# HIPAA

By signing below, I authorize the Rosenstein Vision to use any protected health information, or PHI, in any of the following circumstances:

1. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. In addition, we may use and disclose PHI about you when referring you to another health care provider for additional care.

2. Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services we provided to you. Specifically, sharing information with your health plan (s) allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of your medical information with the following:

- Billing departments
- Collection departments
- Insurance companies, health plans and their agents which provide you coverage

3. I am aware that there is a copy of this office's Notice of Privacy Practices as required by HIPAA in each examination room, in the waiting room, and at the front desk. All of these copies are available for my review while I am in the office.

PRINTED NAME:_____

SIGNATURE:_____ DATE:_____

EST 1904

ROSENSTEIN VISION

**Patient Acknowledgement of Financial Responsibility**

Thank you for choosing our practice for your eyecare needs. We are committed to the success of your eyecare treatment and health. Please understand that payment of your bill is considered part of your treatment. The following explains our Financial Policy, which we ask you to read, sign, and return to us prior to your visit.

- I agree to provide accurate and complete personal and insurance information prior to being seen by my provider, and it is my responsibility to update any changes in insurance, home address, contact information and any other pertinent information necessary for billing.

- I acknowledge that all applicable copays, co-insurance, balances due, both current and prior including eyeglass and/or contact lens purchase(s) are ***due at the time of service.***

- If Rosenstein Vision is unable to verify my insurance at the time of service, I will be asked to pay for the visit at the discounted self-pay rate.

**Regarding Insurance**
If you have health insurance, it should be understood that the agreement is between you and your insurance company. Therefore, as a courtesy to you, we will verify and bill your insurance company for all covered services. You will be responsible for any charges that are not paid for within 90 days of our claim submission. **You are responsible for payment of your charges regardless of the status of your insurance claim**. We do not guarantee the accuracy of benefit information given to us by insurance companies.

- **Contracted Insurance:** If you are a member of an insurance company with which our office is contracted, you will be asked to pay all copays, and non-covered services at the time of service. We are contracted with many insurances, but NOT in network with every plan. Therefore it is advised that you verify with your insurance company that we are in network with your particular plan.

- **Non-Contracted Insurance and Non-Covered Services**: If we are not contracted with your insurance or are not in network with your plan, payment is due at the time of service; and you will be given an itemized receipt to file with your insurer. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or your insurance deems not medically necessary. In the event that your insurance company does not cover your services, you will be responsible. In some cases, prior authorization may be required by the insurance company, but this does not guarantee payment.

_____ _____

Printed Name Date

_____

Signature

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# ROSENSTEIN VISION

**PLEASE PRESENT PHOTO ID, VISION AND MAJOR MEDICAL INFORMATION AT CHECK IN**

**If insurance cards are in digital format only, please email to: frontdesk@rosensteinvision.com**

**IMPORTANT NOTE: Our office requires a 24-hour notice for appointment cancellations. If notice is given less than 24 hours in advance, you may be subject to a cancellation fee.**

| **Demographics** | | | |
|---|---|---|---|
| Patient Name: | | MI: | Last Name: |
| Date of Birth: | Pronouns: | SSN: | Preferred Name/Nickname (if applicable): |
| Parent/Guardian Full Name: | | | |
| Address: | | City/State: | Zip: |
| Home Phone: | Cell Phone: | | Daytime/Work Phone: |
| Email Address: | | | |
| Communication Preference: ☐ Email ☐ Postal ☐ Telephone | | | |
| Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ☐ Single ☐ Widowed | | | |
| Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student | | | |
| Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Active Military ☐ Not Employed ☐ Self-Employed | | | |
| Employer: | | Occupation: | |
| Preferred Language: ☐ English ☐ Spanish ☐ Other:_____ | | | |
| Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Decline to Specify ☐ European ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ White | | | |
| Ethnicity: ☐ Decline to Specify ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Not Hispanic or Latino | | | |
| Special Accommodations: ☐ Hearing Impaired ☐ Translator ☐ Wheelchair ☐ Other: _____ | | | |
| How did you hear about us? | | | |
| Signature of Patient/Representative: | | | Date: |

