NEW YORK CORNEA, PLLC

CORNEA AND EXTERNAL EYE DISEASE

GEORGE J. FLORAKIS, MD
CLINICAL PROFESSOR
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ALEXANDRA HERZLICH, MD
CLINICAL INSTRUCTOR
JACOBI MEDICAL CENTER

Demographic Information:

First Name: _____ Middle: _____ Last name: _____
Birth date: _____ Sex: M____ F____ Social Security #: _____
Local Address: _____City:_____ State: _____ Zip:_____
Secondary Address: (if applicable) _____
Home Phone #:_____Work Phone#:_____ Cell Phone #:_____
Preferred method of contact: _____ Email: _____
May we leave a message: Yes___ No___ Occupation: _____
Referring Physician: _____Referring Physician #: _____
Referring Physician Fax#: _____
Primary Care Physician: _____ Primary Care Physician Fax #:_____
Emergency Contact: _____ Contact #:_____
Marital Status: _____ Student Status: FT____ PT____

Federal Standards require us to collect the following:

Preferred Language_____
Please Choose One Ethnicity: Hispanic/ Latino___ Non-Hispanic/Latino___ Unknown___ Patient Refused___
Please Choose One Race: Asian ___ Black: ____ African American___ Multiracial_____ Unknown____
White_____ Other_____ Patient Refused_____

Insurance Information

Name of Policy Holder: _____ Date of Birth: _____
Social Security_____ Relationship to Patient: _____
Primary Insurance Carrier:_____ ID#_____
Secondary Insurance Carrier::_____ID#_____
Copayment Amount: _____

*** Please Note: We Are Not Responsible For Secondary Insurance Billing. We Only Accept The Automatic Crossovers From Medicare. ****

The Receptionist Will Need To Make Copies of Your Insurance Cards & Photo ID

Pharmacy Information:

Pharmacy Name: _____
Address: _____
City: _____ State:_____ Zip:_____
Phone Number: _____ Fax Number: _____

I verify the accuracy of the above information and I authorize the release of medical information necessary to process insurance claims and payment of services rendered. I also assume responsibility for services not covered under my medical insurance plan.

Signature: _____ Date:_____

Medical History Questionnaire

Name _____ Date: _____

Date of Birth _____ Date of **last eye exam:** _____

List any **medications** you currently take (prescription and over-the-counter)

_____

_____

Do you have any **allergies to medications**? ( ) YES ( ) NO
If YES, please list the medications:

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, etc.) or **injuries**

_____

_____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, etc.)

_____

_____

Pregnancy	**YES**	**NO**	
Is there any chance you may be pregnant?			
Are you currently breastfeeding?			

Do you ***currently*** have any of the following problems? If YES, please explain.

Symptoms	**YES**	**NO**	**EXPLANATION** (which eye, severity, duration)
EYES (glaucoma, cataract, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy/Gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess Tearing/Watering			
Glare/Light sensitivity			
Pain or soreness			
Infection (blepharitis)			
Tired eye(s)			
Crossed/Lazy eye(s)			
Drooping eyelid(s)			

General	YES	NO	EXPLANATION
Fever			
Weight Loss			
Fatigue			
High blood pressure			
Ear, Nose, Throat			
Cardiovascular			
Respiratory			
Kidney, Bladder, Genital			
Blood/Lymph			
Skin (acne, skin cancer, etc.)			
Gastrointestinal/Digestive System			
Musculoskeletal			
Endocrine/Reproductive			
Allergic/Immunologic (Sjogren's, etc)			
Psychiatric (depression, etc.)			
Neurological (multiple sclerosis, etc.)			
Family History	**YES**	**NO**	**Relationship to Patient** (circle)
			M = mother **F** = father **S** = sibling **GM** = grandmother **GF** = grandfather
Blindness			**M F S GM GF**
Glaucoma			**M F S GM GF**
Arthritis			**M F S GM GF**
Cancer			**M F S GM GF**
Diabetes			**M F S GM GF**
Heart Disease			**M F S GM GF**
Kidney Disease			**M F S GM GF**
Thyroid Disease			**M F S GM GF**
Lupus			**M F S GM GF**
Stroke			**M F S GM GF**
Other			
Social History	**YES**	**NO**	
Do you drive?			
Do you have visual difficulty when driving?			
Do you have problems with night vision?			
Do you currently wear glasses?			
If **yes**, how long have you had the current prescription?			
Do you currently wear contact lenses?			
If **yes**, how for how long?			
Have you ever tried contact lenses before?			
Do you drink alcohol?			
If **yes**, how often?			occasional 1 per day 2-3 per day 4+ per day
Do you smoke?			
If **yes**, how often?			occasional ½ pack/day 2-3 pack/day 4+pack/day
Have you ever had a blood transfusion?			

