The Cataract & Laser Institute of Pennsylvania

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www.cataractandlaserinstitute.com

WELCOME TO OUR OFFICE! PLEASE PRINT THIS PAGE, COMPLETE AND BRING WITH YOU. AT CHECK-IN PLEASE GIVE THIS DOCUMENT TO THE FRONT DESK RECEPTIONIST.

LAST NAME: _____ FIRST NAME: _____ MI: _____

STREET: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

DOB: _____ SEX: _____ AGE: _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

DRIVER'S LICENSE # _____ SSN: _____

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MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ SEPARATED □ WIDOWED

PRIMARY INSURANCE: _____ POLICY # _____

GROUP # _____ SUBSCRIBER: _____

RELATIONSHIP: _____ SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER SOCIAL SECURITY NUMBER: _____

SUBSCRIBER'S ADDRESS: _____

SECONDARY INSURANCE: _____

GROUP # _____ SUBSCRIBER: _____

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HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IT IS OUR HOPE TO MAKE YOUR VISIT HERE A PLEASANT ONE. EYE APPOINTMENTS TAKE TIME SO PLEASE EXPECT TO BE HERE FOR ONE AND A HALF TO TWO HOURS FROM YOUR SCHEDULED ARRIVAL TIME. **THE FOLLOWING PAGES ARE OUR FINANCIAL POLICY AND NOTIFICATION OF THE HIPAA HEALTH**

PRIMARY LANGUAGE (Check option that applies)
____ENGLISH
____OTHER. SPECIFY: _____

RACE (Check option that applies)
____AMERICAN INDIAN OR ALASKA NATIVE
____ASIAN
____BLACK OR AFRICAN AMERICAN
____NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
____WHITE
____OTHER RACE
____DECLINE TO SPECIFY

ETHNICITY (Check option that applies)
____HISPANIC OR LATINO
____NOT HISPANIC OR LATINO
____UNKNOWN
____DECLINE TO SPECIFY

PCP NAME

_____

PCP NUMBER

_____

PHARMACY NAME

_____

PHARMACY NUMBER

_____

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Payment Policy

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees and methods of payments are comparable with other Ophthalmologists in the Pittsburgh area. We ask for payment at the time of service. This includes payment for the office visit and any tests that are performed. We commonly require payment at the time of check-in. **Any laboratory tests which require an outside lab company to perform will be billed separately by that company.**

As a courtesy, we will file all applicable office and hospital charges with your insurance carrier(s). By your signature below, you authorize and request that insurance payments be made directly to ***The Cataract & Laser Institute of PA***. **However, you are ultimately responsible for all charges**. We advise that you familiarize yourself with the benefits of your plan. Prior to any procedure, we can assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to the procedure. We accept Cash, Checks, Master Card, Visa, or Discover. **Please note that for any returned checks for non-sufficient funds there will be a $25 additional charge. Any account referred to an outside collection agency will be assessed a $12.00 fee.**

After you have paid for your visit, you will receive an itemized statement. You can attach this copy to your insurance claim and send it to your carrier for processing if necessary.

We are providers for several HMO and PPO plans, in which case the above may not apply. However, you are responsible for your co-payment, deductible, or other non-covered services as set by your insurance carrier. Co-payments and deductibles are collected at the time of service.

If your insurance carrier requires a referral number to receive services form our office, it is your responsibility to contact your Primary Care Physician to obtain the number prior to your office visit.

This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Your cooperation is greatly appreciated.

CONSENT TO TREATMENT AND PRIVACY

I authorize and consent to all examination and treatment necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the physicians and clinicians of *The Cataract & Laser Institute of PA* including but not limited to blood and urine tests, drug tests, and any other diagnostic procedures or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of all my medical records, if necessary. I further acknowledge that I have been given the opportunity to review the Notice of Privacy Practices of *The Cataract & Laser Institute of PA*.

Patient Name: _____

☐ I have read and understand the above policies and consent to treatment.

_____ _____

Signature Date

Printed Name: _____ Relationship to Patient: _____

The Cataract & Laser Institute of Pennsylvania

PATIENT WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of the CATARACT & LASER INSTITUTE OF PA. I hereby acknowledge receipt of the CATARACT & LASER INSTITUTE OF PA's **Notice of Privacy Practices.**

Name [please print]: _____

Signature: _____

Date: _____

I am a patient of the CATARACT & LASER INSTITUTE OF PA. I hereby authorize the practice to **use an automated appointment reminder system** for contacting me. The practice may use any telephone numbers provided by me including, but not limited to ***home and cell numbers.***

Name [please print]: _____

Signature: _____

Date: _____

I am a patient of the CATARACT & LASER INSTITUTE OF PA. I hereby acknowledge, authorize and **Consent to All Examination and Treatment** necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the physicians, doctors of optometry and clinicians of the Cataract & Laser Institute of PA including but not limited to blood and urine tests, drug tests, and any other diagnostic procedures or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of all my records, if necessary.

Name [please print]: _____

Signature: _____

Date: _____

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PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Cataract & Laser Institute of PA not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ____________________________________ ______ yes ______ no

Parent: ____________________________________ ______ yes ______ no
Other:______________________________________ ______ yes ______ no

____________________________________ ______ yes ______ no

____________________________________ ______ yes ______ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:____
____
____

PRINTED NAME____

Patient/Parent/Guardian Signature:____

Date: _______________________________

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FOR OFFICE USE
Changes to above authorized by patient over phone:

Change	Date	Staff Initials
____	_______	_____
____	_______	_____
____	_______	_____