Norwich Ophthalmology GROUP
You'll see the difference.

Name _____ Date _____

Address _____
Street City State Zip

Email address _____

Social Security # _____ ☐ M/ ☐ F Date of Birth _____

Phone: Home ( ) _____ Cell ( ) _____

Preferred Contact Method: ☐ Text ☐ Phone Call ☐ Email

Referred by: ☐ Friend/Relative _____ ☐ Doctor _____
Name Name

☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other: _____

Primary Care Physician _____ Phone _____

INSURANCE INFORMATION

Primary Insurance Name _____

Group # _____ ID# _____

Secondary Insurance _____

Group # _____ ID# _____

Additional Insurance _____

Group # _____ ID# _____

COMPLETE IF PATIENT IS UNDER 18 YEARS OR A STUDENT

Parent or Guardian Name _____

Address _____ _____

Phone _____ Social Security # _____

Email Address: _____ Date of Birth _____

FINANCIAL AGREEMENT

Patient Name _____ DOB _____

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and the difference between the allowable charge and the amount Medicare pays. You are also responsible for refraction fees as they are a Medicare non-covered service. If you have supplemental insurance we will bill it for you. Any remaining balance will be your responsibility.

HMO/PPO/Commercial: All co-payments and account balances are due at time of service. You are responsible for verifying what your insurance plan will cover and that we are participating providers in your plan.

Workmans Compensation: If you are here as a result of work related injury we will require information regarding both health insurance and your employer's Workman's Compensation insurance. We will require a claim number, insurance address, adjuster's name and phone number. If payment is not received, the balance is your responsibility.

Self Pay: A minimum of $50 is due at the time of service for all self pay patients. Any subsequent visit charges will be due at the time of service.

____ (INITIAL) I understand that my insurance company may pay less than the actual billed services and I am responsible for any charges that the insurance carrier deems a "non-covered service" and assign responsibility of payment to the patient/guarantor.

____ (INITIAL) I understand that it is my responsibility to verify what services my insurance company will cover and that Norwich Ophthalmology Group, P.C. and it's physicians are participating providers in your plan.

____ (INITIAL) Unpaid balances that remain outstanding may be turned over to a collection agency. I realize failure to keep this account current may result in my being discharged from the practice.

____ (INITIAL) I understand in case of default in this account, I agree to pay collections costs and reasonable attorney fees incurred in attempting to collect on this amount or any future account balances.

____ (INITIAL) I understand that I may be liable for the full amount of services provided, if I have not provided accurate and correct information within the TIMELY FILING LIMIT set by my insurance carrier. TIMELY FILING LIMITS are as little as 60 days from the date of service.

HIPAA Acknowledgement: I understand that I have rights regarding my protected health information. These reights are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been informed of, and given the opportunity to review and secure a copy of Norwich Ophthalmology Group, P.C. Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected hatlh information. I understand that Norwich Ophthalmology Group, P.C. complies with eh Public Act No. 08-167 concerning the confidentiality of social security numbers.

RELEASE OF INFORMATION

I authorize my physician, health care provider and their representative to release any information relating to an illness, injury, diagnosis or care of treatment to my insurance company, health plan or third party payer or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to, any medical records and medical information. I understand that the reason for furnishing such information may include the following: for use in medical, financial and or provider auditing or such other auditing as may be legally required for utilization and/or quality of care review and assessment and of determining available health benefits and coverage.

PLEASE SIGN ACKNOWLEDGEMENT OF THE ABOVE FINANCIAL STATEMENT, HIPAA AND RELEASE OF INFORMATION ACKNOWLEDGEMENT

I attest I have disclosed all active insurance and agree the proper information is on file with my provider. I understand if the insurance information is incorrect, I will be responsible for payment.

