***Welcome to our office! Please complete this form in <u>black ink only</u> and return it to our receptionist. Please provide your insurance card & photo ID for a copy.***

## <u>Personal Information:</u> Date: ____/____/____

Name: _____ _____
Last First

Home Phone # _____ Cell Phone # _____

E-Mail Address: _____

Mailing Address: _____
(No P.O. Box)

_____
*City State Zip*

SS#: _____ Date of Birth: _____ Age: _____

Sex: M F Marital Status: Single Divorced Married Widowed

Language: _____ Ethnicity: _____ Race: _____

## <u>Insurance Information:</u>

What type of insurance do you currently have?

Medicare Other None

<u>Primary Insurance Carrier</u>: _____

Primary Subscriber's Name: _____ **Date of Birth**: _____/_____/_____

ID# _____ Relationship to patient: _____

<u>Secondary Insurance Carrier</u>: _____

Primary Subscriber's Name: _____ **Date of Birth**: _____/_____/_____

ID#: _____ Relationship to patient: _____

## <u>Employer Information:</u>

Employer: _____
*(If retired, please list previous employer)*

Employer's Address: _____

_____

Occupation: _____ Full or Part time / Retired

In case of emergency, please notify: _____

Person's relationship: _____ Phone # _____

Person's Address: _____

## Information about Spouse:

Name: _____ Age: _____ Date of Birth_____

SS#: _____ Daytime Phone # _____

Employer and Address: _____

_____

*(If retired, please list previous employer)*

You were referred by: _____

Name of Your Family Physician: _____

Address: _____ City: _____

Phone #: _____

## MEDICAL INFORMATION:

Today's visit is related to the following (please circle one):

Medical Problem Work Related Injury

## Person Financially Responsible for this Bill:

_____
(Please Print)

_____
(Signature)

*MEDICARE PATIENTS PLEASE KEEP IN MIND: You will be responsible for your yearly deductible and your co-payment/co-insurance (20%) at the time the service is rendered. As a courtesy, our office will file your claim with a secondary insurance carrier if it is a Medigap Participant.*

I authorize any holder or other information about me to release to my insurance carrier or to the Centers for Medicare and Medicaid Services (CMS) or its agents, intermediaries or carriers, any information, including medical, needed to process this claim or a related Medicare claim. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance or any health plan to: James E. Haberman, MD. I permit a copy of this authorization to be used in place of the original. This shall serve as a lifetime authorization, including Medicare. Any outstanding balance that is sent for collections will be charged an additional $75 fee.

_____ ___/___/___
Patient's Signature Today's Date

**James E. Haberman, M.D., F.A.C.S.**
Excel Eye Care & Surgery Center

Date:___/___/___

# Medical History Questionnaire

## Medical History

Name: _____

List all major illnesses and injuries _____

_____

List any surgeries you have had _____

_____

List all illnesses, injuries and surgeries to the eye _____

_____

List any medications you take (including ocular) _____

_____

Do you have any allergies to medications? ___ Yes ___ No

If yes, list medication(s) _____

## Review of Systems – Do you have any problems in the following areas? If yes, provide information.

**Explanation of Problem**

**Constitutional Problems**-Fever, weight loss _____

**Eyes-**Loss of vision, blurred vision, distorted vision (halos), _____

Loss of side vision, double vision, dryness, mucous discharge, _____

Redness, sandy or gritty feeling, itching, burning, tired eyes, _____

Glare/light sensitivity, eye pain or soreness, chronic infection, _____

Difficulty **with** night vision _____

**Ears, nose, mouth, throat-**Sinus congestion, runny nose, _____

Post nasal drip, chronic cough, dry throat/mouth _____

**Cardiovascular**-Palpitations, chest pain _____

**Respiratory**-Chronic bronchitis, shortness of breath _____

**Explanation of Problem**

**Musculoskeletal-**Arthritis _____

**Psychiatric** _____

**Allergic**-Head allergy symptoms, seasonal of hay fever _____

## Family History

| Disease | Yes | No | Relationship to Patient |
|---|---|---|---|
| Glaucoma | ___ | ___ | _____ |
| Macular Degeneration | ___ | ___ | _____ |
| Retinal Problem | ___ | ___ | _____ |
| Arthritis | ___ | ___ | _____ |
| Diabetes | ___ | ___ | _____ |
| High Blood Pressure | ___ | ___ | _____ |
| Stroke | ___ | ___ | _____ |
| Tuberculosis | ___ | ___ | _____ |
| Other | ___ | ___ | _____ |

## Social History

Do you drive? ___ Yes ___ No Do you smoke? ___ Yes ___ No

Do you wear glasses? ___ Yes ___ No

Do you drink alcohol? ___ Yes ___ No If yes, ___ meals ___ socially __ other

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**PHYSICIAN USE ONLY**

History reviewed. ___ No changes. ___ Additions as noted above.

