [ ] Hearing Loss
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Hyper/hypothyroidism
- [ ] Lymphoma
- [ ] Myasthenia Gravis
- [ ] Seizures
- [ ] Strokes
- [ ] Radiation Treatment
- [ ] Other____________

Explanation:____

____

Past Surgeries

Name of Procedure	Date of Surgery	Surgeon
1.		
2.		
3.		
4.		
5.		

Review of Symptoms - *Please check all that apply*

Do you have any problems currently? Please check all that apply and provide a brief explanation

- [ ] Allergies
- [ ] Anemia
- [ ] Arthritis
- [ ] Bleeding
- [ ] Burning on Urination
- [ ] Changing Moles
- [ ] Chills
- [ ] Congestion
- [ ] Cough
- [ ] Diabetes
- [ ] Diarrhea
- [ ] Dry Mouth
- [ ] Earache
- [ ] Fever
- [ ] Hay Fever
- [ ] Headaches
- [ ] High Blood Pressure
- [ ] Hives
- [ ] Incontinence
- [ ] Insomnia
- [ ] Jaw Pain
- [ ] Joint Pain
- [ ] Paralysis
- [ ] Rapid Heart Beat
- [ ] Rash
- [ ] Redness
- [ ] Scalp Tenderness
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Stiffness
- [ ] Stroke
- [ ] Stuffy Nose
- [ ] Thyroid Abnormalities
- [ ] Upset Stomach
- [ ] Urinary Frequency
- [ ] Weight Loss
- [ ] Wheezing
- [ ] Other____________

Explanation:____

____

Alerts - *Please check all that apply*

- [ ] Artificial Heart Valve
- [ ] Artificial Joints (Within the last two years)
- [ ] Blood Thinners
- [ ] Defibrillator
- [ ] Flomax
- [ ] MRSA
- [ ] Narrow Angles
- [ ] Pacemaker
- [ ] Pregnant / Planning
- [ ] Premedication Prior to Surgery
- [ ] Pseudoexfoliation Syndrome
- [ ] Rapid Heart Beat with Epinephrine
- [ ] Steroid Responder

Explanation:____

____

Glasses and Contact Prescription

Date of Last Eye Examination: ________

Glasses Prescription Right Eye: ________ Glasses Prescription Left Eye: ________

Contact Prescription Right Eye: ________ Contact Prescription Left Eye: ________

Type of Contact ☐ Soft ☐ Toric ☐ RGP

Last Time Contacts Were Worn: ____________

Current Ocular Review - *Please check all that apply*

Do you have any problems in the following areas currently? Please check all that apply and provide a brief explanation

- [ ] Amblyopia
- [ ] Blurred Vision
- [ ] Burning
- [ ] Difficulty Driving
- [ ] Distorted Vision
- [ ] Drooping Eyelid
- [ ] Dryness
- [ ] Excessive Tearing
- [ ] Eye Injury
- [ ] Eye Pain or Soreness
- [ ] Fluctuating Vision
- [ ] Foreign Body Sensation
- [ ] Glare or Light Sensitivity
- [ ] Infection of Eyelid
- [ ] Itching
- [ ] Keratoconus or any Corneal Disease
- [ ] Loss of Side Vision
- [ ] Loss of Vision
- [ ] Mucous Discharge
- [ ] Poor Night Vision
- [ ] Redness
- [ ] Sandy or Gritty Feeling
- [ ] Tired Eyes
- [ ] Other __________

Explanation:____

____

Past Ocular History - ***Please check all that apply, circle R for right eye and L for left eye and provide a brief explanation***

- [ ] Allergic Conjunctivitis
- [ ] Blepharitis
- [ ] Corneal Dystrophy R L
- [ ] Diabetic Retinopathy Background R L
- [ ] Diabetic Retinopathy Proliferative R L
- [ ] Dry Eyes
- [ ] Glaucoma R L
- [ ] Macular Degeneration R L
- [ ] Macular ERM R L
- [ ] Narrow Angles R L
- [ ] Ocular Hypertension R L
- [ ] Ophthalmic Migraine
- [ ] Pseudoexfoliation
- [ ] Retinal Detachment R L
- [ ] Strabismus (lazy eye) R L
- [ ] PVD R L
- [ ] Floaters
- [ ] Optic Neuritis R L
- [ ] Orbital Fracture R L
- [ ] Herpes Simplex
- [ ] Herpes Zoster (Shingles)
- [ ] Trauma
- [ ] Corneal Ulcers
- [ ] Other_______________

Explanation:____

____

Ocular Surgery - ***Please check all that apply, circle R for right eye and L for left eye, and provide a brief explanation***

