**Schenectady Eye Surgery Associates, PLLC**

Ophthalmology

FranklinLongo, M.D.
Brian Strickler, M.D.

# FINANCIAL POLICY

We are committed to providing you with the best possible care and are willing to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy, or your financial responsibility.

**PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.**

WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD AND PHOTO ID FOR YOUR FILE.

**COPAYMENTS** - By law, we must collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each time of visit.

**MISSED APPOINTMENTS** - Appointments are confirmed 3 days prior to your appointment date. Your appointment MUST be cancelled 24 hours prior to your appointment. If you fail to show for your confirmed appointment, and do not notify us 24 hours prior YOU WILL BE CHARGED $50.00.

**NON-COPAY PLANS** - If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible, co-insurance, and balance your plan indicates on your explanation of benefits.

**REFERRALS** - If your plan requires a referral from your primary care physicians, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.

**MEDICARE** - We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

**PATIENT RESPONSIBILITY**: I realize that I am responsible for my copy plus any deductible or amount indicated on my explanation of benefits as patient responsibility. I am aware that there is a $20 fee for all returned checks. If my account is sent to collection, I realize that I am responsible for the collection fees and reasonable attorney's fees.

THANK YOU for taking the time to review our policies.

_____ SIGNATURE OF RESPONSIBLE PARTY

____/____/_____ DATE

## Patient Registration Form

Last Name:_____ First Name:_____ M.I:_____

Date of Birth:_____ Male_____ Female_____

Race: Caucasian/White Black/African American American Indian/Alaska Native Native Hawaiian Asian Other Patient Declined/Unkown

Ethnicity: Spanish/Hispanic Origin Not of Hispanic Origin Patient Declined/Unkown

Primary Language Spoken:_____

Address:_____ City:_____ Zip Code:_____

Home Phone:(____)_____-_____ Cell:(____)_____-_____ Work:(____)_____-_____

Pharmacy Name:_____ Pharmacy Phone:(____)_____-_____

Insurance Name:_____ ID#:_____

Secondary Insurance:_____ ID#:_____

Primary Care Physician:_____ Phone #:(____)_____-_____

Cardiologist:_____ Phone #:(____)_____-_____

Endocrinologist_____Phone #:(____)_____-_____

Employer:_____ Phone #:(____)_____-_____

## Spouse or Alternate Contact

Name:_____ Relationship:_____

Phone #:(____)_____-_____

## Ocular History

___Cataracts ___Lazy Eye ___Retinal Disease ___Corneal Disease ___Glaucoma

___Macular Degeneration Other: _____

Have you ever had Lasik? Yes or No If so, When?_____ Doctor #:(____)_____-_____

Eye Surgery/Laser Procedures: _____

## Medical History

| | | | |
|---|---|---|---|
| Anemia | Yes | No | |
| Arthritis | Yes | No | |
| Asthma/Emphysema/COPD | Yes | No | Specify: _____ |
| Autoimmune Disease | Yes | No | Specify: _____ |
| Cancer | Yes | No | Type: _____ |
| Diabetes | Yes | No | Type 1 or Type 2 |
| Kidney/Liver Disease | Yes | No | Specify: _____ |
| Hearing Loss | Yes | No | |
| Heart Disease | Yes | No | |
| Hepatitis | Yes | No | (A B C) |
| High Blood Pressure | Yes | No | |
| High Cholesterol | Yes | No | |
| HIV/AIDS | Yes | No | |
| Migraine | Yes | No | |
| Pregnant | Yes | No | If So how far along_____ |
| Stroke/CVA | Yes | No | |
| Thyroid Disease | Yes | No | Specify: _____ |

Other: _____

Medication allergies and reactions:_____
_____
_____

Current medications and doses:_____
_____
_____

## Social History

Do you smoke? Yes No If yes, how much for how long? _____
Have you ever smoked? Yes No If yes for how long? _____ Quit: _____
Do you consume alcohol? Yes No If yes, how often? _____
Do you consume caffeine? Yes No
Have you ever used recreational drugs? Yes No

## Family History

Please specify which **immediate family member** has the following:

Blindness Yes or No _____
Cancer Yes or No _____
Cataracts Yes or No _____
Diabetes Yes or No _____
Glaucoma Yes or No _____
Lazy Eye Yes or No _____
Retinal Disease Yes or No _____
Retinitis Pigmentosa Yes or No _____
Sickle Cell Anemia Yes or No _____
Tumors of the Eye Yes or No _____
Other: _____

***EMAIL ADDRESS: _____

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## Medical Information Release Form

## (HIPAA Release Form)

Name: _____ Date of Birth: ___/___/___

### Release of Information

[ ] I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. The information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

_____

[ ] Other _____

[ ] Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date: ___/___/___

## NEW OFFICE POLICY AS OF 11/01/2018

## GLASSES AND CONTACT LENS SCRIPT SERVICE FEE

**PLEASE READ CAREFULLY!! If you have any questions after you have read this please ask the receptionist.**

Most medical insurance plans, including Medicare, do NOT cover routine glasses or contact prescriptions. Insurance allows that we charge separately for that portion of the examination, since it is not a covered service.

The process for the glasses and contact prescription is a separate fee from the exam itself. Our office fee for a new prescription is **$50.00 and this fee is collected at the time of service in addition to any co-payment your plan requires.** Should your insurance plan pay us for the prescription process, we will reimburse you accordingly.

THERE IS NO CHARGE TO GET A COPY OF YOUR OLD PRESCRIPTION IF IT HAS BEEN DONE BY OUR OFFICE IN THE PAST.

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I have read the above information and understand that the prescription is a non-covered service. I accept full financial responsibility for this service and understand that payment is due at the time of service. I understand that any co-payment, co-insurance or deductible I may have are separate and not included in the prescription fee.

_____ I **accept** this fee and will pay 50.00 to have my prescription checked.

_____ I **decline** this service and will go elsewhere to get a new glasses prescription.

**DO NOT ALTER THIS DOCUMENT**

Print Name:

Signature:

Date: