DUMONT
EYE CARE

52 Grant Ave. Dumont, NJ 07628 | Phone#: 201-385-3055 | Fax#: 201-385-3011 | info.dumonteyecare@gmail.com

( )Mr. ( )Miss ( )Mrs. ( )Ms. ( ) Dr. Date: _____ /_____ /_____

_____ _____ _____
Last Name First Name MI

_____ _____ _____ _____ _____
Address Line Address Line 2 City State Zip

_____ _____ _____ _____
Social Security Number Date of Birth Age Gender

_____ _____ _____
Home Phone# ☐ Cell Phone# ☐ Work Phone# ☐ *Check preferred phone number

_____ _____ _____
Occupation Email Address *(Protected under HIPPAA)* Responsible Party(s) or Guardian

Patient Status: ( ) Single ( ) Married ( ) Other _____
( ) Full Time Student ( ) Part-time Student ( ) Employed

Primary Care Physician Name: _____ **Pharmacy Name:** _____
Primary Care Physician Address: _____ **Pharmacy Address:** _____
_____ _____
Primary Care Physician Phone#: _____ **Pharmacy Phone#:** _____

REASON(S) FOR VISIT: EYE GLASSES_____ CONTACT LENS_____ EYE PROBLEM _____ LAST EYE EXAM: _____

PRIMARY INSURANCE INFORMATION

Primary Medical Insurance Company: _____

_____ _____ _____
Insured's Last Name Insured's First Name MI

_____ _____ _____
Insured's Identification Number Group Number Insured's Date of Birth

_____
Insured's Social Security No. ( ) Male ( ) Female

Patient Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

SECONDARY MEDICAL INSURANCE INFORMATION

Secondary Medical Insurance Company: _____

_____ _____ _____
Insured's Last Name Insured's First Name MI

_____ _____ _____
Insured's Identification Number Group Number Insured's Date of Birth

_____
Insured's Social Security No. ( ) Male ( ) Female **Patient Relationship to Insured**: ( ) Self ( ) Spouse ( ) Child ( )

MEDICAL HISTORY QUESTIONNAIRE

Eye History

Headaches	Yes	No	Blurred Vision Near	Yes	No
Glare/Light Sensitivity	Yes	No	Distorted Vision (halos)	Yes	No
Tired Eyes	Yes	No	Double Vision	Yes	No
Lazy Eye	Yes	No	Floaters or Spots/Flashes	Yes	No
Burning	Yes	No	Fluctuating Vision	Yes	No
Dryness	Yes	No	Loss of Vision	Yes	No
Excess Tearing/Watering	Yes	No	Loss of Side Vision	Yes	No
Eye Pain or Soreness	Yes	No	Drooping Eyelid	Yes	No
Foreign Body Sensation	Yes	No	Redness	Yes	No
Infection of Eye or Lid	Yes	No	Sandy or Gritty Feeling	Yes	No
Itching	Yes	No	Crossed Eyes/Eye turn	Yes	No
Mucous Discharge	Yes	No	Glaucoma	Yes	No
Macular Degeneration	Yes	No			
Blurred Vision Distance	Yes	No			

General Health Condition

Fever	Yes	No	Muscle, Bones, Joints	Yes	No
Weight Loss	Yes	No	Skin	Yes	No
Other Constipation Symptoms	Yes	No	Neurological (MS)	Yes	No
Ear, Nose, Throat Condition	Yes	No	Anxiety, Depression	Yes	No
High Blood Pressure	Yes	No	Insomnia	Yes	No
Respiratory (Asthma)	Yes	No	Diabetes, Thyroid	Yes	No
Gastrointestinal	Yes	No	Blood/Lymph (cholesterol)	Yes	No
Allergic/Immunologic	Yes	No			
Kidney	Yes	No			

Past Illnesses: _____

Past Surgeries: _____

Current Medications: _____
_____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

Do you smoke? ( ) Yes ( ) No If yes, how much? _____

Family History

Lazy Eye	Yes	No	Cancer	Yes	No
Blindness	Yes	No	Diabetes	Yes	No
Cataracts	Yes	No	Heart Disease	Yes	No
Color Blindness	Yes	No	High Blood Pressure	Yes	No
Glaucoma	Yes	No	Kidney Disease	Yes	No
Macular Degeneration	Yes	No	Lupus	Yes	No
Retinal Detachment	Yes	No	Stroke	Yes	No
Eye Turn	Yes	No	Other: _____		
Thyroid	Yes	No			
Arthritis	Yes	No			

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FOR FINANCIAL POLICY AND HIPAA PRIVACY

Insurance and Billing:
We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. You are responsible for providing us with up-to-date insurance information. If your insurance company requires referrals, advance notification is required for non-emergent referrals. Also, when coming to Dumont Eye Care specialist, you must have a referral before being seen or you will be responsible for payment in full at the time of service. We accept payment from all participating insurance plans but require that you pay your copay at the time of service. You will be responsible for any deductibles, coinsurance and non-covered services. If you do not have insurance, payment for services is expected at the time of service. Most major credit cards are accepted for payment. The office policy is that the parent requesting treatment for a minor is responsible for all fees incurred. We cannot become involved in billing disputes in cases involving divorce or separation.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits. Your insurance policy is a contract between you and your insurance company. We attempt to verify our patient's information before or the time of service, however a disclaimer is read at the time of all verifications by the insurance companies that the information may not be accurate and is subject to review by your insurance company before authorizing and processing claims. You may be billed in the event that your insurance plan does not pay in a timely manner or is unresponsive to our claims submission. All fees are ultimately your responsibility.