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# ROSENSTEIN VISION

## INSURANCE INFORMATION

**WE WORK WITH INSURANCE COMPANIES TO FILE CLAIMS DIRECTLY AS A COURTESY**

In order to successfully file insurance claims, it is your responsibility to provide any and all insurance cards and information at the time of service and know your current insurance providers. By choosing to provide this information you are allowing Rosenstein Vision Center to bill your insurance. If you do not provide this information on the date of service then you are responsible for filing to your insurance company, and we will provide all necessary documents to do so.

***Please keep in mind insurance companies determine all copays, coinsurances and deductibles that may apply to your visit and are not set by Rosenstein Vision Center.***

## CONTACT LENSES

**The FDA (Federal Food and Drug Administration) law requires that all contact lens patients be evaluated annually.**

***An additional fee will be due at the time of the exam.***

The evaluation fees are determined based on *the complexity of the fit*. This fee may be covered, in part, by your insurance - usually with a copay determined by your insurance company. In some situations, your insurance company will determine the type of fit as well as the charge. If you have any questions, please check with your insurance company.

☐ I wear Contact Lenses ☐ I **DO NOT** wear Contact Lenses ☐ I am **interested** Contact Lenses

## CONTACT LENS OFFICE POLICIES

***If you are receiving a contact lens exam with our office, it is our policy that you must have back up glasses with a functional prescription.***

It is important to have back up glasses for many reasons:

**Emergencies such as:** allergies, infections, contact lens discomfort, scratched cornea, foreign body or chemical accidents, etc.

**Daily Occurrences such as:** tired eyes, allergies, dryness, discomfort, air quality issues, etc.

**Complications such as**: losing or tearing a lens, waiting on your order to be delivered, waiting for an exam appointment due to an outdated prescription, etc.

Keep in mind, with standard contact orders with **no complications** it will take roughly 7-10 business days from the day you place your order for contact lenses to arrive.

**Once a prescription is finalized and an order for contact lenses has been placed all sales are final.**

☐ I have functioning glasses ☐ I **DO NOT** have functioning glasses ☐ I am **interested** in getting glasses

**I understand and agree to these policies:** _____ _____

**Signature** **Date**

NAME: _____ DOB: _____

| REASON FOR VISIT/CURRENT CONCERNS? |
|---|
| |
| |
| |

| CURRENT MEDICATIONS |
|---|
| |
| |
| |

| ALLERGIES |
|---|
| |
| |
| |

| PREFERRED PHARMACY |
|---|
| Pharmacy Name: |
| Pharmacy Location/Address: |

| PROVIDERS | |
|---|---|
| Primary Care Physician/Location: | Approximate date of last visit: |
| Previous Eye Doctor/Location: | Approximate date of last visit: |

| MISCELLANEOUS | | | | | |
|---|---|---|---|---|---|
| Y | N | | Y | N | |
| □ | □ | Do you wear glasses? | □ | □ | Do you wear Contact Lenses? |
| □ | □ | Are you interested in refractive surgery? | □ | □ | Do you perform fine or close-up work? |
| □ | □ | Are you outdoors all or part of the time? | □ | □ | Are you sensitive in bright sunlight? |
| □ | □ | Are you bothered by glare from overhead lights? | □ | □ | Are you bothered by glare from a computer screen? |
| □ | □ | Are you bothered by glare from oncoming headlights at night? | □ | □ | Do you have trouble reading signs when driving at night? |
| □ | □ | Are you Pregnant? | □ | □ | Are you Breastfeeding? |
| □ | □ | Do you use recreational drugs? | □ | □ | Do you drink? |
| □ | □ | Are you a tobacco smoker? | | | |

| | |
|---|---|
| How many hours per day do you use a computer? | |
| What kind of hobbies/recreational activities do you enjoy? | |

