office use only: *ATHENA ID:* _____

PATIENTS - IF YOU ARE PRINTING THIS FROM HOME, PRINT SINGLE-SIDED PAGES, NOT DOUBLE-SIDED!!

Fleetwood Ophthalmology / Seth A. Biser, M.D., P.C. / 654 Gramatan Ave. / Fleetwood, NY 10552

NEW PATIENT REGISTRATION
PAGE 1 OF 5 – YOU MUST FILL OUT ALL 5 PAGES!

Welcome to our office! Please PRINT all answers on this form.

Patient's LAST NAME	First Name & M.I.	Title/Suffix	Sex M F	Birth Date	Social Security #

Primary Care Doctor/Phone # ☐ I have no primary doctor	Optometrist / Optician	Other Physician(s) needing reports

Home Address	City / State / Zip	Home # ( ) Cell # ( ) Email:

Occupation	Employer / Business Name	Work # ( )

Pharmacy (Name/Location/Telephone #):

Check One: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If married, name of : ☐ **Spouse** **If under 18**, name of: ☐ **Parent /Guardian**	Spouse or Parent's Employer	Work Phone # ( )

Emergency Contact	Relationship	Phone # ( )

Who is responsible for payment, if not patient?

Primary Insurance Company	ID and Group#	Policy Holder's Name (if not patient) Tel #

Secondary Insurance Company	ID and Group#	Policy Holder's Name (if not patient) Tel #

WE DO NOT ACCEPT MEDICAID, WORKER'S COMPENSATION, OR NO-FAULT (AUTO ACCIDENT) INSURANCES.

All professional services rendered are charged to the patient. Forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance. I authorize my insurance carrier or company to make payment directly to Seth A. Biser, M.D., for professional services rendered. I authorize Dr. Biser to release to my insurance carrier or company any medical information required to process my insurance claims. I authorize Dr. Biser to send a consultation report to my doctor should this prove necessary.

I have read, understand, and agree to all of the above.

Date: _____ Signature: _____

If signer is not patient, name of signer and relation to patient: _____

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EYE AND MEDICAL HEALTH QUESTIONS

Who referred you to our office? (Please be specific: if you were referred by a doctor, give name of doctor). Also, indicate if referred by another patient, your insurer, or if self-referred by a web search, etc.:

What is the main reason for your visit today? (Note: even if you have no specific complaints, what is the main concern you have about the health of your eyes?)

Eye Conditions/History – provide details below for any boxes checked:

☐ Cataract ☐ Glaucoma ☐ Macular Degeneration ☐ Dry Eye Syndrome
☐ Uveitis ☐ Amblyopia ☐ Diabetic Eye Disease ☐ Eye Injury (include details below)

Details, Including Past Eye Surgeries (with approx. year of surgery):

Current Eye Drops, including over-the-counter drops. ☐ I take no eye medications

GENERAL MEDICAL QUESTIONS

Drug Allergies, or drugs you cannot take for any other reason (e.g., side effects). Please list the drug(s) and reaction(s):

☐ I am not aware of any drug allergies

Have you ever smoked? ☐ Y ☐ N
If yes,
Year of: Start: _____ Stop _____ How many cigarettes/day now?

Do you drive? ☐ Y ☐ N

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PAGE 3 OF 5
(MEDICAL HEALTH QUESTIONS)

Current Oral Medications: including prescription, over-the-counter, vitamins, and supplements.
For prescriptions, please include doses (for example, "5 mg") and frequency (for example, "3 x/day").

If currently pregnant, check here: ☐ # of Months: _____

Medical Conditions (Check if "Yes")

☐ Diabetes	☐ Asthma / COPD	☐ Neurologic Condition
☐ Thyroid Condition	☐ Sleep Apnea	☐ Lupus
☐ High Blood Pressure	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Stroke	☐ HIV	☐ Cancer
☐ Heart Condition	☐ Migraine	

For any conditions checked above, <u>as well as any medical conditions you have that are not listed here</u>, please write details below, including approx. year of diagnosis, and any procedures / treatments.

