Gary S. Reiter, M.D.
Disease and Surgery of the Eye

EYE CARE REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date: _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Preferred Language: _____

Race: ☐ Asian ☐ African ☐ American ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Pharmacy _____

Pharmacy Name _____

Pharmacy Phone Number _____

Pharmacy Address _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Dr. Gary, S. Reiter** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

_____

Responsible Party Signature

_____

Relationship Date

3 PHONE NUMBERS

Home _____ Work _____ Ext _____ Spouse's Work _____

Best time and place to reach you _____

4 EYE HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Date of last eye exam? _____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type _____ Hours/Day _____

Describe any problems you have with your contacts _____

Place a mark on Yes" or "No" to indicate you have had any of the following:

Bloodshot Eyes	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Blurred Vision — Distance	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Blurred Vision — Near	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Burning Eyes	☐ Yes ☐ No	Itching Eyes	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Light Sensitive	☐ Yes ☐ No
Color Vision, Poor	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Discharge from Eyes	☐ Yes ☐ No	Night Vision, Poor	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Red Eyes	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Seeing Halos	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Seeing Flashes	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No	Temporary Loss of Vision	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No	Twitching Eyelid	☐ Yes ☐ No
Eye Strain	☐ Yes ☐ No	Vision Poor	☐ Yes ☐ No
Fainting Spells, Blackouts	☐ Yes ☐ No	Watering Eyes	☐ Yes ☐ No

- OVER -

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No	Hepatitis (Type _____)	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No	Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No	Are you pregnant? _____	Number of children _____	
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No	Tobacco use _____	Alcohol use _____	

MEDICATIONS

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

ALLERGIES

List your allergies to medications or other substances:

_____

Surgeries: _____

_____

_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its 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 or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date

PATIENT CONSENT

I agree that Gary S. Reiter MD, may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature Date

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HIPPA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

I hereby authorize: _____ to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to: _____

_____

Please indicate the information or types of information to be disclosed (including dates if necessary):

_____

_____

_____

*The purpose(s) of this authorization is: _____

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to _____

If not revoked by me, this authorization will terminate on: _____ (include date or event).

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, (psychiatric records, psychological records, etc.) sexually transmitted diseases, tuberculos genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS)** This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

_____ _____

Patient or Legal Representative Date

_____ _____

Representative's authority to act on behalf of individual Witness

Gary S. Reiter, MD

Financial Policy

ALL PATIENTS PLEASE READ AND SIGN WHERE APPROPRIATE

MEDICARE PATIENTS

Medicare does not cover or pay for refractions (evaluating your present glasses or prescribing new ones). There is a $60.00 refraction fee. Our office will bill one secondary insurance as a courtesy to you. Any additional billings will incur a $30.00 fee. Please indicate your understanding by signing below.

Signature Printed Name Date

ALL CONTACT LENS PATIENTS

If you wish to have your contact lens prescription evaluated, or if you wish to obtain new contact lenses, there is a professional fee for this service in addition to the fee for you eye examination. The fee will range from $75.00 to $275.00. Your insurance will not cover this cost. Please indicate your understanding by signing below.

Signature Printed Name Date

INSURANCE PATIENTS

If you wish us to bill your insurance, you must have all the information with you at the time of your visit. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. Otherwise, we will accept cash, credit cards, or checks for your payment. We cannot bill your insurance at a later date (too many patients “discover” their insurance after their visit and this creates accounting problems for our staff). This request applies to all insurance plans, including ones which would normally cover all costs for your visit and glasses. If you are uncomfortable with this arrangement, we will be happy to reschedule your visit to a time when you have your insurance and financial information available. If you provide the incorrect insurance information and would still like us to bill and then your visit must be rebilled, you will incur a $50.00 fee. Please indicate your understanding by signing below.

Signature Printed Name Date

Payment for services not covered by insurance: Copayments and deductibles, and glasses are to be paid at the time of service. We will accept cash, check and Visa/Mastercard (minimum $25) for payment. A fee of $1.00 will be charged for credit card payments under $25.00 or payments made over the phone. Returned check fee is $50.00. Appointments canceled without 24 hour notice will incur a $50.00 fee.

Signature Printed Name Date