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

Insurance Verification for your OPHTHALMOLOGY VISIT

If you have any of these plans:
Aetna, Anthem, BCBS (Blue Cross-Blue Shield), MVP, Oxford, United Healthcare,
please complete this page before your first visit.

DO use the words "Ophthalmology Appointment" or **"Ophthalmology Visit"** when speaking to your insurance company. These services apply to your medical plan.

DO NOT use the words "Eye Exam," "Eye Doctor" or "Vision Test." These services apply to your vision plan, not to ophthalmic care.

Purpose of Visit:	Ophthalmic Evaluation and Treatment.
CPT Code:	92004
Dr. Biser's NPI #:	115 431 1793

Call the "Member" number on your PRIMARY health insurance card. Ask these questions:

1. WILL I NEED A REFERRAL FROM MY PRIMARY CARE PHYSICIAN to see an Ophthalmologist?	___ Y ___ N
2. "Are you my PRIMARY insurance company?"	___ Y ___ N
3. "Will my health insurance be ELIGIBLE CONTINUOUSLY for the next two weeks?"	___ Y ___ N
4. "Is Dr. Biser IN-NETWORK WITH MY HEALTH PLAN?" **Dr. Biser's NPI #: 115 431 1793**	___ Y ___ N

Make sure you get a REFERENCE NUMBER for your call:

Reference #: _____ Date: _____ Time: _____

Your Signature: _____

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"WILL DR. BISER MEASURE ME FOR GLASSES?"

Because we get a lot of questions about this topic, here is a detailed explanation!

PLEASE NOTE: If the only reason for your visit is to get a glasses prescription, we are happy to see you, but it may be easier or more cost-effective for you to start with an optometrist or optical shop, especially if you have a Vision Plan. Please read the following information about how, as a medical / ophthalmology office, we deal with glasses prescriptions.

We perform a VISION MEASUREMENT at every visit. This is part of your ocular medical examination.

Your distance vision will be measured using a standardized, "20/20" protocol.
If you wear glasses to drive or to watch TV, we want you to wear your glasses for this test.
If you want to know whether your vision has changed, you can compare today's results with any previous tests.

If You Want Dr. Biser to PRESCRIBE GLASSES FOR YOU, that's a different matter.

Prescribing glasses is NOT like prescribing medication. Each glasses prescription is unique.

Accurate prescriptions are important so that you get the glasses made correctly the first time. Your vision should feel good to you as soon as you put on your new glasses. To create an accurate prescription, Dr. Biser takes several measurements of each of your eyes, and then of both eyes together, using your immediate feedback about your visual quality. This is called "refracting." Dr. Biser does not rush his refractive measurements, and as a result his track record for accurate prescriptions is excellent (ask any local glasses shop).

Prescribing glasses is NOT covered by medical insurance. We charge $75 for glasses prescriptions (and a variable price for contact lens prescriptions). If you have vision insurance, however, you can go to a provider in your vision plan for these services.

Glasses and contact lens prescriptions are an OPTIONAL service. We will only perform these services if you tell us AT THE START OF YOUR EXAM. Once Dr. Biser places drops in your eyes as part of your MEDICAL evaluation, he can no longer measure you for glasses or contact lenses on that day!

The medical portion of your eye exam (for retinal disease, glaucoma, cataracts, dry eye, etc.) is covered by health insurance.

"But DO I NEED a new or updated glasses prescription?"

If you are not sure, answer this question. WITH YOUR CURRENT GLASSES, are you:

A. Reasonably happy with your vision?

B. Not very happy with your vision?

C. Not sure?

THINK ABOUT YOUR RESPONSE TO THE QUESTION.

Doing so should help you decide whether or not you want Dr. Biser to measure you for a new prescription!

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office use only: *ATHENA ID:* _____

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

NEW PATIENT REGISTRATION – YOU MUST FILL OUT ALL PAGES!

Please PRINT CLEARLY.

Patient's LAST NAME	FIRST Name & M.I.	Sex M F	Birth Date	Social Security #

Home #: Cell #: *Your Preference:* ___ *Home #* ___ *Cell #* **Email**:	Home Address / City / State / Zip

Occupation	Employer / Business Name	Work Phone #

Primary Care Doctor/ Phone #	Optometrist / Optical Shop	Other Physician(s) needing reports

Pharmacy (Name/Location/Telephone #):

Emergency Contact	Relationship	Phone #: Email:

Check One: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

If married, name of : ☐ **Spouse** If under 18, name of: ☐ **Parent /Guardian** *Or check here:* ☐ *Same as Emergency Contact*	Spouse or Parent's Employer / Work Phone #

PRIMARY Insurance Plan:	**SECONDARY** Insurance Plan:

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

CONTINUED →

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. We do not accept Workers' Compensation, Medicaid, or No-Fault (Auto Accident) insurance.

C. 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 PCP 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: Your medical insurance covers the cost of Dr. Biser's medical eye examination. However, medical eye examinations do not include refractions (glasses measurements) or contact lens fittings. Those services may be covered by "Vision Plans," but as a medical office, we do not participate with vision plans. A glasses prescription is entirely optional—it's up to you—so we will not measure you for glasses unless you ask at the START of your visit! If Dr. Biser refracts you for glasses and provides 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 may not be able to provide a contact lens fitting at your first visit. We will be happy to provide receipts for any glasses or contact lens prescriptions we provide, so that you can submit receipts to your vision plan, to see whether you can be reimbursed.

4. Diagnostic Copayments for Patients with: NYS EMPIRE, GHI, UMR, and UNITED HEALTHCARE. These plans often charge a diagnostic copayment (on top of the regular specialist copayment) for routine diagnostic items 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

CONTINUED →

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 _____