Registration : **Albany Eye Associates**

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate Age	Social Security #

Address	Home: / Work: / Cell:	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Provider **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Albany Eye Associates , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Albany Eye Associates	
X		63 Shaker Rd, Suite 101 Albany, NY 12204	Phone: 518-434-1042 Email:

Please attach all pertinent insurance ID cards for photocopying.

Patient History Form

Name: _____ Today's Date: _____

Date of birth: _____ Age: _____How did you hear about us: _____

Phone: (home) _____ (work) _____ (cell) _____

Primary Care Physician:

Name: _____

Address: _____

_____

Phone: _____

Other healthcare providers you wish us to communicate with:

Name: _____

Address: _____

_____

Phone: _____

Were you **referred by a doctor** for this visit? Yes / No If yes, who? _____

What **medical/visual problem** brings you here? _____

_____

Eye History: (circle)

Do you wear glasses? Yes / No
Are you looking for a new glasses prescription? Yes / No

Do you wear contact lenses? Yes / No
If YES, are you happy with your current contact lenses? Yes / No
Are you looking for a new contact lens prescription? Yes / No

Have you ever been told you have an eye disease such as amblyopia, "lazy eye", strabismus, macular degeneration, retinal detachment, cataracts, or glaucoma? _____ If so, what? _____

_____

Have you ever had eye surgery or an eye injury? _____ If so, what and when? _____

_____

Do you currently use eye drops? If so, which eyedrops?

Medical History:

Have you recently been vaccinated for Influenza? Y / N
Have you ever been vaccinated for Pneumonia? Y / N

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No
Diabetes	_____	_____	Autoimmune disease	_____	_____
High blood pressure	_____	_____	Arthritis	_____	_____
Heart disease	_____	_____	Headache/migraine	_____	_____
High cholesterol	_____	_____	Seasonal allergies	_____	_____
Stroke	_____	_____	Asthma/COPD/Emphysema	_____	_____
Numbness/Weakness/ Paralysis	_____	_____	Depression/anxiety	_____	_____
			Thyroid	_____	_____
Parkinson's	_____	_____	Cancer	_____	_____
Alzheimer's	_____	_____	Skin disorders	_____	_____
Intestinal disease	_____	_____	Kidney	_____	_____
Cerebral palsy	_____	_____	Blood disorder	_____	_____

Are there any conditions/illnesses you have been treated for that are not listed on this form? _____
If yes, please specify: _____

OVER

Please list all medications you are currently taking: OR ☐ I do not take any medications, over the counter supplements, or vitamins.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list all surgeries you have had: OR ☐ I have not had any surgeries in my lifetime.

_____

_____

_____

_____

Please list any allergies you have to medications: OR ☐ I have no allergies to medications

_____

_____

_____

_____

Family history: M=Mother F=Father S=Sibling G=Grandparent

	Yes	No	Relationship to patient
Glaucoma	_____	_____	_____
Macular degeneration	_____	_____	_____
Retinal disease	_____	_____	_____
Strabismus	_____	_____	_____
Amblyopia ("lazy eye")	_____	_____	_____
High blood pressure	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lupus	_____	_____	_____
Arthritis	_____	_____	_____
Thyroid	_____	_____	_____
Cancer	_____	_____	_____

Are there any conditions/illnesses for family members not listed on this form? YES / NO

If yes, please specify: _____

Social History:

Occupation: _____

Marital Status: (circle) Single Married Divorced Widowed

Do you smoke? (circle) Yes No Amount: _____

Do you drink alcohol? (circle) Yes No Amount: _____

Do you have a history of substance abuse? (circle) Yes No

ALBANYEYEASSOCIATES

OUR FINANCIAL POLICY

BILLING YOUR MEDICAL INSURANCE:

Our office participates with most major insurance plans. We will submit a **MEDICAL** claim to your medical insurance company. We do not bill or participate with any **VISION** plans. You may submit a claim to your vision insurance company to seek reimbursement for any routine services denied by your medical insurance company.

REFRACTIVE SERVICES:

A refractive examination is not a covered service by most medical insurance companies, including Medicare. A refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of many eye exams and necessary to write a prescription for glasses**. Our office charges a $35 refraction fee if your medical insurance does not cover the refraction and you receive a prescription for glasses**. This will be collected at the time of service in addition to your copay, coinsurance and/or deductible. There will be an additional charge of $35 for prescription re-checks after 90 days. **There is also a separate charge for contact lens fittings** and those fees vary based on your individual needs. Please ask one of our secretaries if you have questions about the associated fees for contact lens prescriptions.

PAYMENT AT THE TIME OF SERVICE IS REQUIRED:

In accordance with your insurance contract, you must be prepared to pay your copay at each visit**. If you do not pay your copayment at the time of the visit, you will be charged an additional $25 service fee.** If your insurance plan has a deductible that has not been met, we require a **$100 deductible deposit** at the time of service. We appreciate payment in full for any outstanding balances. **Any checks that do not clear the bank will be subject to a $30 returned check fee.** We accept cash, checks, all major credit cards and Care Credit. For patients without insurance, payment for your visit is due when you check-in. Any additional testing or services performed during the visit will be collected upon check-out. For all services rendered to minor/dependent patients, the adult accompanying the patient will be responsible for payment.

MISSED APPOINTMENTS:

It is important that you keep your scheduled follow-up appointments. Failure to do so will result in **a $40 missed appointment fee** for not calling our office at least 24 hours in advance to reschedule. Any patient who cancels a **scheduled surgery without giving 2 business days notice will be charged a cancellation fee of $250**. Legitimate emergencies will be taken into consideration.

KNOW YOUR INSURANCE PLAN:

It is the patient's/parent's/guardian's responsibility to be familiar with the benefits of your insurance plan including copays, coinsurance, deductibles and referral requirements. **Bring all of your current insurance cards to all visits in addition to your photo ID**. Provide our office with current information including your full address and phone numbers. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If your insurance requires a referral and you do not have one, you can still be seen however you will be asked to pay for the visit prior to your examination.

If you have any questions on our financial policy, one of our staff members will be glad to assist.

I have read and understand the above financial policy.

Signed_____ Date_____

ALBANYEYEASSOCIATES

Information Regarding Dilating Eye Drops:

Dilating drops are used to dilate or enlarge the pupil of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you **make arrangements not to drive yourself.** Adverse reaction, such as acute-angle closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.

I have read and understand the above information regarding dilating eye drops.

Signed_____ Date_____