PHILADELPHIA OPHTHALMOLOGY ASSOCIATES
NEW PATIENT INTAKE

LAST NAME:_____ FIRST NAME:_____M.I.:_____

DATE OF BIRTH:_____ MARITAL STATUS:_____ GENDER:_____

PHONE# YOU WANT
TO BE CONTACTED AT:_____EMAIL:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

OCCUPATION:_____ REFERRED BY:_____

ER CONTACT PERSON:_____ (RELATION)_____

ER CONTACT PERSON CELL#_____

PRIMARY CARE PHYSICIAN:_____ WORK#:_____

PHARMACY:_____ LOCATION:_____

ANY ALLERGIES (Food, Drug or
Other):_____

REASON FOR VISITING OUR OFFICE TODAY

If applicable, when did symptoms begin?

IF YOU DID NOT BRING YOUR INSURANCE CARD, PLEASE PROVIDE YOUR INSURANCE INFORMATION BELOW:

HEALTH INSURANCE:_____ NAME ON POLICY:_____

POLICY ID#:_____ MEDICARE#:_____

VISION BENEFITS:_____ LAST ROUTINE EYE EXAM:_____

PHILADELPHIA OPHTHALMOLOGY ASSOCIATES
PATIENT HISTORY

PATIENT NAME:_____**DOB:**_____

DO YOU WEAR GLASSES?	Y	N	
DO YOU WEAR CONTACT LENSES?	Y	N	
ARE YOU INTERESTED IN CONTACT LENSES?	Y	N	
DO YOU SMOKE?	Y	N	Prior
DO YOU DRINK ALCOHOL	Y	N	How Often?
DO YOU WORK AT COMPUTER SCREEN	Y	N	

DO YOU HAVE A FAMILY HISTORY OF: (please circle and if "Y", write the blood relation to you)

GLAUCOMA?	Y	N
BLINDNESS?	Y	N
CATARACT?	Y	N
MACULAR DEGENERATION?	Y	N
DIABETES?	Y	N
OTHER EYE-RELATED ISSUES OR DISEASES?	Y	N

DO YOU HAVE ANY OF THE FOLLOWING: (please circle and if "Y", write when condition began)

HIGH BLOOD PRESSURE?	Y	N
DIABETES?	Y	N
ASTHMA?	Y	N
CARDIOVASCULAR ISSUES?	Y	N
THYROID ISSUES?	Y	N
OTHER MEDICAL ISSUES?	Y	N

PLEASE LIST PRIOR SURGERIES AND THEIR APPROXIMATE DATES:

PHILADELPHIA OPHTHALMOLOGY ASSOCIATES
LIST OF MEDICATIONS

PATIENT NAME:_____**DOB:**_____

PLEASE LIST ALL EYE MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDE OVER-THE-COUNTER EYE MEDICATIONS/DROPS IF TAKEN WITH REGULARITY:

1.

2.

3.

4.

5.

6.

PLEASE LIST ANY AND ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDE OVER-THE-COUNTER MEDICATIONS IF TAKEN WITH REGULARITY:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

PHILADELPHIA OPHTHALMOLOGY ASSOCIATES
HIPPA ACKNOWLEDGEMENT & AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:_____DOB:_____

I hereby acknowledge the opportunity to read and review the HIPAA privacy statement for Philadelphia Ophthalmology Associates (aka Accuvision Eyecare, and hereinafter referred to as POA).

_____ DATE:_____

Signature of Patient

I hereby certify that the above patient was given the opportunity to read and review the HIPAA Privacy statement and declined the opportunity to do so.

_____DATE:_____

Signature of POA Staff Member

MANY OF OUR PATIENTS ALLOW FAMILY MEMBERS SUCH AS THEIR SPOUSE, PARENTS OR OTHERS TO CALL AND REQUEST MEDICAL OR BILLING INFORMATION. UNDER CURRENT HIPAA MANDATES, WE ARE NOT ALLOWED TO GIVE THIS INFORMATION TO ANYONE WITHOUT THE PATIENT'S CONSENT. IF YOU WISH FOR OTHER PEOPLE TO DISCUSS OR RECEIVE YOUR MEDICAL AND/OR BILLING INFORMATION, YOU MUST SIGN THIS FORM. YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME.

_____ Relation to Patient:_____

Name of Authorized Recipient

_____ Relation to Patient:_____

Name of Authorized Recipient

_____ Relation to Patient:_____

Name of Authorized Recipient

PHILADELPHIA OPHTHALMOLOGY ASSOCIATES
SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

FINANCIALLY RESPONSIBLE PARTY NAME		**DOB:**	

1. **MEDICARE AND INSURANCE:** I request that payment of authorized Medicare and/or Insurance benefits be made on my behalf to Philadelphia Ophthalmology Associates (aka Accuvision Eyecare, and hereinafter referred to as POA) for services furnished me by POA. 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. POA accepts the charge determination of the Medicare carrier as the full charge. I understand that I am responsible only for the deductible, coinsurance or the 20% Medicare does not pay, and any non-covered 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 HCFA 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 POA, if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** POA 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 POA for reimbursement for services rendered, and (2) any health care provider for continued patient care. POA 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 POA maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. ***The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by POA if I belong to a plan that does not appear on the above mentioned list.***
5. **NON-COVERED SERVICES:** I understand that POA'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 POA to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by POA, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to POA for payment. If an account is sent to an agency for collection, I agree to pay collection expenses and reasonable fees. 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, are hereby assigned to POA. If copayments and/or deductibles are designated by my insurance company or health plan, I shall pay them to POA.

I understand that I am primarily responsible for my bill. If Medicare/Insurance carrier does not pay within 45 days from the day services were billed, I am responsible for payment in full.

Financially Responsible Party Signature _____ Date _____