Patient Signature _____ Date _____

Physician Signature _____ Date _____

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REFRACTION EXAMINATION

Dear Patient:

Medicare and many insurance carriers require the refraction portion of our examination fee to be billed separately from the medical portion. Medicare and most other health insurance carriers will not cover this fee because they consider the refraction a "ROUTINE NON-COVERED SERVICE." In most instances, the cost of this must be paid for by our patients.

If your health insurance has a clause to cover routine eye care, thus refraction fee will be covered. Please check with your insurance carrier.

DR. FLORAKIS, DR. FAN-PAUL AND DR. HERZLICH ARE CORNEA CONSULTANTS AND MAY ASK THAT YOU RETURN TO YOUR PRIMARY OPHTHALMOLOGIST OR OPTOMETRIST FOR GLASSES.

The fee for this refraction portion of your examination is $50.00 and includes the following:

1. Measurement of your vision with your current prescription.
2. Computerized Automated Refraction if needed.
3. Quantitative measurement of the best prescription to give you the most accurate and comfortable vision possible. (**REFRACTION**)
4. Determination of your distance, and when appropriate, near vision with the newly measured prescription.
5. When requested, a written prescription for glasses for your use or records.

This entire procedure is necessary to judge if new glasses are to be prescribed or if your current prescription still serves you well.

We hope this helps to clarify any questions you may have.

Patient Signature_____ Date_____

COLUMBIA UNIVERSITY MEDICAL CENTER | WEST 165TH STREET, SUITE 303 | NEW YORK, NEW YORK, 10032 | TELEPHONE: (212) 305-3378 | FAX: (212) 781-1188
WESTCHESTER OFFICE | 110 BROOK STREET | SCARSDALE, NEW YORK 10583 | TELEPHONE: (914) 723-1641 | FAX: (914) 723-5468
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Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (Print):_____Medicare Number: _____

1. MEDICARE:

I request that payment of authorized Medicare benefits be made on my behalf to New York Cornea PLLC for services furnished me by New York Cornea PLLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

New York Cornea PLLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP:

I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to New York Cornea PLLC if possible or otherwise to me.

3. RELEASE OF INFORMATION:

New York Cornea PLLC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to New York Cornea PLLC for reimbursement for services rendered, and (2) any health care provider for continued patient care. New York Cornea PLLC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE:

I understand that New York Cornea PLLC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that New York Cornea PLLC has no contract, expressed or implied, with any plan that doers not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by New York Cornea PLLC if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES:

I understand that New York Cornea PLLC contracts with health care service plans (i.e. HMO's, PPO's) state items and services which are "covered" by health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non covered services include, but are not limited to, services not specified as being covered in a patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with New York Cornea PLLC to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT:

I agree in return for the services provided to the patient by New York Cornea PLLC, I will pay my account at the time service is rendered or will make financial agreements satisfactory to New York Cornea PLLC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action, I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to New York Cornea PLLC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to New York Cornea PLLC. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

Beneficiary Signature or Authorized Party:_____Date:_____

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Referral Waiver

I am aware that obtaining a valid referral form is my responsibility. If I do not provide New York Cornea, PLLC with a valid referral within the next **two days**, I agree to pay in full for all services rendered.

Name of Patient _____

Name of Relation or Guardian _____

Signature _____

Date _____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD Privacy Officer at 635 West 165th St, Suite 303, New York, NY 10032.

With my consent, George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, George J. Florakis, MD/Nancy Fan-Paul, MD/Alexandra Herzlich, MD may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian