PATIENT REGISTRATION

Patient Name				**Circle One**	◯ Mr. ◯ Mrs ◯ Ms. ◯ Miss ◯ Dr.
Date of Birth		**Age**		**Race**	
SS #				**Sex**	
Address				**Country**	

COMMUNICATION					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Email**			
Preferred Contact Method					

GUARDIAN INFORMATION IF PATIENT IS UNDER 18 YEARS			
Name		**Relationship**	
Date of Birth		**Phone Number (if different)**	

INFORMATION			
Primary Language		**Special Needs**	
Marital Status		**Ethnicity**	

PRIMARY INSURANCE			
Insurance			
ID #		**Group #**	
Insured Name		**Insured Date of Birth**	

SECONDARY INSURANCE			
Insurance			
ID #		**Group #**	
Insured Name		**Insured Date of Birth**	

I am responsible for providing the correct insurance cards and information. If incorrect information is given, I, the patient, will be billed in full. BEP will not resubmit the claim. Payment is due at time of service. If my insurance requires a referral, I must provide one to be seen, without it I will have to reschedule my appointment, as BEP cannot see me without one. If my account becomes delinquent, the doctor, his assigns, or lawful agents may pursue collection procedures. I will be responsible for all collections costs, including and not limited to court filing fees, service of procedure costs, interest and attorney fees. I understand there is a $25.00 charge for all returned checks. I authorize Baltimore Eye Physicians, LLC to request and receive information regarding my insurance coverage and benefits paid. Also to apply for benefits on my behalf for services rendered to me and request payment from my insurance company to be made directly to Baltimore Eye Physicians, LLC.

REFRACTION FEE: A refraction is the most reliable way to check your vision. There is a separate $50 fee for a refraction. The fee is in addition to any co-pay or co-insurance. This is a NON-COVERED service by most insurance plans. You may defer this service.

CANCELLATION / NO SHOW POLICY FOR DOCTOR APPOINTMENT: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.
If an appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

_____ _____

Patient's Signature Date

Date: _____ Chart # _____

Name: _____ Date of Birth: _____

Primary Care Doctor:_____
Pharmacy:_____
Primary reason for today's (first) visit: _____

	YES	NO			
GENERAL					
Have you had your flu shot?	○	◉			
Have you had the pneumonia immunization?	○	○			
Do you exercise regularly ?	○	○			
Do you use recreational drugs?	○	○			
Have you ever smoked cigarettes or cigars?	○ Current smoker		○ Former	○ Never	
Are you diabetic?	○ Type 1		○ Type 2	○ No	
Do you drink alcohol?	○ Socially		○ Daily	○ Non-Drinker	

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If "YES", please check or explain.

Eyes:	YES	NO	**EXPLANATION**
Loss or blurred vision	○	○	_____
Loss of side vision, double vision	○	○	_____
Itching, burning, or discharge	○	○	_____
Redness	○	○	_____
Gritty feeling, dryness or tearing	○	○	_____
Glare / light sensitivity or halos	○	○	_____
Eye pain or soreness	○	○	_____
Infection or eye lashes or lids, styes?	○	○	_____
Flashes of light/ Floaters?	○	○	_____
Ears, Nose & Throat:			
Sore throat	○	○	_____
Difficulty hearing	○	○	_____
Cardiovascular (heart, blood vessels):			
High Blood Pressure	○	○	_____
High Cholesterol	○	○	_____
Respiratory (lungs, breathing):			
Trouble breathing	○	○	_____
Gastrointestinal (stomach, intestines):			
Ulcer disease	○	○	_____
Gastritis	○	○	_____
Colitis	○	○	_____
Diverticulitis (intestinal wall)	○	○	_____
Hepatitis (liver)	○	○	_____

	YES	NO	EXPLANATION
Genitourinary:			
Prostate trouble	☐	☐	_____
Frequent urination	☐	☐	_____
Musculoskeletal (muscles, joints):			
Chronic back pain	☐	☐	_____
Arthritis	☐	☐	_____
Integument (skin, breast):			
Rashes, lesions	☐	☐	_____
Lumps or sores	☐	☐	_____
Rosacea	☐	☐	_____
Neurological:			
History of strokes	☐	☐	_____
Seizures	☐	☐	_____
Nervous disorders	☐	☐	_____
Neurological medication	☐	☐	_____
Psychiatric:			
Drug or alcohol addiction	☐	☐	_____
Depression	☐	☐	_____
Endocrine (hormones, glands):			
Hyperthyroid	☐	☐	_____
Hypothyroid	☐	☐	_____
Hematologic / Immunologic (blood):			
Easy bruising	☐	☐	_____
Anemia	☐	☐	_____
Blood clots	☐	☐	_____
Easy bleeding	☐	☐	_____
Do you have seasonal allergies?	☐	☐	_____
PAST EYE HISTORY			
List eye drops currently in use:			_____
Eye injury or other disease	☐	☐	_____
Eye surgery	☐	☐	_____

