PATIENT REGISTRATION FORM

Welcome to our office. Please complete this form and return it to the receptionist.

□Mr. □Mrs. □Miss □Ms. □Dr. □ Single □ Married □ Widowed □ Divorced

Name: _____ M____ F____ Date: _____
First Middle Last

Address: _____
Number & Street Apt # City & State Zip Code

Home Phone: _____ Business Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Social Security No.: _____

If Patient is a Minor – Responsible Party: _____
First Middle Last Relationship

Were you referred to us by your:
□Primary Care Physician – Name:_____ □Other Eye Doctor – Name: _____

If referred by both providers, please include both providers' information.

We are required by the Federal Government to ask and collect information on race, ethnicity, and employment status and language preferences.

We appreciate you providing us with this information.

Occupation/Employer: _____

Please select one of the below choices:
□American Indian/Alaskan Native □Asian □Black/African American □Caucasian
□Native Hawaiian or Other Pacific Islander □Hispanic/Latino □Other □Declined to answer

Please select your language preference: □English □Other _____

Required

Emergency Contact: _____ Phone: _____

E-mail Address: _____ Relationship: _____

Do you allow this person access to the patient portal on your behalf? Yes _____ (Email Required) No _____

Primary Medical Doctor: _____ Phone: _____

Address: _____
Number & Street Apt # City & State Zip Code

Optometrist Name: _____ Phone: _____

Your Preferred Pharmacy: _____ Location/Phone: _____

Insurance Information

Primary Insurance: _____ Policy Number: _____

Insured Name:_____ Phone Number:_____
(If different from patient)

Date of Birth: _____ Social Security Number: _____

Address: _____

Secondary Insurance:_____ Policy Number:_____

Insured Name:_____ Phone Number:_____
(If different from patient)

Date of Birth: _____ Social Security Number: _____

Address: _____

BILLING POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing staff.
By signing this form, I am acknowledging that:

- It is my responsibility to provide complete and correct insurance/billing information including presentation of a current insurance card to Ramapo Ophthalmology Associates. This also includes effective start and termination dates. I understand that failure to do so may result in denial of benefits from my insurance carrier. In this event, I understand that I shall be responsible for services rendered by Ramapo Ophthalmology Associates.

- I am responsible for any co-pays, co-insurance, and deductibles required by my insurance plan. I understand that payment will be made at time of service. If payment is not made at time of service I understand an additional $20 will be added.

- I understand that Ramapo Ophthalmology Associates participates with Medicare. This means we accept the fees set by Medicare for medical/surgical services covered by the Medicare program. Medicare patients will be responsible for co-payments, co-insurance, deductibles and any non-covered services, such as refractions and routine eye exams or for premium services categorized as "non-covered" by Medicare.

- I am responsible for providing a referral or necessary authorization needed to be seen at Ramapo Ophthalmology Associates. I understand if proper documentation is not provided I will be responsible for the cost of my visit.

- A $50 fee will be imposed for any missed appointments, no shows, or late (less than 24 hour) cancellations of office visits. This will not be covered by my insurance.

- For any overdue balances greater than 30 days, 6% interest will be applied to the total balance due. If the bill is not paid within 3 months it will be forwarded to collections.

- A fee of <u>up to</u> $100 may be imposed for any outside forms or letters that need to be completed {i.e. DMV forms, housing expenses, employment forms, etc},copies of medical records and other administrative requests.

- I understand that before any surgical procedure or exam which may entail greater expense, our office will provide insurance coverage information and estimate what, if any, balance may remain once insurance has paid. At your request, we will provide information on coverage to the best of our ability for any examination or procedure we perform, even when not of great expense. Payment of any balance is expected prior to the surgery/procedure date. If special financial circumstances warrant an extended payment plan, our staff will be glad to help you.

- I understand that contact lens evaluations/fittings are performed by our optometrist. Contact lens evaluations/fittings are an out of pocket expense, not covered by my medical insurance. Cost of the evaluation and fitting are due at the time they are rendered.