Major Surgeries (with approx. year of surgery):

Family History. Check any blood relatives with:	**NONE**	Mother	Father	Sibling	Grandparent
Glaucoma	☐				
Macular Degeneration	☐				
Retinal Detachment	☐				
Blindness (of other or unknown cause)	☐				

Cancer (list cancer type, and individuals affected)

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PAYMENT POLICIES AGREEMENT

1. YOU ARE RESPONSIBLE FOR PROVIDING accurate insurance and personal information at each visit.

A. We make every effort to contact your insurers on your behalf, but you should double-check to make sure we are in-network with your insurer, and that you are "eligible" at the time of service. If your primary insurer refuses to pay because of network or eligibility issues, you will be personally responsible for the full charge of our services.

B. You must inform us of any changes to your health insurance status and/or personal information (name, address, etc.). Failure to do so may result in charges that become your responsibility.

C. Please note that we do NOT take Medicaid, Worker's Compensation, or No-Fault (Auto Accident) insurance plans.

D. You are responsible for resolving all outstanding balances before being seen.

2. YOU ARE RESPONSIBLE FOR OBTAINING any Primary Care Referrals required by your health plan (HMO, etc.). You are also responsible for knowing whether or not you need a referral.

If, before your visit, we discover that you need a PCP referral and do not have one on that day, you will not be seen and must reschedule (unless you agree to pay for the full cost of the visit out of pocket).

If the need for a PCP referral is only discovered after you receive services from us, you will be held responsible for the full cost of the services.

3. If You Want a GLASSES OR CONTACT LENS PRESCIPTION, READ THIS: WE DO NOT PARTICIPATE WITH VISION PLANS. We only take medical insurance. MEDICAL INSURANCE DOES NOT COVER GLASSES OR CONTACT LENSES. A glasses prescription is entirely optional—it's up to you—so we will not measure you for glasses unless you ask. If you decide that you do want Dr. Biser to refract you for glasses and provide you with a glasses prescription, there will be a $75 out-of-pocket charge, due at the time of service. If you want a contact lens prescription, the out-of-pocket charge is often higher, and we will often NOT be able to provide a contact lens prescription at your first visit. If you want to try to get reimbursed for any glasses or contact lens prescriptions we provide, you can submit receipts to your insurance plan.

4. Double Copayments for Patients with: NYS EMPIRE, GHI, UMR, and UNITED HEALTHCARE. These plans often charge an additional copayment ("double copay") for many diagnostic tests such as dilated retinal exams, visual field testing, etc. You may receive a bill by mail, AFTER your exam, for such copayment amounts.

5. Missed or non-completed appointments. We reserve the right to charge returning patients a $40 fee for any appointment missed or cancelled with less than 24 hours' advance notice. For new patients who submit a completed New Patient Packet, and for whom we create a new Medical Chart, we reserve the right to charge a $75 fee if the patient walks out or fails to complete the first appointment for any reason (including not understanding our glasses or contact lens policy, written above!). If you miss 3 consecutive appointments which you fail to cancel in advance, Dr. Biser reserves the right to end the doctor-patient relationship and refer you to another physician. Each case will be taken into consideration, as we realize that unexpected circumstances may occur.

6. Payments are due at the time of service. For those with health insurance, this includes co-payments, coinsurance, and deductible charges. Deductibles may only be calculated after we bill your insurance; you will get a bill in such cases.

I have read the above policies, and I understand and agree to the above policies.

_____ _____

Patient Name Date

_____

Signature

If another person is signing for the patient:

_____ _____

Name of Signer Relationship of Signer to Patient

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PAGE 5 OF 5
HIPAA CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996, 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 been informed by you of your Notice of Privacy containing a more complete description of the uses and disclosures of my health information. I have been given the right to review your Notice of Privacy prior to signing this consent. I understand that the office of Seth A. Biser, M.D., P.C. can change its Notice of Privacy Practices from time to time and that I can contact your office to get a current copy.

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 then you must abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name _____

Signature _____

Date _____

If signer is not patient,
Name and Relationship to Patient _____