SCARSDALE OPHTHALMOLOGY
ASSOCIATES PLLC

IRA S. SOLOMON, M.D. F.A.C.S.
SHERRY K. SOLOMON, M.D.
MEGAN RIDLEY-LANE, M.D.
MICHAEL NEWTON, M.D.
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MULTISPECIALTY MEDICAL & SURGICAL OPHTHALMIC CARE
DIPLOMATES, AMERICAN BOARD OF OPHTHALMOLOGY
700 WHITE PLAINS ROAD
SUITE 343
TELEPHONE: (914) 725-5400
FAX: (914) 725-2599

PATIENT INFORMATION

LAST NAME: ______________________ FIRST NAME: ______________________ MI: ________

DATE OF BIRTH: _____ / _____ / _____ SEX: ________ SOCIAL SECURITY NUMBER: _______ - _____ - __________

STREET ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: ______________

HOME PHONE: ______________________ CELL PHONE: ______________________

EMAIL: ____

MARITAL STATUS: ____________ MAIDEN NAME: ____________ SPOUSE'S NAME: ____________

OCCUPATION: ____________ EMPLOYER: ____________ WORK PHONE: ____________

EMERGENCY CONTACT: ______________ RELATION: __________ PHONE: ____________

PRIMARY CARE PHYSICIAN: ______________________ PHONE: ______________

REFERRING PHYSICIAN: ______________________ PHONE: ______________

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

LAST NAME: ______________________ FIRST NAME: ______________________ MI: ________

PHONE: ______________________ RELATION TO PATIENT: ______________________

STREET ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________ ID: __________ GROUP: ____________

NAME OF POLICY HOLDER (IF DIFFERENT THAN THE PATIENT): ______________________

SECONDARY INSURANCE: ______________________ ID: __________ GROUP: ____________

NAME OF POLICY HOLDER (IF DIFFERENT THAN THE PATIENT): ______________________

(OVER)

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INSURANCE AUTHORIZATIONS AND CONSENT FOR SERVICES

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage as provided and assign directly to the physicians of Scarsdale Ophthalmology Associates, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: ______________________________ Date: ____________________

Relationship (if patient is a minor): ____________________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the physicians of Scarsdale Ophthalmology Associates, PLLC for any services furnished to me. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits made payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releases information to the insurer or agency shown. IN Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: ______________________________ Date: ____________________

CONSENT FOR REFRACTION

Refraction (billing code 92015) is the procedure which allows your doctor to produce an eyeglass prescription for you. Many insurances, including Medicare, do NOT cover this service. For those insurances that DO cover this service, we will bill the insurance company directly. For all others, there will be a $75 fee for refraction payable at the time of service. I certify that I have read the policy on refraction and agree to pay the $75 fee at the time the services are rendered.

Signature: ______________________________ Date: ____________________

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FINANCIAL POLICY

Thank you for choosing Scarsdale Ophthalmology Associates, PLLC for your ophthalmological care. We are dedicated to providing you with the best possible care and we have developed this policy in response to the increasingly confusing and complex healthcare system.

It is important to understand that your insurance plan constitutes an agreement between yourself and your insurance company and NOT between Scarsdale Ophthalmology Associates, PLLC and your insurance company. Therefore, it is your responsibility to understand and meet the requirements of your plan. It is also important you bring your insurance card to each visit and you notify us as soon as possible of any change in coverage. Failure to notify the office of a change in coverage may result in charges for services becoming your responsibility regardless of whether or not we participate in your insurance plan. **All payments are due at the time of service** unless arrangements have been made in advance with the office.

INSURANCE: You are responsible for any coinsurance, deductibles, and any non-covered services such as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of this statement.

CO-PAYS: Your insurance company requires that co-payments be collected at the time of service. The co-pay requirement cannot be waived by our practice as it is a requirement placed by your insurance carrier. Please note: some insurance companies (Empire Blue Cross Mediblue, GHI, and NYS Empire Plan, among others) will take an additional co-pay for any diagnostic testing performed during the office visit.

REFERRALS: Some insurance plans require a referral from your primary care physician before specialty services are rendered. It is your responsibility to obtain he referral and to make sure that our office has received it prior to your visit or you must reschedule your appointment. The cost of any services received without a referral or proper authorization will be your responsibility.

MEDICARE: We accept assignment on Medicare claims. If you have Medicare and do not have secondary coverage, you will be required to pay your 20% coinsurance (and your deductible, if applicable) upon receipt of statement.

NO INSURANCE: Payment is due at the time of service. Questions and issues should be discussed prior to your appointment with our billing manager.

MEDICAL RECORDS: We will provide you with a copy of your medical records upon request. You will be asked to sign a release forma t the time of pick up. Please allow 30 days for us to copy your records. If you wish for us to mail your records, there may be an associated fee to cover the mailing costs. Additional copies of your medical records may be obtained at a per page charge.

I have read and understand the financial policy of Scarsdale Ophthalmology Associates, PLLC. My questions have been answered and I agree to abide by the policy.

Signature: ____ Date: __________________________

(OVER)

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HIPAA AWARENESS

With my permission, the physicians of Scarsdale Ophthalmology Associates, PLLC may use and disclose protected health information (PHY) about me to carry out treatment, payment, and healthcare operations (TOP). Please refer to the office's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. All doctors reserve the right to revise their Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, Scarsdale Ophthalmology Associates, PLLC may call or text my home or other designated locations and leave a message on voicemail or in person with reference to any items that assist the practice in carrying out my TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including my laboratory results among others.