- [ ] Blepharoplasty R L
- [ ] Cataract R L
- [ ] Corneal Transplant R L
- [ ] Eye Muscle Surgery R L
- [ ] Intravitreal Injections R L
- [ ] LASIK R L
- [ ] Laser Iridotomy R L
- [ ] PRK R L
- [ ] Ptosis Repair R L
- [ ] Punctal Plugs R L
- [ ] Retinal Laser Surgery R L
- [ ] Strabismus Surgery R L
- [ ] Trabeculoplasty R L
- [ ] Tube Shunt R L
- [ ] YAG Capsulotomy R L
- [ ] Botox / Fillers
- [ ] Other___________

Explanation:____

____

Allergies - ***Please check all that apply***

- [ ] Latex Allergy
- [ ] Adhesive
- [ ] Lidocaine
- [ ] Other ___________
- [ ] No Known Drug Allergies

Social History

How many hours a day do you work on a computer? _________

Do you drive? [ ] No [ ] During the Day [ ] At Night [ ] Both

Do you drink alcohol? [ ] No [ ] Occasionally [ ] 1/day [ ] 2-3/day [ ] 4+/day

Do you smoke? [ ] Never [ ] Everyday Smoker [ ] Occasional [ ] Former

Present Medications

Medication Name (*including strength*)	Directions (*dose, route, and frequency*)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Family History - *Please check all that apply and provide a brief explanation*

- ☐ ARMD
- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Retina Detachment
- ☐ Strabismus
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other ______________

Explanation:____

____

_______________________________________ ____________________

Signature of Patient, Parent, or Legal Guardian **Date**

Wyckoff ophthalmology
Diseases and Surgery of the Eye

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

I hereby authorize the employees and agents of Wyckoff Ophthalmology to provide medical evaluation and care for the patient listed below. This authorization will remain in effect unless revoked in writing. I understand that if this consent is not signed, medical care may only be provided in the event of an emergency.

Patient Name (Please Print): ____________________________________

Signature of Patient, Parent, or Legal Guardian: ____________________________ Date: __________

I accept full financial responsibility for all services provided. Payment is due at the time services are rendered unless prior arrangements have been made. If a grace period is granted, I acknowledge that payment remains my responsibility and is due upon receipt of the billing statement.

If my account becomes delinquent for more than 30 days, I agree to pay a finance charge of 1.5% per month on any outstanding balance. I also agree to cover reasonable collection costs, including attorney fees, court costs, and any additional expenses incurred in the collection of this account, not to exceed 50% of the balance.

Signature of Patient, Parent, or Legal Guardian: ______________________ Date: __________

MINOR / LEGAL GUARDIAN AUTHORIZATION (IF APPLICABLE)

Complete this section only if the patient is a minor or requires a legal guardian.

I authorize Dr. ____________________________ to make medical decisions on behalf of the patient listed above when I am not available. This includes consenting to evaluation, treatment, and any necessary medical or surgical procedures.

This authorization will remain in effect until it is revoked in writing.

Signature of Parent or Legal Guardian: ____________________________ Date: __________

Patient Preferences Regarding Communion of PHI (Protected Health Information)

My preferred method of communication regarding my medical conditions and/or appointment information is selected below

☐ Home Phone

☐ Cell Phone

☐ Other: ____________

If I am unreachable at my preferred contact number please do one of the following

☐ Leave a message with detailed information

☐ Leave a message with a call-back number only

Please let our office know if you have any special requests regarding communications. For example, please inform us if you would like to be contacted at a separate number for test results.

Keeping our patient's information private is extremely important to us, as as a result we will only disclose information related to the Billing Account and medical conditions only to the patient, parent, or legal guardian.

If you would like to add additional contacts, other than a parent or legal guardian that Wyckoff Ophthalmology is allowed to disclose information to please designate them down below. I understand that I am not required to list anyone and I may change this list at any time in writing.

Print Name: ______________ Relationship: __________ Contact Phone Number: __________

Print Name: ______________ Relationship: __________ Contact Phone Number: __________

Print Name: ______________ Relationship: __________ Contact Phone Number: __________

______________________________________ __________

Signature of Patient, Parent, or Legal Guardian **Date**

Notice of Privacy Practices and Acknowledgement

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. II understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up appointments 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 understood the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may contact Wyckoff Ophthalmology at any time 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________

Relationship to Patient: ________________

Signature: __________________________

Date: ______________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of this Notice of Privacy Practices, but was unable to do so as document below

Initials: _____ Date: _______ Reason: ________________ ______________