

**PRECISION
EYE CARE**



Richard G. Davis, M.D., F.A.A.O.
Adam H. Bloom, M.D., F.A.A.O.
Barbara L. Reiss, O.D., F.A.A.O.
1700 East Jericho Turnpike • Huntington, NY 11743
631-462-2020 • Fax 631-462-2227
www.precision-eyecare.com

REFRACTION ACKNOWLEDGEMENT

As part of your visit you may have a Refraction. This is a test to determine the prescription for your eyeglasses. This test requires special equipment and staff training to give you the most accurate prescription possible. Without a Refraction, it will be impossible to give you a prescription for glasses. Most insurance carriers, such as Medicare, consider this routine and do not cover the cost of the test. Our front desk staff will be able to advise you as to whether or not this is a covered service by your specific insurance at the time of your visit. If it is not covered, we offer you a courtesy discount of **\$20 OFF THE NORMAL FEE OF \$60 IF PAID AT THE TIME OF THE VISIT.** If not paid at the time of visit, you will be billed for the full amount of \$60.

By signing below, I acknowledge that I understand the above information regarding Refraction and agree to be responsible for any payments due for this service if it is not covered by my insurance.

Patient Name (please print)

Patient/Parent Signature

Today's Date

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Signature on file, Assignment of benefits, Financial Agreement

I request that payment of authorized benefits be made to either me or to Precision Eye Care on my behalf for services furnished to me by the provider. I authorize the release of my medical information by or between any of my treating physicians and my health benefits payer (insurance company) or any other entity, including but not limited to third party administrators, management companies and provider networks involved with Precision Eye Care.

I agree that in return for services provided by Precision Eye Care, I will pay my account at the time service is rendered including all deductibles, copayments, coinsurances and non-covered services. If my account is sent to a collection agency or to an attorney for collections, I agree to pay collection expenses and/or reasonable attorney's fees as established by the court.

Print Patient Name

Patient's signature or patient's legal agent

Date

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HIPAA Patient Consent Form

In response to the misuse of Personal Health Information, the Department of Health and Human Services has established a "Privacy Rule" to insure that your Personal Health Information is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your Personal Health Information in order to provide health care that is in your best interests.

We support your full access to your medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose your Personal Health Information for purposes of treatment, payment, and/or health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your Personal Health Information. This refusal must be made in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your Personal Health Information. If you give consent to disclose your Personal Health Information, by signing this document, you can at some future time request to refuse future disclosures of your Personal Health Information. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our Administrative staff if you have objections to this consent.

Please list below the individuals to whom we may talk medical problems
(E.g. spouse, family member, etc.)

Signature

Print Name

Date

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New Update

Patient Information: Male Female

Last Name _____ First Name _____ MI _____

St. Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Primary Care Physician _____ PCP Phone # _____

Referred by _____ Employer _____

Emergency Contact _____ Relation _____ Phone # of Contact _____

If the Patient is a Child, Parent or Guardian's Name _____

Primary Ins. Company _____

Secondary Ins. Company _____

Ins. Address _____

Ins. Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Patient's ID _____

Patient's ID _____

Patient's Group # _____

Patient's Group # _____

Policyholder's Name _____

Policyholder's Name _____

Policyholder's DOB _____

Policyholder's DOB _____

Policyholder's SS# _____

Policyholder's SS# _____

Policyholder's St. Address _____

Policyholder's St. Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Policyholder M F Relation _____

Policyholder M F Relation _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance including deductibles, coinsurance, co-payments, and any non-covered services. I also authorize Precision Eye Care or insurance company to release any information required to process my claims

Signature _____

Date _____