With my permission, Scarsdale Ophthalmology Associates, PLLC may mail to my home or other designated 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" or "Confidential".

With my permission, Scarsdale Ophthalmology Associates, PLLC may e-mail to my home or other designated location any items that assist the practice in carrying our TPO, such as appointment reminder cards and patient statements. I have the right to request that the physicians restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions if in the best interest of my well-being, but if it does, it is bounded by this agreement.

By signing this, I am allowing Scarsdale Ophthalmology Associates, PLLC to use and disclose my PHI for 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.

____ ________________________

Signature of Patient or Legal Guardian Date

____

Printed Name

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NAME: ______________________________ DATE OF BIRTH: ____ / ____ / ________
LAST EYE EXAM: ________________

EYE HISTORY

DO YOU WEAR GLASSES: ☐ NO ☐ YES:
(PLEASE CIRCLE) READING / DISTANCE / PROGRESSIVE / BIFOCAL

DO YOU WEAR CONTACT LENSES: ☐ NO ☐ YES:
TYPE/BRAND AND POWER: ________________
(PLEASE CIRCLE) DAILIES / BI-WEEKLY / MONTHLY

DO **YOU** HAVE ANY OF THE FOLLOWING:

- ☐ CATARACTS
- ☐ GLAUCOMA
- ☐ MACULAR DEGNERATION
- ☐ DIABETIC RETINOPATHY
- ☐ RETINAL TEAR OR DETACHMENT
- ☐ OCULAR MIGRAINE
- ☐ IRITIS / UVEITIS
- ☐ DRY EYE
- ☐ FLOATERS
- ☐ FLASHES
- ☐ TEARING
- ☐ LOSS OF VISION
- ☐ DOUBLE VISION
- ☐ OTHER: ________________

HAVE **YOU** HAD ANY EYE SURGERY: ☐ NO ☐ YES
IF YES, PLEASE PROVIDE DETAILS: ________________

HAVE **YOU** HAD ANY EYE TRAUMA: ☐ NO ☐ YES
IF YES, PLEASE PROVIDE DETAILS: ________________

DOES ANYBODY **IN YOUR FAMILY** HAVE ANY EYE CONDITIONS:
☐ NONE ☐ GLAUCOMA ☐ MACULAR DEGENERATION ☐ RETINAL DETACHMENT
OTHER: ________________

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MEDICAL AND SURGICAL HISTORY

DIABETES MELLITUS	☐ NO	☐ YES	______
HEART DISEASE / STENTS	☐ NO	☐ YES	______
HEART FAILURE	☐ NO	☐ YES	______
IRREGULAR / RAPID HEARTBEAT	☐ NO	☐ YES	______
HIGH BLOOD PRESSURE	☐ NO	☐ YES	______
STROKE	☐ NO	☐ YES	______
ANEMIA	☐ NO	☐ YES	______
ASTHMA / EMPHYSEMA / COPD	☐ NO	☐ YES	______
LIVER DISEASE / HEPATITIS	☐ NO	☐ YES	______
STOMACH / DUODENAL ULCER	☐ NO	☐ YES	______
KIDNEY PROBLEM / STONES	☐ NO	☐ YES	______
ARTHRITIS	☐ NO	☐ YES	______
RHEUMATOID ARTHRITIS	☐ NO	☐ YES	______
SYSTEMIC LUPUS ERYTHEMATOSIS	☐ NO	☐ YES	______
AUTOIMMUNE DISEASE	☐ NO	☐ YES	______
THYROID DISEASE	☐ NO	☐ YES	______
CANCER OR TUMORS	☐ NO	☐ YES	______
SEIZURES / NEUROLOGIC	☐ NO	☐ YES	______
BLEEDING DISORDERS	☐ NO	☐ YES	______
AIDS / HIV	☐ NO	☐ YES	______
ANXIETY / DEPRESSION / PSYCH	☐ NO	☐ YES	______

OTHER: ______________________________

____

PLEASE LIST ANY SURGERIES YOU HAVE HAD: ______________________________

____

____

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PLEASE LIST ANY **ALLERGIES** INCLUDING **ALLERGIES TO MEDICATIONS** AND REACTION, IF KNOWN:

____

____

PLEASE LIST **ALL MEDICATIONS** THAT YOU CURRENTLY TAKE WITH STRENGTH AND DOSE
(INCLUDING NON-PRESCRIPTION MEDS)

SOCIAL HISTORY

DO YOU DRINK ALCOHOL ☐ NO ☐ YES ____________________

DO YOU CURRENTLY SMOKE ☐ NO ☐ YES ____________________

HAVE YOU EVER SMOKED ☐ NO ☐ YES ____________________

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ NO ☐ YES ____________________

HAVE YOU HAD ANY FALLS IN THE LAST YEAR? ☐ NO ☐ YES ____________________

FAMILY HISTORY

HAS ANY MEMBER OF YOUR FAMILY HAD THE FOLLOWING:

☐ NONE

☐ HEART DISEASE ☐ DIABETES

☐ STROKE ☐ HYPERTENSION

☐ CANCER ☐ AUTOIMMUNE DISEASE

☐ OTHER: ________________________________

____

PREFERRED PHARMACY

NAME: ____________________________________

ADDRESS: __________________________________

CITY: ____________________ STATE: ________ ZIP CODE: __________

PHONE NUMBER: ______________________

☐ MAIL ORDER PHARMACY: ____________________________