

Patient Information

Patient Last Name		First Name		Middle Name		Maiden Name	
Address (Street or Box)				City		State	Zip Code
Home Phone Number		Cell Phone Number		Work Phone Number		E-Mail	
Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Age	Social Security Number		Driver's License Number	
Marital Status (Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Spouse's Name (If Applicable)			
Race (Check One) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other _____				Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Facility	
Employer Name						City	Phone Number
Employer Address				Primary Care Physician Name		Phone Number	
Emergency Contact		Phone Number		Referring Physician Name		Phone Number	

Complete this section if Patient is a minor or has a Legal Guardian.

Responsible Party

Responsible Party Last Name		First Name		Middle Name		E-Mail:	
Address (Street or Box)				City		State	Zip Code
Home Phone Number		Cell Phone Number		Work Phone Number			
Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Age	Social Security Number		Driver's License Number	

Insurance and Subscriber Information

PRIMARY Insurance Company			Effective Date			SECONDARY Insurance Company			Effective Date		
Claims Mailing Address (Street or Box)						Claims Mailing Address (Street or Box)					
City		State	Zip Code		State		State	Zip Code			
Policy ID Number		Group ID Number				Policy ID Number		Group ID Number			
Subscriber Name (Policy Holder)		Date of Birth				Subscriber Name (Policy Holder)		Date of Birth			
Subscriber Social Security Number		Relationship to Patient				Subscriber Social Security Number		Relationship to Patient			
Subscriber Employer		Work Phone Number				Subscriber Employer		Work Phone Number			
Subscriber Employer Address (Street or Box)						Subscriber Employer Address (Street or Box)					
City		State	Zip Code		City		State	Zip Code			

Pharmacy

Preferred Pharmacy Name		Pharmacy Address		Pharmacy Phone Number	
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Signature of Patient, Parent, or Legal Guardian

Date

Account Number: _____

Vision Insurance (if applicable)

Vision Insurance and Subscriber Information

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

Signature of Patient, Parent, or Legal Guardian

Date

Consent to Treat and Financial Responsibility

Consent to Treat HECC_NP_F101

I hereby authorize employees and agents of Associated Retinal Consultants, LLC ("ARC") dba Hackensack Eye Care Center, an affiliate of PRISM Vision Group, including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

Complete this section ONLY if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Patient, Parent, or Legal Guardian

Date

Financial Responsibility HECC_NP_F102

I hereby authorize Associated Retinal Consultants, LLC ("ARC") dba Hackensack Eye Care Center, an affiliate of PRISM Vision Group, to apply for benefits on my behalf and for payment of medical benefits directly to ARC for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to ARC. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to ARC. I further understand that should my account balance become delinquent and sent to a third-party collector, I agree to pay an additional 30% of the balance or \$50, whichever is greater. I also understand that a returned check fee of \$35 will be assessed if the check is returned by my bank.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

Patient Name (Please PRINT)

Signature of Patient, Parent, or Legal Guardian

Date

Preferred Method of Communication HECC_NP_F104

Yes, I want Associated Retinal Consultants, LLC (“ARC”) dba Hackensack Eye Care Center, an affiliate of PRISM Vision Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my medical conditions and/or appointment information is indicated below:

- | | | |
|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Work Phone |
| <input type="checkbox"/> Mailed Letter | <input type="checkbox"/> Guardian | <input type="checkbox"/> Email |

If the above method of communication is by **phone**, please do one of the following (**please check ONE**):

- Leave a message with detailed information.
- Leave a message with a call-back number only.

If the above method of communication is by **email**, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.

Approved HIPAA
 Contacts HECC_NP_F105

Keeping our patient’s information private is important to us, and by default we will disclose information related to the patient’s Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that Associated Retinal Consultants, LLC (“ARC”) dba Hackensack Eye Care Center, an affiliate of PRISM Vision Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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- | | | |
|--|--|--|
| <input type="checkbox"/> Billing Account Information | <input type="checkbox"/> Medical Condition Information | <input type="checkbox"/> Emergency Contact |
|--|--|--|

Additional Notes: _____

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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- | | | |
|--|--|--|
| <input type="checkbox"/> Billing Account Information | <input type="checkbox"/> Medical Condition Information | <input type="checkbox"/> Emergency Contact |
|--|--|--|

Additional Notes: _____

**Notice of Privacy Practices and
Acknowledgement of Receipt**

HECC_NP_F107

Notice of Privacy Practices and Acknowledgement of Receipt

Patient Name: _____

Date: ____/____/____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Associated Retinal Consultants, LLC (“ARC”) dba Hackensack Eye Care Center, an affiliate of PRISM Vision Group is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. “Protected Health Information” is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On ____/____/____, I, _____, received a copy of this office’s Notice of Privacy Practices.
(Today’s Date) (Patient’s Name)

Please Print Name

Signature

Date

** Hackensack Eye Care Center’s Notice of Privacy Practices can also be found on our website: www.hackensackeye.com

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

This Acknowledgement Form will become part of your permanent medical record.

