

NEW PATIENT INFORMATION

Patient Name:

Mrs. Mr. Miss

Dr. Rev. Ms.

FIRST

MIDDLE

LAST

Address: _____

STREET

CITY

STATE

ZIP CODE

Home Phone: _____

Cell Phone: _____

Date of birth: _____

Social Security #: _____

Spouse's Name: _____

Family Doctor: _____

Who referred you to our office? _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Extension _____

Person we can contact in an emergency (please include phone number):

The following will not be released to any source without your consent.

Explain the problem you are having with your eyes: _____

Do you have a hearing problem? _____

Do you have any allergies to medications? (please list): _____

List all prescription medications you are taking: _____

NEW PATIENT INFORMATION

Do you currently smoke or use any tobacco products? No _____ Yes _____

If yes, for how many years? _____

If you smoked or used tobacco products in the past, when approximately did you discontinue?

Do you drink alcohol? No _____ Yes _____ If yes, how often? Please specify:

Rarely ___ Weekly ___ Daily ___ Other _____

Do you use illegal drugs? No _____ Yes _____

Have you been exposed to HIV? No _____ Yes _____

Have you been exposed to other sexually transmitted diseases? No _____ Yes _____

Please specify if you have any of the following:

Glaucoma _____ Diabetes _____ High blood pressure _____

Cataract _____ Lazy eye _____ Heart Disease _____

Bleeding Disorder _____ HIV/AIDS _____ Lung disease _____

Other _____

Prostate enlargement/disease or cancer _____

If yes, are you currently or in the past treated by Flomax (tamsulosin) No ___ Yes ___

Any herbal or over-the-counter medications for this problem? No _____ Yes _____

If yes, please list _____

Have you had any past eye surgeries or injuries? If so, please describe:

To the best of your knowledge, do any of your blood relatives have the following:

Macular degeneration _____ Cataract _____ Corneal disease _____ Glaucoma _____

If any member of your family has glaucoma, please specify who: _____

NEW PATIENT INFORMATION

Please provide our office with a list of persons (if any) with whom we may discuss your medical care, such as a spouse, caregiver, etc. (Not including your family doctor)

NAME	RELATIONSHIP TO YOU
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Patient Signature: _____

POA/Guardian: _____

Date: _____

**INSURANCE FINANCIAL LIABILITY
ACKNOWLEDGEMENT FORM**

Elmwood Eye Center
Brian L. Vitz, D.O.
1601 Second Avenue
York, PA 17403

Patient's Name: _____ **ID#:** _____

Insurance Plan: _____ **Provider ID#:** _____

Our office is required to notify all medically insured patients and patients who qualify for medical assistance or are covered by a commercial medical assistance plan of any service(s) that could be the patient's financial liability, prior to rendering services(s).

LIST OF SERVICES/PROCEDURES/SUPPLIES:

- ____ Refraction or prescription of spectacles or an update of your current spectacles.
- ____ Supplies provided by our office, including but not limited to post-operative kits following cataract surgery and bandage contact lenses.
- ____ Other: _____

You may be responsible for the above listed services(s) due to the following reason(s):
(Check one)

- ____ Medicare, your insurance plan or medical assistance plan does not pay for a non-covered service(s) or supplies. For patients covered by a commercial plan, see your Evidence of Coverage for a complete listing of non-covered services and supplies.
- ____ The service or supplies(s) is not covered without a Referral from your Primary Care Physician.
- ____ The service or supplies is not covered because it is investigational.
- ____ The service(s) or supplies is not covered unless it is due to an emergency.

Note: This form is invalid if the service(s) is not specified in the spaces above prior to the execution of this form.

BENEFICIARY AGREEMENT

I have been notified by the provider identified above that the requested service(s) is not covered by my insurance plan or medical assistance and medical assistance commercial plans for the reason(s) stated above. I understand that I may be fully responsible for payment.

SIGNED: _____ DATE: _____
(Beneficiary Signature)

**ELMWOOD EYE CENTER
BRIAN L. VITZ, D.O.
1601 SECOND AVENUE
YORK, PA 17403
(717) 848-2520**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose health information about you. You have the right to review our notice and ask questions about our privacy practices. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by_____.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

Patient Signature: _____

POA/Guardian: _____

Date: _____

NEW PATIENT INFORMATION

INSURANCE AND PAYMENT OF SERVICES INFORMATION

We participate with several insurance companies. If you are a member of any of these plans, we will make a copy of your insurance cards for our records. If your insurance company covers provided services, we will forward charges to your carrier. However, payment of any non-covered services is requested at time of service.

If we do not participate with your insurance carrier, payment is required at time of service. We will provide you with a detailed receipt that outlines your visit and contains all information needed for processing by your carrier.

MEDICARE PATIENTS

NAME _____ HIC# _____ PART B _____

I request that payment of authorized Medicare benefits be made to Brian L. Vitz, D.O. on my behalf for services furnished me by above physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or the benefits payable to related services.

NON-MEDICARE PATIENTS AND SECONDARY CARRIERS

INSURED NAME _____ CARRIER _____

I.D. # _____ GROUP # _____

INSURED S.S. # _____ - _____ - _____

I request that payment of authorized benefits from my insurance company of Medigap company be made to Brian L. Vitz, D.O. on my behalf for services furnished me by above physician. I authorize any holder of medical information about me to release to above named carrier any information needed to determiner these benefits payable to related service.

ALL PATIENTS

PATIENT (or authorized person) SIGNATURE _____

PRINT PATIENT NAME _____

DATE _____