Signature: _____ Date: ___/_____/___

**James E. Haberman, M.D., F.A.C.S.**
Excel Eyecare & Laser Surgery Center

2333 Morris Avenue
Suite C-103
Union, New Jersey 07083
Tel. (908) 688-4000
Fax (908) 688-1717

## Verification of Receipt of Health Information Privacy Practices

By signature below, I verify that I have received a copy of the Health Information Privacy Practices of James E. Haberman, M.D., P.A.

_____
Signature of Person or Personal Representative

_____
Date

_____
Printed Name of Person or Personal Representative

_____
Description of Personal Representatives Authority

**James E. Haberman, M.D., F.A.C.S.**
Excel Eyecare & Laser Surgery Center
2333 Morris Ave. C 103
Union, New Jersey 07083
Tel. (908) 688-4000
Fax (908) 688-1717
www.NewJerseyLasikCenter.com

# FINANCIAL POLICY

Prior to your visit we will contact your insurance company to verify coverage and benefits. Please be advised that verification of coverage and benefits is not a guarantee of payment.

You, as the patient are financially responsible for your co-pay, coinsurance, deductible, and any other amount your insurance company deems as your responsibility.

It is our policy to collect co-pays, co-insurance or any other amount due at the time of service as indicated by your insurance company, when we verified your coverage and benefits. We will also collect the deductible at the time of service, as verified with your insurance carrier. Payment can be made by Cash, Visa, and Master Card, with an additional service fee.

**Any outstanding balance due after the processing by the insurance carrier will be applied to the Credit Card on File. A statement and receipt will be mailed to you. If you prefer not to leave a Credit Card on File, feel free to pay $200 at the time of the visit and any credit will be refunded to you after processing.**

Our office does not extend credit and payment for services rendered is expected immediately upon receiving any billing statement. Unpaid balances are subject to collection and/or attorney fees.

We must emphasize that as a physician's office, our relationship is with you, not your insurance company. All charges are strictly your responsibility from the date services are rendered. Temporary financial problems or resolving and inquiring about your benefits and/or payment with your insurance carrier may affect your ability to make timely payment on your account. However, we expect you to pay your bill in full as agreed to at registration.

Any payment you make to the office that is deemed an overpayment will be refunded to you within 30 days of our receiving such notification. If you lose the check or fail to cash the check in a timely manner, you may be charged a re-processing and a stop payment fee for the replacement check.

We have 30 days from the date of your office visit to submit the claim to your insurance carrier. If you fail to provide us with current insurance information, we will not re-bill any other insurance carrier. The claim will be deemed "untimely filing" and will not be paid. You will be responsible for the charges. This also applies to Coordination of Benefits issues.

If you have any questions regarding your account, please email **Frontdesk@njlasikcenter.com.**

**James E. Haberman, M.D., F.A.C.S.**
Excel Eyecare & Laser Surgery Center

## Credit Card on File Agreement (CCOF)

FOR YOUR SAFETY, our practice has implemented a new credit card policy. This is a safe, no-touch billing process for the future. The office requires all patients to have a credit card which may be used later to pay any balance that may be due on your bill.

If you choose not to leave a card or are unable to do so, the office will accept $200 toward the visit. After processing by your carrier, any credit remaining will promptly be refunded.

Co-pays and deductibles are due at the time of service.

At check-in, your credit card information will be obtained and kept securely. After insurance(s) processes the visit, the credit card on file will be charged. If there are discrepancies with the carrier, the credit card will be charged as well.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

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By signing below, I authorize James E. Haberman, M.D., P.A., to keep my signature and my credit card information securely on-file. I authorize James E. Haberman, M.D., P.A., to charge my credit card for any outstanding balances when due.

If the credit card that I provide today changes, or expires, please notify the office. If the credit card is denied for any reason, I agree to provide a new, valid card which can be charged over the phone and that the new card may be used with the same authorization as the original card. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee.

PATIENT NAME: _____ DOB:_____/_____/_____

**CREDIT CARD AUTHORIZATION**
**VISA, MASTERCARD, OR AMEX (circle one)**

NAME (as it appears on credit card) _____

LAST 4 DIGITS OF CREDIT CARD NUMBER. PLEASE PROVIDE CARD TO RECEPTIONIST TO SECURELY SCAN INFORMATION INTO OUR SYSTEM _____

EXP. DATE_____/_____ CVV (3 DIGIT CODE ON BACK OF CARD) _____
THE OFFICE DOES NOT MAINTAIN PERSONAL CREDIT CARD INFORMATION. IT IS SAVED SECURELY.

BILLING ADDRESS OF CREDIT CARD_____
(Where your statement is mailed to)
_____

EMAIL ADDRESS: _____

AUTHORIZED SIGNATURE_____ DATE ___/___/___