Patient's Name:		Date		/	/
What ocular problem brings you in?					
When was your last eye exam?	/	/	Eye Doctor		
What did your doctor tell you?					

YES NO

Do you wear glasses for vision?					
Do you wear contact lenses?			If so, last time they were changed?		
Do you have Glaucoma?			If so, how is it being treated?		
Have you had cataract surgery?			If so, Which Eye?	Date of Surgery	Name of Surgeon
			Left Eye	/ /	
			Right Eye	/ /	
Have you had other surgery? Please list details below.					

Medical History – Social History

Primary Doctor Last Name	First Name	Telephone Number			
Address (Street or Box)		City	State	Zip Code	

Have you ever suffered from any of the following?

	YES	NO	Comment
Born Prematurely?			
History of Weight Loss, Fever?			
Headaches, Sinus, Tonsillectomy?			
Heart Condition?			
High Blood Pressure?			
Circulatory Problems?			
Lung Disease?			
Ulcers, Liver, Gall Bladder Disease?			
Do you Smoke?			
Do you Drink?			
Kidney, Bladder, Prostate Disease?			

	YES	NO	Comment
Joint Disease?			
Skin Disease or Breast Cancer?			
Stroke or Neurological Disease?			
History of Psychological Disease?			
Thyroid Disease?			
Diabetes?			
Date of Last Blood Sugar Results:			
Bleeding Disorder, Anemia?			
Aids or Infectious Disease?			
Cancer?			

List ALL Medications that you are presently taking, including any eye drops:

_____	_____	_____
_____	_____	_____

List ALL Medication Allergies:

FAMILY HISTORY

Is there a family history of	YES	NO	Relative:
Cataracts?			
Glaucoma?			
Retinal Disease?			
Diabetes?			
Hypertension?			
Anemia?			
Other Eye or Systemic Disease?			

**Medical History Questionnaire /
 Review of Symptoms**

Account Number: _____

HECC_NP_F109

Patient's Name:	Date / /
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Do you have any problems in the following areas?

YES NO

YES NO

GENERAL		
Fever		
Fatigue		
Weight Loss / Gain		
Frequent Colds		
EYES		
Blurred Vision		
Double Vision		
Redness		
Sandy or Gritty Feeling		
Blind Spots		
Floaters		
Flashes		
Lazy Eye		
Itching / Burning		
Excess Tearing		
Glare / Light Sensitivity		
Eye Pain		
Chronic Infection Eye / Lid		
ENT: Ears, Nose & Throat		
Sinus Infection		
Cough		
Trouble Walking		
Hoarseness		
Loss of Hearing		
Nose Bleeds		
HEART		
Chest Pain		
Irregular Heart Beat		
Pacemaker		
Heart Murmur		
Swollen Feet / Ankles		
Leg Cramps when Walking		
LUNGS		
Wheezing, Shortness of Breath		
Coughing up Blood / Phlegm		

GI / GU		
Vomiting		
Bloody Bowel Movement		
Heartburn		
Loss of Appetite		
Difficulty with Urination		
Blood in Urine		
Frequent Urination		
Pain in Urination		
MUSCULOSKELETAL		
Muscle Pain		
Joint Pain, Arthritis		
INTEGUMENTARY		
Rash, Bruise Easily		
Breast Disease		
NEUROLOGICAL		
Fainting, Frequent Headaches		
Seizures		
PSYCHIATRIC		
Depression		
Anxiety		
Psychiatric Problems		
ENDOCRINE		
Excessive Thirst		
Excessive Sweating		
HEMATOLOGIC / LYMPHATIC		
Swollen Glands		
ALLERGIC / IMMUNOLOGIC		
Seasonal Allergies		
Hay Fever		
OTHER		
Pregnant		
Menopausal		
Vaginal Bleeding		
Breast Lumps		

COMMENTS REGARDING ABOVE ANSWERS: (PLEASE PRINT)