**REVIEW OF SYSTEMS**
**Do you currently have, or have you ever had any of the following? (Please check any/all that apply).**

| Allergic/Immunologic | Cardiovascular | Constitutional | Ear, Nose, Mouth, Throat |
|---|---|---|---|
| □ Eczema | □ Heart Disease | □ Fever w/weight loss/gain | □ Allergies |
| □ Hives | □ High Blood Pressure | | □ Sinus Congestion |
| □ Lupus | □ High Cholesterol | | □ Post Nasal Drip |
| □ Organ Transplant | □ Stroke | | □ Chronic Cough |
| | □ Vascular Disease | | □ Dry Mouth/Throat |
| **Endocrine** | **Gastrointestinal** | **Genito-Urinary** | **Integumentary (skin)** |
| □ Diabetes Type I | □ Constipation | □ Bladder/Genital/Kidney | □ Skin Cancer |
| □ Diabetes Type II | □ Crohn's Disease | □ Herpes Simplex | □ Skin Disease |
| □ Thyroid/other Glands | □ Hepatitis A | □ Prostate | □ Herpes Zoster/Shingles |
| □ Chronic Cough | □ Hepatitis B | | |
| ____ Last HgA1c | □ Hepatitis C | | |
| | □ Ulcer/Reflux | | |

| Lymphatic – Hematologic | Musculoskeletal | Neurological | Psychiatric | Respiratory |
|---|---|---|---|---|
| □ Anemia | □ Joint/Muscle Pain | □ Headaches | □ Anxiety | □ Asthma |
| □ Bleeding Problems | □ Osteo Arthritis | □ Migraines | □ Depression | □ Chronic Bronchitis |
| | □ Rheumatoid Arthritis | □ Multiple Sclerosis | | □ Emphysema |
| | | □ Gout | | □ Sleep Apnea |
| | | □ Seizures | | |

| List any previous surgeries (with approximate dates): |
|---|
| |
| |

**Ocular History**
**Do you currently have, or have you ever had any of the following? (please check any/all that apply)**

| | | | |
|---|---|---|---|
| □ Age-related macular degeneration | □ Amblyopia (Lazy eye) | □ Blindness (one eye) | □ Blindness (both eyes) |
| □ Cataracts | □ Glaucoma | □ History of refractive surgery | □ Injury to the eye region |
| □ Keratoconus | □ Retinopathy | □ Strabismus (Crossed eyes) | □ Tear film insufficiency (dry eye) |

**Patient Past Medical History**
**Do you currently have, or have you ever had any of the following? (Please check any/all that apply)**

| | | | |
|---|---|---|---|
| □ Acquired Immune Deficiency Syndrome (AIDS) | □ Arthritis | □ Asthma | □ Cancer |
| □ Chronic obstructive lung disease (COPD) | □ Diabetes Mellitus | □ Emphysema | □ Heart Disease |
| □ Human immunodeficiency virus infection (HIV) | □ Hypercholesterolemia (high cholesterol) | □ Hypertensive disorder (Hypertension) | □ Seasonal allergies |
| □ Thyroid dysfunction | □ Mental disorder | □ Rheumatoid arthritis | □ |

**Family Health History**
****If checked, please specify which family member including maternal/paternal indicators****

| | |
|---|---|
| □ Amblyopia (Lazy eye): | □ Blindness and/or vision impairment: |
| □ Cataracts: | □ Macular Degeneration: |
| □ Glaucoma: | □ Retinal Disorder: |
| □ Strabismus (cross eyes): | □ Arthritis: |
| □ Cancer: | □ Diabetes Mellitus: |
| □ Hypertension (high blood pressure): | □ Cardiovascular disease: |
| □ Stroke: | |