New Patient Information

Eye Associates of Monroe County
570-476-1114

Name _____

Mailing Address _____

_____

Home Phone _____

Cell Phone _____

Email _____

Preferred Contact Home Cell Email

Patient Social Security _____ Date of Birth _____

Sex _____ Occupation _____ Marital Status _____

Language _____ Race _____ Ethnicity _____

Insurance Information

Primary Member's Name _____ Date of Birth _____

Social Security _____

Primary Medical Insurance _____ ID # _____

Secondary Medical Insurance _____ ID # _____

Vision Insurance _____ ID # _____

Relationship to Member Spouse Child Other Self

**IF MINOR (under 18)

Responsible Person's Name _____ Date of Birth _____

Mailing Address _____

_____

Phone # _____ Home Cell

Relationship to Minor Parent Guardian SS# _____

Review of Medical Conditions:

Review of Medications

_____

_____

Review of Allergies

_____

_____

Constitutional	Ear, Nose, Throat	Neurological	Psychiatric
Developmental Disability	Hearing Loss	Multiple Sclerosis	Depression
Cancer	Sinusitis	Epilepsy	ADD / ADHD
Fatigue	Dry Mouth	Cerebral Palsy	Anxiety
	Laryngitis	Tumor	Bipolar
		Stroke/CVA	
		Migraine	

Cardiovascular	Respiratory	Gastrointestinal	Genitourinary
High Blood Pressure	Smoker	Crohn's	Kidney Disease
Stroke	Asthma	Colitis	Prostate Disease
Heart Disease	Bronchitis	Ulcer	STD
Vascular Disease	Emphysema	Acid Reflux	Pregnant/ Nursing
Congestive Heart Failure	Sleep Apnea	Celiac Disease	

Musculoskeletal	Integumentary	Hematologic	Allergies
Osteoarthritis	Eczema	Anemia	Drug
Arthritis	Rosacea	Large Blood Loss	Environmental
Fibromyalgia	Psoriasis	Ulcer	Rheumatoid
Osteoporosis	Herpes/Cold Sores	Cholesterol	Lupus
Gout	Herpes/Shingles		Sjogren's

Endocrine	Family History						
Diabetes Type 2	Cancer	Mom	Dad	Brother	Sister	Son	Daughter
Diabetes Type 1	Diabetes Type 1	Mom	Dad	Brother	Sister	Son	Daughter
A1C _____	Diabetes Type 2	Mom	Dad	Brother	Sister	Son	Daughter
FBS _____	High Blood Press.	Mom	Dad	Brother	Sister	Son	Daughter
Thyroid	Thyroid Dys.	Mom	Dad	Brother	Sister	Son	Daughter
Hormonal Dysfunction	Heart Disease	Mom	Dad	Brother	Sister	Son	Daughter
	Cataract	Mom	Dad	Brother	Sister	Son	Daughter
	Macular Degen.	Mom	Dad	Brother	Sister	Son	Daughter
	Glaucoma	Mom	Dad	Brother	Sister	Son	Daughter

Notice Of Privacy

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was signed by: _____

Printed Name Patient or Representative: _____

Relationship to Patient (if other than patient): _____

How can we contact you?

Home phone: _____	Yes	No
Cell phone: _____	Yes	No
Text: _____	Yes	No
Email: _____	Yes	No

Authorization for Assignment of Benefits – I request that payment of authorized medical benefits be made directly to Dr. Anthony S. Diecidue, P.C. for services furnished to me by Dr. Anthony S. Diecidue, P.C. or his associates. I authorize any holder of medical information about me to release to insurer and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature is indicted in item 9 of the CMS 1500 Form or elsewhere on other approved claim forms; my signature authorizes releasing the information to the insurer or agency shown. Dr. Anthony S. Diecidue, P.C. or his associates accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible only for the deductable, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier.

Patient Responsibility – Payment is due in full when services are rendered or good are delivered unless prior arrangements have been made. Failure to pay returned check or delinquent payments will result in additional charges related to collection of fees to your account.

This office will make every reasonable attempt to obtain payment from your insurance provided we have received accurate coverage information from you. You are required to disclose to us your insurance information PRIOR TO YOUR EXAMINATION. Coverage information disclosed after your examination will not be processed. If we are unable to collect payment from your insurance company, you will be responsible for all remaining outstanding charges incurred at this office.

Our Financial Policy

We are committed to providing you with the highest quality eye examination services. If you are covered by insurance, we are anxious to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our policy regarding payments on patient accounts.

We are participating providers for Blue Cross of NE PA, PA Blue Shield, First Priority Health, Geisinger Health Plan, VSP, Medicare, and most other large insurance programs. For your convenience, our billing staff may be able to submit your claims for you. We do accept assignment for many insurance carriers, which means your insurance company, will send their payment directly to us. However, you are responsible for any non-covered services and co-payments and deductibles due after your insurance pays their portion of the fee. **PAYMENT FOR YOUR COPAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED.** We accept, cash, checks (PA), MasterCard, VISA, Discover and American Express.

It is important that you understand the following:

1. Your insurance is a contract between you, your employer, and/or the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. We must emphasize that **our relationship is with you, not your insurance company.** While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility from the date the service is rendered.

We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to notify us promptly for assistance in management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Please sign here indication you have read and understand the information on this page:

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____