ATLANTIC EYE CENTER 207 STONE HARBOR BLVD, CMCH, NJ 08210 PATIENT INFORMATION

Ph: 609-465-1616 FAX: 609-465-3213 HIGHLIGHTED SPACES MUST BE FILLED OUT.

Patient Name _____ DOB _____

Mailing Address _____

Physical Address(If different from mailing) _____

Primary Phone _____ Secondary Phone _____ work _____

SS# _____ Marital Status _____ Preferred Language _____

Male/Female _____ Occupation/Student Grade _____

Ethnicity _____ Race _____ Email Address _____

Preferred Pharmacy/Phone# _____

Referred Physician _____ Phone _____

Primary Physician _____ Phone _____

INSURANCE

Primary _____ ID _____ Group _____

Subscriber _____ DOB _____ Relationship _____

Subscriber SS# _____ Active Date _____

Subscriber Phone # _____

Secondary _____ ID _____ Group# _____

Subscriber _____ DOB _____ Relationship _____

Subscriber SS # _____ Active Date _____

Subscribe Phone # _____

IF patient is a minor; Parents/Guardian info _____

Name _____ DOB _____ Phone _____

Address _____

Name _____ DOB _____ Phone _____

Address _____

If patient has a Medical and/or Financial Power of Attorney or Living Will, this must be brought in at visit.

Power of Attorney Name _____ Phone _____ Relationship _____

Medical POA _____ Financial POA _____ Living Will _____

How Did You Hear About Us (Referred by)Doctor _____ Friend _____ Relative _____ Other _____

Emergency Contacts/Name/Phone#/Relationship _____

ATLANTIC EYE CENTER **MEDICAL HISTORY QUESTIONAIRE**

Name_____ Date_____

Do you have allergies to ay medications? Latex? Or Seasonal? YES or NO , if yes, please list below

_____

List all major illnesses and/or major surgeries (glaucoma, diabetes, high blood pressure, heart attack, cancer etc...)

_____

_____

Medication List OR Provide List at Check In

Medication	Dosage	Instructions

Review of Systems	YES	NO	DETAILS
General/Constitutional Fever, Weight Loss, Cancer			
Ear, Nose, Throat, Stuffy nose, cough, seasonal allergies			
Cardiovascular Heart disease, High blood Pressure, Heart Attack, Angina			
Muscles, Bones, Joints Joint pain, Stiffness, Arthritis, Myasthenia Gravis			
Gatrointestinal Upset Stomach, diarrhea, constipation, IBS			
Respiratory Breathing issues			
Skin			
Neurological MS, Stroke, Headache, Migraines, Aneurysm, dizziness			

Review of Systems (Continued) **YES** **NO** **DETAILS**

Psychiatric Anxiety, Depression			
Endocrine Diabetes, Thyroid			
Blood/Lymph Anemia, Cholesterol			
Allergic/Immunologic Rheumatoid Arthritis, Raynauds, Sjorgens			

Family History **M=Mother** **F=Father** **S=Siblings** **GP Grandparents**

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Macular Degeneration			
Cancer			
Diabetes			
Heart disease or Hypertension			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Arthritis			

SOCIAL HISTORY **YES** **NO** **Check Appropriate Boxes.**

Living Arrangements			Live alone	family	Nursing home	other
Do you drive?						
Have difficulty driving?						
Problems with night vision?						
Wear contact lenses?			Hard contacts	Soft contacts		
Do you wear glasses?			Date of last exam			
Do you smoke?			occasional	Half pack	1 pack	1+ pack
Do you drink alcohol?			Occasional	1 per day	2-3 per day	4+ per day
Do you take recreational drugs?			Occasional	Frequency daily	weekly	monthly

What type of recreational drug?_____

If applicable, list your physician who is managing your diabetes_____

If applicable, list your physician who is managing your long term drug therapy_____

If applicable, list your retinologist_____

If applicable, other specialist_____

Bring the following to your appointment: Any glasses or contacts you are currently wearing, photo id, insurance cards, any recent lab results, Power of Attorney papers (if applicable).

Patient signature_____ **Date**_____

Physician Signature_____ **Date**_____

ATLANTIC EYE CENTER **BILLING POLICIES & PROCEDURES**

I request that payment of authorized (Primary Insurance) _____benefits be made to me or on my authorized behalf to Dr. Caruso for any services furnished to me by Dr. Caruso and/or Cape Cataract Center. I authorize any holder of medical information about me to release to the above-mentioned insurance company and its agents. Any information needed to determine these benefits or the benefits payable for related services.

I also request that payment of authorized medigap benefits be made to either me or on my behalf to Dr. Caruso for any services furnished to me by Dr. Caruso. I authorize any holder or medical information about me to be released to (secondary insurance)_____. Any information needed to determine these benefits payable for related services.

Patient Signature_____Date_____

Print_____Date_____

Payment is due at the time of services if you have no insurances you will be provided with a receipt upon payment. Copayments, deductibles and refractions are due at time of service. A $10.00 billing charge will be added if not paid at time of service. A photo ID will be required at check in.

If you are an emergency visit or out of town emergency and you need a referral, you are required to obtain that referral before your visit. We do not call, or fax other doctors for referrals. We will not hold your appointment while you get a referral, you will need to reschedule. All out of town emergencies, and patient that are not our current patients require a credit card on file. A photo ID will be required at check in.

If your insurance co requires a referral, it is patient's responsibility to obtain and monitor referrals from your primary physician. If you have an HMO-no one will be seen for an initial office visit without a referral in our office on the day of your visit. We cannot back bill insurance companies for referrals.

If you are here for a routine visit-you must know who your routine carrier is, if you are not sure, call the number on the back of your insurance card. Upon arrival give the routine insurance information to the receptionist.

