Wayne Regional Eye Center

1210 Driving Park Avenue
Newark NY 14513

PATIENT'S INFORMATION: (Please fill form out completely) **Today's Date: ___________________**

______________________________ ___________________________ ________ _____-_____-______ ___________
Last name **First Name** **MI** **Date of Birth** **Age**

_________-_____-__________ **Married / Widowed/ Single/ Other** ________________ ________________________
Social Security Number **Circle one: Marital Status** **Occupation / Retired?** **Employer**

English/ Spanish/__________ **Mail / Phone/ Email/Text Message** **YES / NO** _____________________________________
Preferred Language: Other? **Contact Preference : (Circle)** **Would you like email updates? If so please give Email Address**

Gender: Male / Female **Race:** White /African Amer/Amer Indian/ Asian / Hispanic-Latino/ other? ______________

Ethnicity: American / Mexican / Japanese / Chinese/ Asian / European / Latino/ other? _______________________

____ ___________________ __________ ______________
Patient's Home Address **City** **State** **Zip code**

(_____)________________ (_____)______________ (______)__________ ________________________________
Home Phone **Work Phone/ Extension** **Cell Phone** **Alt. Phone #/ Who's Number or Type?**

____ ______________ _____________ (____)_____________
Patient's Employer Address **City** **State / Zip** **Phone Number**

___________________________________ _____-_____-______ ___-___-______ _________ (____)_________
Spouse's Full name **Spouse's SSN #** **Spouse's DOB** **Spouse's Age** **Spouse's Cell #**

____________________ ______________________________________ ___________ __________ (____)________
Spouse's Employer **Spouse's Employer Address** **City** **State/Zip** **Spouse's Work #**

DO YOU HAVE AN "ADVANCED DIRECTIVE?:

YES or NO **Living Will / Organ-Tissue Donor / Durable Power of Attorney / Do Not Recessutate (DNR)**
Circle **Circle Type of Directive**

REFERRED BY: **Yellow pages / Radio / Newspaper / Internet / Friend / Dr.____________/ Other:________________**
Circle or Fill in Name of referring Source

EMERGENCY CONTACT : (IF UNABLE TO REACH PATIENT)

__________________________ ______________ ( )___________ ( )_____________ ( )_______________
Name **Relationship** **Home Phone** **Cell Phone** **Work Phone / Extension**

IF PATIENT IS A MINOR: PLEASE COMPLETE):

__________________________________ _______-_____-________ ______________ ( )_______________
Mother's Full Name **Social Security #** **Date of Birth** **Phone # Cell or Home?**

_________________________________ (____) _____________ ____
Mother's Employer **Work Phone # and Ext** **Home Address if different from Above**

__________________________________ _______-_____-________ ______________ ( )_______________
Father's Full Name **Social Security #** **Date of Birth** **Phone # Cell or Home?**

_________________________________ (____) _____________ ____
Father's Employer **Work Phone # and Ext** **Home Address if different from Above**

PHARMACY INFORMATION:

Preferred Pharmacy	Street Address	City	State	Phone #
				( )

PHYSICIAN INFORMATION:

Physician	Street Address	City	State	Phone #
Primary Care Physician				( )
Other Physician's Name and Specialty				( )
Other Physician's Name and Specialty				( )

INSURANCE INFORMATION: (Please give insurance cards to receptionist to copy)

Primary Insurance: ______________________ **Owner Name:** ______________

Secondary Insurance: ______________________ **Owner Name:** ______________

Third Insurance: ______________________ **Owner Name:** ______________

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of M.S. Napoleon MD PC dba Wayne Regional Eye Center to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of M. S. Napoleon MD PC dba Wayne Regional Eye Center.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:	Relationship:

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to M.S. Napoleon MD PC dba Wayne Regional Eye Center use and disclosure of protected health information about myself for treatment, payment and health care operations.

______________________________ **Signature of the Patient or Patient Representative**

I have been provided a copy of the M.S. Napoleon MD PC dba Wayne Regional Eye Center Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

______________________________ **Signature of the Patient or Patient Representative**

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to M. S. Napoleon MD PC dba Wayne Regional Eye Center.

______________________________ **Signature of the Patient or Patient Representative**

Signature on File, Assignment of Benefits, Financial Agreement

Name:____ Date of Birth:______________________

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to M.S. Napoleon MD PC, dba Wayne Regional Eye Center, for services furnished me by M.S. Napoleon MD PC, dba Wayne Regional Eye Center. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly 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 CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. M.S. Napoleon MD PC, dba Wayne Regional Eye Center 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 CMS 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 M.S. Napoleon MD PC, dba Wayne Regional Eye Center, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** M.S. Napoleon MD PC, dba Wayne Regional Eye Center 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 M.S. Napoleon MD PC, dba Wayne Regional Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. M.S. Napoleon MD PC, dba Wayne Regional Eye Center 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 M.S. Napoleon MD PC, dba Wayne Regional Eye Center 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 M.S. Napoleon MD PC, dba Wayne Regional Eye Center has no contract, expressed or implied, with any plan that does 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 M.S. Napoleon MD PC, dba Wayne Regional Eye Center if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that M.S. Napoleon MD PC, dba Wayne Regional Eye Center's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the 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 the 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 M.S. Napoleon MD PC, dba Wayne Regional Eye Center to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by M.S. Napoleon MD PC, dba Wayne Regional Eye Center, will pay my account at the time service is rendered or will make financial arrangements satisfactory to M.S. Napoleon MD PC, dba Wayne Regional Eye Center 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 M.S. Napoleon MD PC, dba Wayne Regional Eye Center. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to M.S. Napoleon MD PC, dba Wayne Regional Eye Center. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

____ __________________

Signature of Patient or Authorized Party Date