Eye Associates of Monroe County
208 Main St.
Stroudsburg, PA 18360
(570) 476-1114

New Patient Information

Patient Name: _____

Mailing Address: Street_____

City, State Zip _____,_____ _____

Preferred Contact: Home or Cell _____

Text/E-mail OK? Yes/No (Circle)

E-Mail Address: _____

Date of Birth: _____ /_____ /_____ Sex: Male/Female (Circle)

Patient Social Security #: _____ - _____ - _____

Employment status: _____Occupation: _____ Marital Status: _____

Emergency Contact:_____ Relationship_____ Phone: _____

Insurance Information We are a medical office and therefore require both Medical and Vision Insurance (If applicable) to be on file. Vision insurance will not cover all aspects of your exam and we may need to submit a bill to your medical insurance. Co-pays, Co-insurances, and Deductibles will apply.

Primary Member's Full Name: _____ DOB: _____

Social Security #: _____ - _____ - _____

Vision Insurance: _____ ID#: _____

Primary Medical Insurance: _____ ID#: _____

Secondary Medical Insurance: _____ ID#: _____

Relationship to Member: Self Spouse Child Other

Responsible party for charges:_____ Relationship to patient:_____ Phone:_____

***IF MINOR (Under 18)* Responsible Party**

Full Name: _____ DOB: _____

Address: _____

☐ (Check Box if same as listed above)

Phone #: _____ ☐ (Check Box if same as listed above)

Relationship to Minor: Parent / Guardian / Sibling (Circle)

Reason for current visit:_____ First Visit? Y /N (Circle) Last Eye Exam date_____

Primary Care Physician: _____

Phone_____ Fax _____

Address_____ Date of last medical exam:_____

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Review of Medical Conditions

Eye Health Check all that apply

	Amblyopia		Blurred Vision- Far		Blurred Vison- Near
	Burning Eyes		Cataracts		Double/ Distorted Vision
	Drooping Eyelid		Dry Eyes		Eye Surgeries
	Eye Turn		Floaters/Spots		Fluctuating Vision
	Foreign Body Sensation		Glaucoma		Glare/ Light sensitivity
	Headaches		Itchy Feeling		Infection of eye/ lid
	Loss of Vision- Central		Loss of Vision - Side		Mucus/ Discharge
	Redness		Retinal Detachment		Tearing/ Watery Eyes

General Health Check all that apply

	Allergies/ Hay Fever		Asthma/ Respiratory		Blood Disorders
	Cancer		Cardiovascular/ High BP		Chronic Bronchitis
	Chronic Cough		Diabetes		Emphysema
	Gastrointestinal Problems		Heart Attack/ Strokes		Headaches/ Migraines
	Kidney Disease		Psychiatric Depression		Rheumatoid Arthritis
	Thyroid/ Endocrine Disease		Skin Disorders		Weight Loss/ Gain

Family History Check all that apply

	Amblyopia		Eye Turn
	Eye Surgeries		Cataracts
	Glaucoma		Retinal Detachment
	Loss of Vision		

Medications:	**Conditions:**

Allergies:

Do you smoke?.....Yes / No
Are you pregnant or nursing? .....Yes / No
Do you have trouble driving at night? .....Yes / No
Do you wear glasses?.....Yes / No
Do you wear contacts?.....Yes / No
Do you experience blur, headaches, or eyestrain with computer use? .....Yes / No
Are you interested in laser (refractive) surgery to correct your vision? .....Yes / No

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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 the receipt of treatment upon execution of this Consent**
- **The patient acknowledges that he/she has received a copy of our HIPAA practices brochure**

This Consent was signed by: _____Date: _____

Printed Name Patient/Representative: _____

Relationship to Patient (if other than the patient): _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to family members you must sign below. Singing below will only give information to the family members indicated below.

I authorize Eye Associates of Monroe County to release my medical, billing, and/or appointment information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Patient Information

1. **I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.**
2. **I understand that information disclosed to any above recipient is no longer protected by federal or stat law and may be subject to re-disclosure by the above recipient**
3. **You have the right to revoke this consent in writing.**

Patient Signature: _____ Date:_____

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Our Financial Policy

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 indicated 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 Insurance Carrier as the full charge, and I'm responsible only for the deductible, co-insurance, and any non-covered services. Co-insurance/deductible are based upon the determination of the Insurance Carrier.

Patient Responsibility – Payment is due **IN FULL** when services are rendered or goods 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 of $30.00 and/or 30% dependent on severity of delinquency.

This office will make any 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 held financially responsible for all remaining outstanding charges incurred at this office.

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. To achieve these, goals, we need your assistance and your understanding of our policy regarding payments on patient accounts.
We are participating providers for BlueCross of NEPA, PA BlueShield, Highmark, Geisinger Health Plan, United Healthcare, Medicaid, Medicare, Aetna, Cigna, VSP, VBA, NVA, Davis Vision, Spectera, Eyemed, 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, copayments, and deductibles due after your insurance pays their portion of the fees. PAYMENT FOR YOUR COPAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED. We accept cash, checks, MasterCard, VISA, AMEX, Discover, Debit Cards, and Care Credit.

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, the patient, 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 services are rendered.**

We realize that temporary financial problems may affect timely payments of your account. If such problems 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 uncertainty regarding insurance coverage, PLEASE, don't hesitate to ask us. We are here to help you.

Please sign below indicating you have read and understand the information on this page.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____ Phone: _____