Charges/Fees:
In the event that a check is returned to us by your bank for any reason, there will be a $25.00 service charge.
Collection Agency:
All patient accounts that become delinquent will be processed in-house for collection proceedings. A past due and final dunning notice will be sent for overdue accounts. The account will then be reviewed for referral to an outside agency. All accounts turned over to a collection agency will be assessed a 25% administrative fee.
Financial Hardship:
Financial hardship should not stand in the way of medical care. Please discuss hardship with the billing staff as soon as possible.

HIPAA PRIVACY
Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that the location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the location (for example: mailings of exam reminders or information about services/products provided by location).

I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the services and products that I have received from the location.

REFRACTION

What is Refraction?
Refraction is the process by which your doctor determines the lens combination that helps you see the best. Your doctor performs a refraction to determine you distance and near prescriptions. The refraction will provide information about your eye-muscle balance, focusing strength, and focusing ability.

Medicare and Commercial Insurance Patients:
The refraction is not a covered procedure under the Medicare program, but it is one of the most frequent and important tests performed by an Optometrist/Ophthalmologist. Under Medicare & Commercial programs, the beneficiary is responsible for paying for this test. Our fee for the **refraction is $15** dollars; which we will collect at the time of service for all patients.

If we receive payment from your insurance company for your refraction, you will be reimbursed by our corporate office in a timely manner.

Please sign below that you have read and understand the above statements.

_____	_____	_____
Patient Signature or Patient's Legal Representative	**Date**	**Printed Name**

DUMONT EYE CARE

optomap® Retinal Exam

Experience the Convenience of the Daytona Optomap Retinal Exam

The Optos Daytona provides an unequaled 200 degree view of your retina in a high-resolution, high-contrast digital image- the Optomap. This comprehensive view of up to 82% of the retina (in one image) gives our doctors the opportunity to identify and follow peripheral retinal pathology much more easily. In many cases, we can **now avoid the strong dilating drops during the exam.**

To provide the highest level of care, we strongly recommend that all our patients have this procedure performed annually. It is especially important for people who have any or more of the following:

1. Headaches
2. Floaters, spots or flashes of light in vision
3. Family (or personal) history of hypertension or high cholesterol
4. Family (or personal) history of diabetes
5. Family (or personal) history of glaucoma
6. Family (or personal) history of macular degeneration or retinal disorders
7. Recent changes in vision
8. Vision not correctable to 20/20
9. Never had the procedure previously
10. Nearsightedness

If pathology or unusual anatomy is documented with this testing, these image studies can be billed to your insurance as part of your treatment plan. If the scans do not detect any unusual condition, then the photos will not be covered by insurance, and you are responsible for the fee of $30.

The **opto**map® Retinal Exam is fast, easy, and comfortable.

Please check the appropriate line and sign at the bottom

☐ I DO want the procedure performed,

☐ I would like to talk to my doctor and get more information first.

_____ _____

Signature Date

_____

Patient Name

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Contact Lens Fitting and Evaluation Agreement

The contact lens evaluation and fitting is an additional fee and is not included in your comprehensive examination cost. This type of examination includes: evaluation, fitting of contact lens samples, and class. The price of the fitting fee ***(between $20 - $80)*** is dependent on the type of contact lens that the doctor deems necessary for your prescription and follow up visit. The fee includes the initial visit and up to three subsequent follow up visits directly related to contact lens wear and fit within a 90 day period. If you decide to change the type of contact lens prescribed after the 90 day period, additional charges may apply.

Policies:

- Charges for fitting fees are due in full at the time of the fitting/evaluation.
- Progress checks and other contact lens-related services performed after three follow-up visits may be subject to normal office charges.
- Many insurance plans do not cover the full cost of contact lens fees. You will be responsible for any uncovered costs incurred.
- Professional fees for the contact lens fitting/evaluation are **non-refundable.**
- The fitting/evaluation fee *does not* include the cost of your contact lens supply.
- **Contact lens may only be returned within 30 days of initial order. All boxes must be unopened and in unmarked packaging.**
- Your prescription is valid for **ONE YEAR** from the date the contact lens prescription is finalized.
- Contact lens prescriptions are *not* the same as eyeglass prescriptions. This **Federal Guideline** is managed by the Fairness to Contact Lens Consumers Act (Pub.L. 108-164, 117 Stat. 2025, 2026, 2027, 2028 and 2029, codified at 15 U.S. C. ch. 102 et seq.), also known as **FCLCA**)

Patient Name: _____ Date: _____

Patient or Legal Guardian Signature: _____ Date: _____

(Due to the health risks involved with contact lenses, we require parental consent for all minor Patients)