Signature_____ **Date**_____

RAMAPO
OPHTHALMOLOGY

3 Medical Park Drive
Pomona, NY 10970
Tel: 845-362-1450
Fax: 845-362-3830
www.ramapoeyecare.com

***In consideration of services to be provided to me or my dependent, I hereby assign, transfer, and set over to Ramapo Ophthalmology Associates all rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to Ramapo Ophthalmology Associates for charges not covered by this assignment. Initial _____

***I certify that I am the patient. If I am not the patient, I certify that I am duly authorized as the patient's general agent to execute the above and accept its terms. I acknowledge that a copy of this consent will be provided to me upon request. Initial _____

*** I understand that it is my responsibility to provide Ramapo Ophthalmology Associates with my current insurance and provide a copy of the card. In the event my insurance changes and I have not presented the correct insurance information/card to our office you may be responsible for out of network rates for all charges. Initial _____

***I understand my insurance may charge a diagnostic co-payment that our office may not be aware of. In the event that your insurance indicates your responsibility, you will be charged for the diagnostic co-pay. Initial_____

***I understand that having active insurance does not guarantee that my insurance will cover claims submitted. In the event a claim is denied, I am responsible for full payment of claim. Initial_____

***I understand if in the event, it is determined that my insurance benefits are cancelled or rescinded I am fully responsible for all charges. Initial_____

*** I understand there may be charges for services that are "non-covered" by any insurance company. If there are such charges, I am fully responsible to make full payment upon receipt of statement from Ramapo Ophthalmology. Initial_____

EXAM FOR EYEGLASSES Major medical insurance plans, including Medicare, **do not** cover refraction (the exam for eyeglasses). This office will charge $60.00 fee for this service **unless** performed by Dr. Richard Gordon the fee will be $100.00 plus any co-payments that apply. This fee is subject to change. Initial_____

_____ _____

Patient's Signature (Parent/Guardian Signature if Minor) Date

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GLASSES/ CONTACT LENS PRESCRIPTION

Dear Patient,

If an eyeglasses prescription is provided for you today, the fee for this examination is **$60.00** unless performed by Dr. Richard Gordon the fee will be **$100.00**. If you request to update your contact lens prescription, the fee for this examination is **$85.00**. These are considered non-covered charges by most major medical insurances.

These payments are expected at the time of service. Please sign this form in acknowledgement that you're aware that there is a fee for these examinations.

Signature _____ Date _____

Printed Name _____

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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate of enlarge the pupils 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 light bothersome. It is not possible for your ophthalmologist to predict how long your vision will be affected. Driving may be difficult immediately after an examination. It is best if you make arrangements **not** to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physicians of Ramapo Ophthalmology Associates, LLP, and/or such assistants as may be designated by the physicians to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient Signature (or person authorized to sign for patient) Date

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I request that payment of authorized insurance benefits be made to Ramapo Ophthalmology Associates, LLP, Dr. Richard N. Gordon and Dr. Sonia Belliappa, for any services provided to me by that physician(s). Authorize any holder of medical information about me to be released to my insurance company and its agents, any information needed to determine these benefits payable for related services.

Signature: _____ Date :_____

****

Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I_____, hereby acknowledge that I have been offered a copy of the notice of privacy practices. I understand that if I have further questions or complaints I may contact: Ramapo Ophthalmology Associates, 3 Medical Park Drive, Pomona, NY 10970. I also understand that I am entitled to receive updates upon request if Ramapo Ophthalmology Associates' notice of privacy practices is amended or changed in a material way.

Signature: _____Date :_____
Signature: _____ Personal Representative: _____ Date :_____
(if patient is unable to sign)

Permission to Disclose Medical Information to Family Members

I give permission for Ramapo Ophthalmology Associates to disclose any necessary medical information with the following family members if I am unable to discuss the information personally. I also understand that ONLY the family members below will be given my medical information if a situation warrants it.

Name: _____ Relationship to Patient: _____

Signature of Patient: _____ Date: _____