REGISTRATION FORM (Please Print Clearly) Date_____

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Birthdate: ____/____/____ Age: _____ SSN: _____ Gender: ____M ____F

Referred by: _____

Primary Care Physician: _____

EMERGENCY CONTACT: _____ Phone: _____

Employer Name & Address: _____

Are you the person responsible for payment on this account: ___Yes ___No If no, fill in section below.

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: _____

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

Birthdate: ____/____/____ SSN: _____

INSURANCE INFORMATION

If an injury was related to an accident, please circle one of the following: Work Related Auto Accident Other

Date of Accident: _____

Please provide insurance card(s) to Receptionist

Primary Insurance_____

Secondary Insurance_____

Patient and/ or Guardian Signature: X _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Allergies to Medications: _____

Pharmacy: _____ Pharm Tel #: _____

REVIEW OF SYSTEMS:

Primary Reason for Today's Visit: { } Routine/Annual { } Cataract { } Glaucoma { } Diabetes { } Dry Eye
{ } Macular Degeneration { } Blurred Vision { } Second Opinion { } Other: _____

Do you presently have any problems in the following areas?

Eyes	**YES**	**NO**		**YES**	**NO**
Loss or blurred vision	[ ]	[ ]	Respiratory (lungs, breathing)	[ ]	[ ]
Loss of side vision, double vision	[ ]	[ ]	Gastrointestinal (stomach, intestines)	[ ]	[ ]
Itching, burning, or discharge	[ ]	[ ]	Genitourinary (genitals, kidney, bladder)	[ ]	[ ]
Redness	[ ]	[ ]	Musculoskeletal (muscles, joints)	[ ]	[ ]
Gritty feeling, dryness or tearing	[ ]	[ ]	Integument (skin, breast)	[ ]	[ ]
Glare/light sensitivity or halos	[ ]	[ ]	Neurological (headache)	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]	Psychiatric	[ ]	[ ]
Infection of eye lashes or lid, styes	[ ]	[ ]	Endocrine (hormones, glands)	[ ]	[ ]
Ears, Nose, Mouth, Throat	[ ]	[ ]	Hematologic/Immunologic (blood)	[ ]	[ ]
Cardiovascular (heart, blood vessels)	[ ]	[ ]	Seasonal Allergies (hay fever, etc)	[ ]	[ ]

PAST EYE HISTORY	**YES**	**NO**	**COMMENTS**
Eye drops currently in use (if yes, please list)	[ ]	[ ]	_____
Allergies to eye drops (if yes, please list)	[ ]	[ ]	_____
History of cataract, glaucoma	[ ]	[ ]	
History of lazy eye/eye muscle imbalance	[ ]	[ ]	
Eye injury or other disease of the eye	[ ]	[ ]	
Eye surgery (list on the lines to the right)	[ ]	[ ]	_____

PAST MEDICAL HISTORY

Major Illnesses:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
High Blood Pressure	[ ]	[ ]	Chronic Cough	[ ]	[ ]	Blackouts	[ ]	[ ]
Low Blood Pressure	[ ]	[ ]	Exposure to TB	[ ]	[ ]	Blood Disorder	[ ]	[ ]
Anemia	[ ]	[ ]	Asthma/Wheezing	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]
Heart Murmur	[ ]	[ ]	Headaches	[ ]	[ ]	Meningitis, Polio	[ ]	[ ]
Heart Palpitations	[ ]	[ ]	Cancer	[ ]	[ ]	Bruising or Bleeding	[ ]	[ ]
Irregular Heart Beat	[ ]	[ ]	Stroke	[ ]	[ ]	Blood Clots	[ ]	[ ]
Pacemaker	[ ]	[ ]	Ulcer/Hiatal Hernia	[ ]	[ ]	Back Problems	[ ]	[ ]
Chest Pain/Angina	[ ]	[ ]	Thyroid Disease	[ ]	[ ]	Abnormal Chest X-ray	[ ]	[ ]
Sickle Cell Anemia	[ ]	[ ]	Nervous Disorder	[ ]	[ ]	Aids/HIV	[ ]	[ ]
Diabetes	[ ]	[ ]	Epilepsy/Seizures	[ ]	[ ]	Immune Deficiency	[ ]	[ ]
Hypoglycemia	[ ]	[ ]	Dizziness	[ ]	[ ]	Hepatitis/Liver Problems	[ ]	[ ]
Blindness	[ ]	[ ]	Kidney Problems	[ ]	[ ]	Heart Attack (date_____)	[ ]	[ ]
Deafness	[ ]	[ ]	Arthritis	[ ]	[ ]	Congestive Heart Failure	[ ]	[ ]
Shortness of Breath	[ ]	[ ]	Intestinal Disease	[ ]	[ ]	Bronchitis/Emphysema	[ ]	[ ]
Recent Cough/Cold	[ ]	[ ]	Psychiatric Disorder	[ ]	[ ]	Pneumonia/Lung Problems	[ ]	[ ]

Major illnesses not listed above: _____

List any major surgical procedures: _____

List any medications that you are currently taking (only if you did not already provide a list of your medications):

Medication	Dosage	Medication	Dosage

FAMILY HISTORY

OCULAR	YES	NO	MEDICAL	YES	NO
Blindness	[ ]	[ ]	Diabetes	[ ]	[ ]
Cataract	[ ]	[ ]	Arthritis, Lupus, Etc.	[ ]	[ ]
Glaucoma	[ ]	[ ]	Other (list) _____		
Macular Degeneration	[ ]	[ ]	_____		
Retinal Detachment	[ ]	[ ]	_____		

OUR OFFICE PHILOSPHY

We feel it is extremely important to spend as much time as necessary with each patient to fully address your eye situations. This enables us to explain our findings and recommendations in depth and answer any questions you may have during your visit. Our staff schedules patients accordingly and we try our best to be as efficient as possible in order to expedite the visit. Please be assured that we value your time. Given the unpredictable and sometimes emergent nature of our work, occasionally there may be a prolonged wait time. On many occasions, we are delayed for such matters as patients' medical problems may require immediate attention. These issues are unforeseen and need to be addressed as they arise. We make every effort to see our patients in a timely manner and minimize delays. Please understand that when you are being seen, you will receive the same thorough treatment.