Signature _____ Date _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Ocular History: (please circle all that apply)

Allergic conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Corneal dystrophy (Left eye, Right eye)
Diabetic retinopathy, background (Left eye, Right eye)
Dry eyes
Glaucoma (Left eye, Right eye)
Macular degeneration (Left eye, Right eye)
Macular ERM (Left eye, Right eye)
Narrow angles (Left eye, Right eye)
Ocular hypertension (Left eye, Right eye)
Ophthalmic Migraine
Pseudoexfoliation
Retinal tear (Left eye, Right eye)
Strabismus
PVD (Left eye, Right eye)
Vitrous floaters (Left eye, Right eye)
None
Other _____

Ocular Surgery: (please circle all that apply)

Blepharoplasty (Left eye, Right eye)
Cataract surgery (Left eye, Right eye)
Corneal transplant (Left eye, Right eye)
DSAEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis repair (Left eye, Right eye)
Punctal plugs (Left eye, Right eye)
Strabismus surgery
Renital laser (Left eye, Right eye)
Trabeculectomy (Left eye, Right eye)
Tube shunt (Left eye, Right eye)
Yag capsulotomy (Left eye, Right eye)
None
Other _____

Family History: (please circle all that apply)

Blindness
Cancer
Cataracts
CVA
Diabetes
Glaucoma
Heart disease
Macular degeneration
Migraine
Retinal detachment
Strabismus
None
Other _____

Medications: (Please list all current medications)

Name	Dosage (i.e. 20 mg)	Frequency	Route: (i.e. oral, topical)

Allergies: (Please enter all allergies)

Allergen	Describe Reaction

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Illicit Drug Use:
- Drug Use
- IV Drug Use

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:
- I feel safe at home.
- I do not feel safe at home.

Other_____

None

No Show and Late Show Policies and Procedures

The goal of Norwich Ophthalmology Group is to provide comprehensive and timely care to each and every patient at all times. Our expectation and the ability to do so depend upon each patient's efforts to maintain and show for all scheduled appointment times. Missing appointments is a detriment to the patient who does not show and the clinic's ability to operate in an effective manner. Therefore, please note the following policies and procedures for "No Show" and "Late Show" appointments and are hereby effective **August 1, 2018**.

"No Shows"

What is a "No Show"?

Norwich Ophthalmology Group defines a "No Show" as a patient missing a scheduled appointment without, at a minimum, a twenty-four (24) hour cancellation or rescheduling notice

What is the impact of a "No Show"?

- Missing the appointment may jeopardize the health of the "No Show" patient.
- Missing the appointment denies care to other patients who need to be seen by a provider.
- Missing the appointment disrupts patient flow and affects other families

How can I avoid being a "No Show"?

Confirm your appointment via the reminder call or text messaging reminders

If you have to cancel or reschedule an appointment provide a twenty-four (24) hour courtesy call OR notify us as soon as you are aware you need to cancel or reschedule.

The twenty-four (24) hour notice allows Norwich Ophthalmology a reasonable amount of time to reschedule the patient's appointment AND allows us to reschedule another patient in the vacant slot.

What happens if I have too many "No Shows"?

New patients that miss their initial appointment will be given the opportunity to reschedule. If the rescheduled appointment is missed, the patient will not be scheduled for any further appointments.

Established patients that miss three (3) or more scheduled appointments in a two (2) year period, without informing Norwich Ophthalmology of the need to cancel or reschedule the

appointment (i.e. No Show), will result in patient being dismissed from the practice. A certified and written notice will be mailed to the patient or guardian officially and effectively discharging from Norwich Ophthalmology Group. We will continue to provide the dismissed patient with any emergent care for the next 30 days.

“Late Shows”

What is a “Late Show”?

Norwich Ophthalmology defines a “Late Show as a patient arriving fifteen (15) or more minutes after the scheduled appointment

Every patient is granted a fifteen (15) minute “grace period” for a scheduled appointment. We understand things come up and the patient and/or guardian may have to modify their personal schedule. In those instances when you know you will be late, Norwich Ophthalmology requires a courtesy call to inform the office staff of your tardiness. This will allow us to plan for your expected arrival and manage our complete patient schedule. If you do not provide Norwich Ophthalmology with a courtesy call, it will be the provider’s decision to work you in to be seen or reschedule the appointment.