South Shore Eye Care LLP

2185 Wantagh Avenue
Wantagh, NY 11793
p 516-785-3900
f 516-783-0033

689 Broadway
Massapequa, NY 11758
p 516-541-4141
f 516-541-4150

Date :_____

WELCOME TO OUR PRACTICE!

Thank you for choosing us as your eye care provider. The physicians and staff at South Shore Eye Care, LLP are dedicated to providing you with the best possible care and services. We have adopted the following financial policies in order to minimize confusion or misunderstanding between our patients and the practice:

Self-Paying Patients: Payment for services is due when services are rendered. If we do not participate in your insurance plan, we will be happy to help you process your insurance claim for reimbursement once all fees are paid.

Participating Insurance: You must provide us with accurate insurance information and allow us to photocopy your insurance card. Any co-payments are due at the time of service. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. If a referral is required by your plan, it must be presented prior to services. You must ensure that the referral is made to the correct doctor, that it has not expired and that the number of visits have not all been utilized. If you receive specialty services without obtaining a required referral, you will be financially responsible for such services. It is your insurance carrier's responsibility (as required by NYS Insurance Law) to pay us for services covered by your contract within 45 days from date of receipt. If your carrier does not comply with the law, we may transfer the responsibility to you.

Medicare and most other insurance companies do not cover the examination for and prescribing of glasses as part of an eye examination. This service is called **REFRACTION**. If you require this examination, our fee is $60.00.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan and understand that I am responsible for following my insurance plan's regulations, policies and procedures.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the doctors of South Shore Eye Care, LLP for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I also request that this authorization apply to any other insurance. I authorize the release of any medical or other information necessary to process this claim as well as payment of medical benefits to the above physician for services rendered.

Payment Responsibility

I understand that co-payment required by my insurance provider is due at the time of service and that I am financially responsible for **ANY** and **ALL** amounts not paid by my insurance carrier.

I understand that my account will be subject to an **ADDITIONAL PROCESSING FEE EACH MONTH** if payment is not received at the time of service.

_____	_____	_____
Signature of Patient or Legal Guardian	Print Patient Name	Print Legal Guardian Name *(if appl)*

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PATIENT INFORMATION

PATIENT NAME _____

ADDRESS: STREET _____

CITY/STATE/ZIP _____

PHONES: HOME _____ WORK _____ CELL _____

PREFERRED METHOD OF CONTACT: *(Please check all that apply)* ❑ HOME | ❑ WORK | ❑ CELL: ❑ Text ❑ Voice

EMERGENCY CONTACT _____
(NAME) (PHONE) (RELATIONSHIP)

E-MAIL ADDRESS _____

DATE OF BIRTH _____ / _____ / _____ AGE _____ SEX: ❑ M ❑ F

SOCIAL SECURITY NUMBER _____

NAME OF SPOUSE/PARENT/GUARDIAN _____

PRIMARY CARE PHYSICIAN: NAME _____

ADDRESS _____ PHONE _____

PHARMACY NAME/PHONE NUMBER _____

REFERRED BY _____

POLICYHOLDER INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID# _____

INSURED NAME _____

INSURED SEX: ❑ M ❑ F | DATE OF BIRTH _____ / _____ / _____ SS# _____

RELATIONSHIP TO PATIENT _____

INSURED'S EMPLOYER _____

SECONDARY INSURANCE _____

INSURED NAME _____

INSURED SEX: ❑ M ❑ F | DATE OF BIRTH _____ / _____ / _____ SS# _____

RELATIONSHIP TO PATIENT _____

INSURED'S EMPLOYER _____

PREFERRED LANGUAGE _____ RACE _____ ETHNICITY _____

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REFRACTION ACKNOWLEDGEMENT

As part of your visit, you may have a REFRACTION.

This is a test to determine the prescription of your eyeglasses. This test requires special equipment and staff training to give you the most accurate prescription possible. Without refraction, it will not be possible to give you a prescription for glasses. Most insurance carriers, including Medicare, consider this routine and do not cover the cost of the test. If it is not covered, $60.00 will be due at the time of service.

We can bill the following insurances for this procedure:

Community Plan (through UHC)
Emblem Health Care Partners (HCP)
Magnacare

This is not a guarantee of coverage. Coverage will be determined by your insurance company.

If your insurance is not listed, the $60.00 fee is expected at time of visit.

Please indicate if you would like to be tested to determine your new eyeglass prescription.

❑ YES, I want to have a new prescription for eyeglasses. I understand I will be charged $60.00 if my insurance does not cover this.

❑ NO, I do not want to have a new prescription for eyeglasses.

Signature of Patient or Legal Guardian	Print Patient Name	Print Legal Guardian Name *(if appl)*

Member of
Northwell Health
Eye Institute

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for South Shore Eye Care, LLP to use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare operations (TPO). (South Shore Eye Care, LLP's Notice of Privacy Practices provides a more complex description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. South Shore Eye Care, LLP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Howard Lane, M.D., Privacy Officer, at 2185 Wantagh Avenue, Wantagh, N.Y. 11793.

With this consent, South Shore Eye Care, LLP may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, South Shore Eye Care, LLP may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, South Shore Eye Care, LLP may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that South Shore Eye Care, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement .

By signing this form, I am consenting to South Shore Eye Care, LLP's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Release of Information

❑ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

❑ Spouse _____ ❑ Other_____

❑ Child(ren) _____

❑ Information is not to be released to anyone.

IF I DO NOT SIGN THIS CONSENT, OR LATER REVOKE IT, SOUTH SHORE EYE CARE, LLP MAY DECLINE TO PROVIDE TREATMENT TO ME.

_____	_____	_____
Signature of Patient or Legal Guardian	**Print Patient Name**	**Print Legal Guardian Name** *(if appl)*

Member of Northwell Health Eye Institute

***The Release of Information** will remain in effect until terminated by me in writing*