Patient is responsible for all fees that your insurance does not cover. If your bill should go to collections, you will be responsible for all legal fees, collection fees, court costs etc... In addition to your original amount owed.

You agree, in order for us to service your account or to collect monies you may owe, AEC and/or our agents may contact you by phone at any number associated with your account including cell phone numbers, which may result in charges to you. We may also contact you by sending text messages, emails, using any email addresses you provide to us, we ay also contact you be social media.

There is a separate fee foe contact lens evaluations and fittings. If you have questions, please direct them to the billing office. Any non-sufficient fund checks will be charged a $20.00 fee.

I understand and agree to these billing policies and procedures. Please sign upon receipt and understanding of these billing policies and procedure policies of Atlantic Eye Center and Cape Cataract Center.

Patient Name (Print)_____Date_____

Responsible Party Signature_____

ATLANTIC EYE CENTER **207 STONE HARBOR BLVD, CMCH, NJ 08210** **609-465-1616**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

BY SIGNING THIS FORM YOU ACKNOWLEDGE THAT YOU HAVE BEEN INFORMED THAT AEC PROVIDES INFORMATION ABOUT HOW WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) . WE ENCOURAGE YOU TO READ AND TAKE HOME A COPY OF THE "NOTICE OF PRIVACY PRACTICES" LOCATED IN OUR LOBBY.

I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ, ASK QUESTIONS AND TAKE HOME A COPY OF ATLANTIC EYE CENTERS PRIVACY PRACTICES.

AEC MAY USE THE FOLLOWING METHODS OF COMMUNICATION REGARDING INFORMATION RELATED TO MY PERSONAL HEALTH, TREATMENT, OR PAYMENT FOR TREATMENT. I ACKNOWLEDGE I AM REAPONSIBLE FOR UPDATING THISINFORMATION AS NECESSARY. THIS REQUEST SUPERCEEDES ANY PRIOR REQUEST FOR METHODS OF COMMUNICATION I MAY HAVE MADE.

CELL PHONE_____**HOME PHONE**_____ **WORK PHONE**_____

EMAIL_____

REGARDING THE PHONE CHOICES ABOVE, ATLANTIC EYE CENTER MAY ONLY SPEAK TO THE FOLLOWING PERSONS:

_____

QUESTIONS AND CONCERNS ABOUT OUR PRIVACY PRACTICE NOTICE SHOULD BE DIRECTED TO THE PRIVACY OFFICER AT 609-465-1616.

____ATLANTIC EYE CENTER MAY LEAVE A MESSAGE ON MY VOICEMAIL.

____ATLANTIC EYE CENTER MAY SPEAK TO ANYONE THAT ANSWERS THE PHONE.

____ATLANTIC EYE CENTER MAY LEAVE A MESSAGE FOR ME AT MY WORK NUMBER.

____ATLANTIC EYE CENTER MAY EMAIL TO MY EMAIL PREVIOUSLY PROVIDED.

INABILIT Y TO OBTAIN ACKNOWLEDGEMENT, TO BE COMPLETED ONLY IF NO SIGNATURE OBTAINED:

_____PATIENT LACKS THE ABILITY TO UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

PRINTED NAME OF PERSONS SIGNING CONSENT_____

RELATIONSHIP_____ **POWER OF ATTORNEY YES**_____ **NO**_____

THE UNDERSIGNED STATES THAT THEY HAS HAD THE OPPORTUNITY TO READ, UNDERSTAND AND ACCEPTS THE ABOVE NOTICE

Signature_____**Date**_____

Witness_____

ATLANTIC EYE CENTER ATLANTIC EYE CENTER OPTICAL CAPE CATARACT CENTER

I, _____authorize Atlantic Eye Center to charge my credit/debit card for the balance NOT paid by my insurance (copays, deductibles and coinsurance amounts.) I give permission to only charge an amount per month not to exceed $100.00, unless otherwise authorized by me. I assign my insurance benefits to the provider listed above. I understand that this form can only be used when filled out completely and is valid unless I cancel this authorization in written notice to Atlantic Eye Center. If your credit card has expired , we will give you one written courtesy notice to update. Failure to contact us with an update will result in the $10.00 fee FOR FUTURE BILLS.

*******Please note effective 1/2/2013, if you decline to participate in the *********

EASY PAY CONSENT PROGRAM

a $10.00 billing fee will be assessed for future bills on your account.

PLEASE PRINT

Patient Name_____

Cardholder Name_____

Cardholder address_____

City_____ State_____ Zip_____

Credit Card Number_____ Visa_____ Master Card_____ Discover_____

Expiration Date_____3 Digit Security code_____

Cardholder Signature_____

Date_____ Email Address_____

Do you want a receipt? Yes_____ No_____, If yes, (check one) fax it_____, Email it_____, Mail it_____

____I DECLINE the EASY PAY CONSENT and I am aware there will be a $10.00 billing fee added to my bill. I agree to pay this $10.00 billing fee.

Signature_____

Print_____Date_____

ATLANTIC EYE CENTER

2022

HIPAA WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Dr. Michael Caruso ta Atlantic Eye Center. I hereby acknowledge

Receipt of

ATLANTIC EYE CENTER'S NOTICE OF PRIVACY PRACTICES.

Name(please print)_____

Signature_____

Date_____

OR

I am a patient of legal guardian of (print patient name)_____

I hereby acknowledge receipt of Atlantic Eye Center's Notice of Privacy Practices with respect to the patient.

Name (please print) _____

Relationship to Patient Parent_____ **Legal Guardian**_____ **Power of Attorney**_____

Signature_____

Print Name_____

Date_____