New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

Date of Birth _____ Age _____ ☐ M / ☐ F Social Security #_____

Address _____

Street Apt# City State Zip

Phone: Home (____) _____ Work (____) _____ Mobile (____) _____

Email _____ Occupation _____

Employer _____ Address: _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Widowed ☐ Divorced

Spouse/Partner Name _____ Spouse/Partner Phone (____) _____

Employer _____

Referred by: ☐ Friend/Relative _____ ☐ Doctor _____

Name Name

☐ Other _____

Pharmacy Name:_____ Address: _____ Phone: _____

Complete if under 18 years or a student

Parent _____ Employer _____

Address _____ Phone (____) _____

Parent _____ Employer _____

Address _____ Phone (____) _____

INSURANCE INFORMATION

☐ Medical Insurance _____

ID# _____ Group #_____

☐ Medicare #_____ Secondary Insurance _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____ Relationship _____ DOB _____

Who to notify in emergency

Name _____ Relationship _____

Address _____

Street City State Zip

Home Phone (____) _____ Work Phone (____) _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to Dr. Hilla Steinberg and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE:** _____

Date of **last eye exam** _____

List any **medications** you currently take (prescription and over-the-counter): _____

_____

Do you have allergies to any medications? **YES** **NO**
If YES, list the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): _____

List any surgeries you have had (cataract, tonsillectomy, appendectomy): _____

	YES	NO	DETAILS
GENERAL / CONSTITUTIONAL (fever, weight loss, other) RECENT			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.) RECENT			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.) RECENT			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.) RECENT			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia**)**			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY **M** = mother **F** = father **S** = sibling **GP** = grandparent

Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Hypertension			

Heart Disease			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Do you drive?	YES	NO					
Do you have visual difficulty when driving?	YES	NO					
Do you have problems with night vision?	YES	NO					
Have you ever tried to wear contact lenses?	YES	NO					
Do you currently wear contact lenses?	YES	NO	If YES, how long? _____				
Do you currently wear glasses?	YES	NO	If YES, how long have you had your current prescription? _____				
Do you drink alcohol?	YES	NO	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	YES	NO	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Are you interested in consulting on the following **skin rejuvenation** procedures?

Botox (erase lines and wrinkles) Yes _____ No _____

Juvederm Filler (smooth wrinkles and folds) Yes _____ No _____

Restylane Filler (smooth wrinkles and folds) Yes _____ No _____

Latisse (fuller, longer and darker lashes) Yes _____ No _____

Kybella (FDA approved injecible treatment used to improve the appearanceand profile of moderate to severe fat below the chin) Yes _____ No _____

Dr. Hilla Steinberg's Signature: _____ Date: _____

HILLA STEINBERG MD, PLLC
Board Certified Ophthalmologist

Acknowledgement of Receipt of Privacy Notice

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may not be used and disclosed by the facility listed at the beginning of this notice, and how I may obtain access to and control this information.

For **PATIENT** to **COMPLETE**:

Patient Name: _____

Signature of Patient: _____

Date: _____

If Applicable, Personal Representative's Name: _____

Description of Personal Representative's Authority: _____

Signature of Personal Representative: _____

Date: _____

For **OFFICE** to **COMPLETE:**

I have been given the Notice of Privacy Practices to the Patient, and the Patient:
[ ] Signed
[ ] Refused to sign
[ ] Was unable to sign because _____

Dr. Hilla Steinberg's Representative:

Signature: _____

Date: _____

Assignment of Benefits and Release of Billing Information Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Hilla Steinberg medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Hilla Steinberg to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Hilla Steinberg on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

<u>Referral</u>

I also understand and acknowledge that attaining referral is the responsibility of the patient. If required by my plan, I understand that it is my responsibility to obtain the referral from my Primary Care Physician and present prior to my visit. Referrals must be provided before appointment or I may not be seen or I may pay for service in full and submit claim to my carrier.

If a claim is denied due to missing invalid referral, I am responsible for a $250 claim denial administration fee and any applicable charges for services/treatment.

_____ _____

Patient/Responsible Party Signature Date

HILLA STEINBERG MD, PLLC
Board Certified Ophthalmologist

REFRACTION AND/OR CONTACT LENS

SERVICES AND FEES

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office fee for refraction is **$75.00**. Please be aware that this fee is **collected at the time of service** in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Contact Lens:

There is a **$150.00 fee** for spherical contact lens update fitting and **$300.00 fee** for multifocal contact lens update fitting. Please be aware that this fee is **collected at the time of service**. The **fee varies** from the type of contact lens update fitting that is required. If you are not satisfied with the fit you have 45 days to notify the practice and be refitted.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

_____ _____

Patient Signature (Parent for Minor) Date

NO SHOW FEE

I have been notified that if I do not show up for the scheduled appointment I will be charge $45 fee.

_____ _____

Patient Signature (Parent for Minor) Date

CREDIT CARD ON FILE POLICY

At Hilla Steinberg MD, we require keeping your credit or debit card on file as a method of payment for delinquent balance but for which you are liable.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Hilla Steinberg MD to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Amex** ☐ **Visa** ☐ **MasterCard**

Credit Card Number _____

Expiration Date _____ **/** _____ **/** _____ **Security code** _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I, the undersigned, authorize and request Hilla Steinberg MD to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Hilla Steinberg MD.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a notification to Hilla Steinberg MD in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____