FAMILY HISTORY (NOT YOURSELF)

	YES	NO				
Are you adopted?	☐	☐				
Mother: Current age (or age of death) _____			Cause of death or unknown: _____			
Father: Current age (or age of death) _____			Cause of death or unknown: _____			
Cataracts	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Glaucoma	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Blindness	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Macular Degeneration	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Retinal Detachment	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Crossed Eyes	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Lazy Eye	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Diabetes	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister
Arthritis, Lupus, etc.	☐	☐	☐ Mother	☐ Father	☐ Brother	☐ Sister

	YES	NO	EXPLANATION
SOCIAL HISTORY			
Have you ever tried to wear contacts?	☐	☐	_____

Have you ever had a blood transfusion? ☐ ☐ _____

Have you ever had contact with a person with an sexually transmitted disease? ☐ ☐ _____

PAST MEDICAL HISTORY

List any medications (other than eye drops) that you are currently using:_____

_____

_____

_____

List all major illnesses: _____

_____

List any major surgical procedures: _____

_____

List any allergies to medication:_____

_____

Patient's signature: _____ Date: _____

Baltimore Eye Physicians

HIPPA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternate means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature Date

MEDICAL vs VISION INSURANCE

An ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides very comprehensive, medical eye exams. You do not need vision/optical coverage in order to see an ophthalmologist.

Baltimore Eye Physicians does not accept vision/optical coverage. However, we can provide you with a receipt that you may submit to your vision/optical insurance carrier.

Do you have vision/optical coverage? ☐ Yes ☐ No

For Patients with both Medical and Vision Coverage

Your vision insurance is intended to provide you with a baseline eye evaluation. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, allergies, dry eyes, double vision, etc.), you are being provided with medical care. Your vision company doesn't provide coverage for medical care. Therefore, we will be billing your medical insurance for visits related to medical complaints and problems.

For Patients with no Vision/Optical Coverage

If you are being seen for a routine eye evaluation and don't have vision/optical coverage, your medical insurance will not pay for an eye exam. However, if you have a medical problem, or an eye complaint (corneal disorders, diabetes, a lazy eye, cataracts, glaucoma suspect, double vision, etc.), your visit is considered a medical problem and can be billed to your medical plan(s).

Also, please be aware that many plans are no longer paying for eye exams because of a diagnosis of blurred vision or a headache. They are considering this a routine vision exam and are often not paying for the visit.

Even though our billers will determine appropriate billing after your evaluation, we'd like to know if you intend on submitting a vision/optical coverage to your insurance carrier after today's visit, or if you prefer us to bill your medical insurance provider. Please check one: ☐ Medical ☐ Vision

_____ _____

Signature Date

FINANCIAL POLICY

Accepted Insurance Plans:
We accept and participate with many medical insurance plans. As a service to our patients, we will bill the insurance company for your services rendered. You will be asked to provide a copy of your current insurance card at **each** visit and should notify us of any changes in your coverage. Please be sure your insurance information is current at the time of service**.**

Authorization/Referrals by a medical carrier obtained at the time of service does not guarantee payment and any denied services will be billed to the patient. If we do not have an authorization on file at the time of your visit, you will be asked to pay for services rendered, or your visit may be rescheduled.

You are responsible for any deductibles, co-insurance or balance not paid by the insurance company. Co-pays will be collected at the time of service.
If your insurance plan does not cover our services, or if you are uninsured, payment in full is the responsibility of the patient. We do accept Medicare Assignment, which means that we agree to charge no more than what Medicare defines as an allowable charge. Please remember that Medicare will pay only 80 percent of that charge. Patients and/or their Medicare supplement are responsible for the remaining 20 percent.

Your health insurance contract is between you and your insurance company. Any questions regarding your specific coverage, including referrals and authorizations, should be directed to your insurance company or your company benefits administrator. Before you visit, contact your insurance company to verify that we are participants in your plan and the services you intend to receive are covered. You are responsible for any amount not covered by your plan.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services they will not pay for. Therefore we cannot guarantee payment of all claims by your insurance company. *Reduction or rejection of your claim does not relieve you of your financial responsibility*. You are responsible for any amount not covered by your plan.

