AMWELL EYE CARE
390 Amwell Road, Suite 401, Hillsborough, NJ 08844
Phone: (908)336-3886 Fax: (908)308-8900
www.amwelleye.com

PATIENT INFORMATION (Please print)

Patient Name:_____ Age:_____ Sex: ☐M ☐F
LAST FIRST MI

Home Address:_____ City: _____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____Work Phone:(_____)_____

Email address:_____

Date of Birth:_____ Social Security Number:_____

Occupation:_____ Employer/School: _____

Language_____ Race_____ Ethnicity_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Name of Responsible Party: (☐Self)_____ Relationship to patient:_____

Referred By: Name_____ ☐Doctor ☐Insurance ☐Friend/Family ☐Internet ☐Brochure

Primary Care Physician**:**_____

Emergency Contact: _____

PRIMARY INSURANCE

Primary Insurance Carrier: _____Policy#:_____ Group#:_____

Name of Primary Policyholder: _____ Date of Birth: _____

Relationship of Patient to Policyholder: ☐SELF ☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

Subscriber SS#:_____

SECONDARY INSURANCE (If applicable)

Secondary Insurance Carrier: _____Policy#:_____ Group#:_____

Name of Secondary Policyholder: _____ Date of Birth: _____

Relationship of Patient to Policyholder: ☐SELF ☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

Subscriber SS#:_____

VISION CARE PLANS VS. MEDICAL INSURANCE

Vision Care Plans

Coverage through most vision plans such as VSP (Vision Service Plan) is designed to determine the prescription for spectacles and/or contact lenses only. These benefits typically include an allowance amount toward materials such as glasses or contact lenses. This excludes additional diagnostic testing/procedures tests needed to determine any ocular ***medical*** condition.

Medical Insurance
If a medical condition is present or diagnosed such as glaucoma, macular degeneration, diabetes, or high blood pressure, it is necessary to provide a comprehensive ocular ***medical*** examination. In this situation we will file a claim to your major medical insurance carrier, and the co-pays, co-insurance and deductibles for that insurance will apply. Generally most carriers will either cover or pay a portion of the diagnostic tests necessary to diagnose and treat the medical condition(s) related to your ocular health. Your vision plan does not cover these services.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. In the event that we do not accept your medical or vision insurance we will provide you with an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself.

I understand the information I've just read about the difference between vision and medical insurance. I authorize *Adam Zhao, OD LLC DBA Amwell Eye Care* to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

X _____

Signature of Responsible Party Date

FINANCIAL RESPONSIBILITY AND AGREEMENT

I understand if I have insurance and have provided accurate and complete information regarding my insurance, I authorize *Amwell Eye Care*, its doctors, and/or agents to apply for reimbursement benefits with my insurance carrier on my behalf for services rendered to me; however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party. I understand that any deductible, copay and/or co-insurance payments are due at the time of service.

I acknowledge that assignment and payment from my insurance carrier will be made directly to *Amwell Eye Care*. I further authorize the release of any information necessary to process any claim with my insurance carrier. If my insurer denies any part of the claim, I am responsible for any payments not covered by my insurance carrier. If I do not have insurance or my charges are not to be filed with insurance, payment in full is due at the time of service. All delinquent accounts will be sent past due and final notices. If there is no response within 10 days, I will be referred to an outside collection agency.
In the event legal action should become necessary to collect an unpaid balance due for services rendered to me, I am liable for all reasonable attorney's fees and any other court costs or costs of collection.

Checks returned for insufficient funds (NSF) will incur a $30.00 charge, the balance due in addition to the $30.00 fee will be due immediately in an alternate form of payment.

X _____

Signature of Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have viewed or have been offered and/or received a copy of the ***Notice of Privacy Practices,*** which details how certain health information identifying me, as necessary for the purpose of obtaining medical treatment, facilitating payments, and to conduct health care operations. Such policy describes these uses and disclosures in detail. It can be viewed on the "Patient Forms" page on www.amwelleye.com.

X _____

Signature of Responsible Party Date

REFRACTION

Refraction is the procedure used to determine your eyeglass prescription for near and far vision. If you have routine vision benefits such as VSP, the refraction is typically covered with your exam benefits.

CMS, the department of the federal government that controls Medicare and Medicaid has determined this is a "non-covered" service, which means the beneficiary is responsible for this fee. As many private insurance carriers adopt the policies of the federal government, many of our contracts with private insurance carriers require us to collect the fee from you as well. The charge for refraction is **$45.00** and is due at the time of service. We will file this amount to the appropriate insurance plan and you will be reimbursed if it is covered by your insurance carrier.

X _____

Signature of Responsible Party Date

DIGITAL RETINAL SCREENING

Digital retinal imaging is a technology which involves capturing a high-resolution digital image of the interior portion of your eye, the retina. This technology provides us with a digital retinal fingerprint and serves as a baseline for comparison at future visits.

To provide the highest level of care, it is strongly recommended that all of our patients have this procedure performed at least annually. It is critical for preventive care especially if you have any or more of the following conditions that often have no outward symptoms:

- Headaches
- Floaters, spots or flashes of light in vision
- Recent changes in vision
- Nearsightedness
- Current or prior use of high-risk medications including steroids or chloroquine
- Family (or self) history of hypertension, diabetes or high cholesterol
- Family (or self) history of glaucoma
- Family (or self) history of macular degeneration or retinal disorders
- Never had the procedure previously

Digital imaging is quick, the images are available immediately and will be reviewed with you by the doctor during the exam. We can also provide you with a copy of your photos via email so you can keep them with you for your own records.

The fee for retinal digital screening is **$35.00**. Currently this service cannot be billed to insurance. Please initial below.

_____YES, I accept the recommended services.

_____NO, I decline these services.