Our office is staffed to adequately meet the needs of our patients. Therefore when patients are scheduled and do not show up for their appointment our staff is disrupted. For this reason we ask that if you need to cancel an appointment, please give us at least 24 hours notice.

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

PATRICK T. CLANCY, M.D., P.A. Diplomate American Board of Ophthalmology

Our Office Financial Policy

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, person checks and as well as debit/credit payments. There is a $35.00 return bank check fee due and payable from for each check payment returned to us by your bank. Should your account be placed for collection you will be responsible for all court costs including but not limited to, collection, attorney's fees, and court costs and accrued interest.

FOR THE PATIENTS WITH INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

MANAGED CARE PARTICIPANTS: Some benefit plans require preauthorization, and a specialist referral forms from your primary care physician. Please provide the proper insurance plan identification and forms necessary prior to your visit. All co-payments or patient out-of-pocket fees are due and payable at the time of service.

REFERRALS: If your insurance plan requires a referral, please be sure that you have it with you for your appointment. According to most insurance plans, it is the patient's responsibility to check if their plan requires a referral for a specialist visit. If you do not provide one, you are responsible for payment.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill your secondary insurance, if applicable. All coinsurance amounts and deductibles are due and payable at the time service is provided. Medicare does not pay for routine eye exams and refraction.

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. *Refraction is non-covered under most insurance plans.

***REFRACTION:** Refraction is the optical determination of the best possible vision of the eye, and is necessary to determine if any medical, optical, or surgical treatment may be indicated. It is a necessary part of the exam and therefore has a value in and of itself. Refraction is NON – COVERED under most insurance plans and is self-pay at the time of visit. **The cost of refraction is $78.00.**

FOLLOW – UP VISITS: Periodic post – operative office visits may or may not be covered under your insurance plan; however, these may be required by Dr. Clancy to monitor your eyes.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality care at low cost to our patients and in fairness to other patients and doctor; we require at least 24 hours' notice when cancelling an appointment.
A fee of $25.00 will be charged for any missed appointments.

Financial Disclosure / Signature Release

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. PATRICK CLANCY FOR ANY SERVICES FURNISHED ME BY PHYSICIAN OR SUPPLIER. I AGREE TO PAY ALL AMOUNTS NOT COVERED BY INSURANCE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR OTHER AUTHORIZED INSURANCE COMPANIES ANY INFORMATION NEEDE TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. IN THE EVENT MY ACCOUNT IS FORWARDED TO A COLLECTION AGENCY, A SURCHARGE OF $50.00 OR 35% OF MY BALANCE, WHICHEVER IS GREATER, WILL BE ASSESSED.

Patient / Guardian: _____ Date: _____

CONTACT LENSES: All contact lenses must be paid for at the time of pick up. We will issue you a receipt to submit to your insurance company.

Remember to check your benefits booklet regarding coverage for eye examinations. Some policies require referrals, while others do not. Because of the large volume of insurance policies we deal with, we unfortunately cannot know the details of each. If you have a question about coverage after reading your benefits booklet, please check with your personnel office at work, or call your insurance carrier. (This will also facilitate your being seen as quickly as possible.) If your appointment is 5PM or later, we often cannot reach anyone at the insurance company to have questions answered.

ASSIGNMENTS OF INSURANCE BENEFITS - Patients with insurance coverage, please read and sign below:

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitles, and private insurance and any other health plans, to Dr. Patrick T. Clancy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient or Guardian's Signature:

X_____ Date: _____

Does your insurance company require a referral or preauthorization? Yes _____ No _____

If so, have you obtained it? Yes _____ No _____

If not, payment is due in full unless other arrangements have been made.

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME.

Patient or Guardian's Signature:

X_____ Date: _____

PATRICK T. CLANCY, M.D., P.A. Diplomate American Board of Ophthalmology

800 Wyckoff Avenue • Wyckoff, NJ 07481
Tel: 201-447-5454 • Fax: 201-447-8922

PATIENT CONSENT FORM

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

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 shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Patient Name: _____

Signature: X_____ Date: _____

Relationship to Patient (if other than patient): _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our office keeps medical information about you. This information is personal and private. We need to use this information in many ways. First, we use the information when we treat you or refer you for treatment. Second, we use the information to obtain payment for your medical care. Finally, we use this information for our health care.

Our NOTICE OF PRIVACY PRACTICES provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our Notice may change and be revised. If we change our Notice, you may obtain a revised copy by requesting one verbally or in writing.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restrictor, but if we do, we are bound by our agreement.

1 acknowledge that 1 was provided a copy of the NOTICE OF PRIVACY PRACTICES.

May our office leave message at your home, either on an answering machine or with a family member, to remind you of appointments, and send a reminder postcard to your home?

YES____ NO____

1 AUTHORIZE DISCLOSURE OF MY INFORMATION TO FAMILY MEMBERS OR OTHERS.

YES____ NO____

TO WHOM DO YOU AUTHORIZE:

NAME: _____ RELATIONSHIP: _____

Patient Name (Please print) _____ Date of Birth_____

X_____

Patient Signature / or personal representative of patient (Guardian / Parent)