Please Note: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is considered insurance fraud and will not be done by our office. If you wish to use a routine eye care benefit, it is your responsibility to inform the front desk prior to your appointment.

HMO Members: For most health plans, a valid referral/authorization is necessary for all visits. You will need to obtain this for your initial visit as well as subsequent visits for new or different medical problems. Following your initial visit, we can assist you with referrals/authorizations for return visits.

Point of Service members: If your insurance is a Point of Service (POS) plan, your office visit will be covered, in most cases, without a referral from your primary care physician. However, if you need surgery, special tests or procedures, you will need to obtain a retroactive referral for the office visit. If you do not obtain one, you will be responsible for the costs of all services rendered.

Pre-certification: Prior approval may be required by your health care plan before certain procedures, tests or surgeries are performed. We will assist you in the pre-certification process for surgical procedures by contacting your insurance company on your behalf. Be sure to confirm that you have been given pre-certification before your procedure so you do not incur any unnecessary personal charges. Any pre-certification needed for services other than surgery will be the responsibility of the patient.

Refraction Fees
There is a separate fee for a refraction. This is a NON-COVERED service by most Insurance plans. The fee is above and beyond any regular co-pay or co-insurance. A refraction is the most reliable way to check your vision. You have the right to defer this service.

Contact Lens Examination Fee
If you wish to be fitted for contact lenses there will be an additional charge to the regular examination. These fees include 6 months of follow-up-care. For disposable lenses, these fees include initial contact lenses. This additional charge will not be submitted to your insurance. It will be up to you, the patient, to submit this charge, after you have paid for it in full, to your insurance if you wish to be reimbursed by them.

Medical vs Vision Insurance
Your coverage may differ between VISION and MEDICAL coverage. Baltimore Eye Physicians is a medical facility and we are not participants of any routine Vision Plans.

Routine Eye Exams
If you are allowed a certain number of routine exams per year through your medical insurance, it is your responsibility to inform the front desk prior to your visit.

Past-Due Accounts
To receive services, you cannot have a past due balance on your account. A $25.00 fee is charged for each returned check. We realize temporary financial difficulty may affect the timely payment of your account. It is your responsibility to contact us promptly for assistance in the management of your account. Remember, we are here to help you. Please contact our billing office for any questions regarding your account or payment plan options.

Billing Office Phone: (410) 377-4001 Ext: 4

Collection Fees
If you have not paid your bill, or have not set up a payment plan within 90 days, we will ask for the assistance of a collection agency. You will be responsible for all collections costs, including and not limited to court filing fees, service of procedure costs, interest and attorney fees.

Medical Records Requests
We charge a $25 processing fee for medical records requests.

Cancellation / No Show Policy for Doctor Appointment
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

If an appointment is not canceled at least 48 hours in advance, you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

Cancellation / No Show Policy for Surgery
If a scheduled surgery is not canceled at least 48 hours in advance, you will be charged a five hundred dollar ($500) fee; this will not be covered by your insurance company.

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I acknowledge that I have read and understand the **Baltimore Eye Physicians' Financial Policy.**

Signature of Patient	Date
Signature of Patient Representative & Relationship (Required if patient is a minor or adult unable to sign form)	Date

Release of Patient Information

I hereby authorize Baltimore Eye Physicians permission to release my protected health information to the individuals I have listed below. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing. In the event that my health information should need to be given over the telephone or in a case where the person requesting the information is not able to show sufficient identification, I have chosen a "secret answer" that I will give to each individual whom I have indicated on this form. Initial (_____)

I also authorize the staff of Baltimore Eye Physicians to contact me and/or leave messages at the numbers I have provided as well as to send appointment postcards and/or reminders to the addresses I have provided. Initial (_____)

The following individuals have my authorization to access my Protected Health Information:

Name	Relationship	Date of Birth

Please chose ***one*** of the following questions and be sure to give the answer to each authorized individual:

- ◯ Mother's maiden name? _____
- ◯ City in which you were born? _____
- ◯ Name of your oldest child? _____

_____ _____

Signature of patient or authorized representative **Date**

Name:_____ **Chart:**_____

Refraction Fee Consent Form

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $50.00, and unless your plan automatically covers the refraction charge, this fee is patient responsibility in addition to any co-payment your plan may require.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

Signature:_____ **Date:**_____

I decline the refraction service today. I understand that without the refraction the doctor may not be able to fully assess the health and function of my eyes.

Signature:_____ Date:_____