Gary S. Hirshfield, M.D., P.C.
REGISTRATION FORM

Today's Date:

PATIENT INFORMATION (PLEASE FILL OUT ALL INFORMATION)

Last Name: First Name:	☐Mr. ☐Miss ☐Mrs. ☐Ms.	Marital status: Single☐ Mar☐ Div☐ Sep☐ Wid☐	
Birth date: Race:	Sex: ☐M ☐F	*Email:*	
Street Address	City & State:	ZIP Code:	
Home phone no.: ( )	Cell Phone no.: ( )	Social Security no.:	
Primary Care Physician:	Employer:	Employer phone no.: ( )	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )
Is this person a patient here? ☐Yes ☐No		Is this patient covered by insurance? ☐ Yes ☐ No	
Occupation:	Employer: Employer address:		Employer phone no.: ( )
Primary Insurance:	**Policy No.**		**Pharmacy Name& Number:**
Secondary Insurance	Policy No.		
Subscriber's name:	Subscriber's S.S. no.:	Birth date: Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gary S. Hirshfield M.D., P.C., or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

GARY S. HIRSHFIELD, M.D., P.C.

PATIENT HISTORY

NAME:_____DATE:____/____/____DOB:____/____/____

Do you have any medical conditions (please select all that apply and please give approximate date of onset)

Diabetes☐_____ Hypertension☐_____ Heart disease☐_____

Cancer☐_____ Stroke☐_____ Seizures☐_____

Depression☐_____ Anxiety☐_____ Prostate problem☐_____

Hypertension☐_____ Asthma☐_____ Emphysema☐_____

Hepatitis B☐_____ Hepatitis C☐_____ HIV/AIDS☐_____

Kidney disease☐_____ Parkinson's disease☐_____ Arthritis☐_____

Lupus ☐_____

Other (Please write in below): _____

Have you been diagnosed with any eye problem (select all that apply and give approximate date of diagnosis):

Cataract ☐_____ Glaucoma ☐ _____ Macular degeneration ☐_____

Retinal detachment ☐_____Lazy Eye ☐ _____ Dry Eye ☐ _____

Diabetic eye disease ☐_____ Other_____

Have you had any eye surgery (please select all that apply and give approximate date):

Cataract RT ☐ LT ☐ _____ Laser for vision correction☐ _____Lasik☐_____

Retinal Laser ☐_____Laser for glaucoma ☐_____Eye Muscle ☐_____

Retinal detachment surgery or Laser ☐ _____

SurgeryOther_____

Please list any surgery you have had in the past such as hernia repair, heart surgery, mastectomy or lumpectomy, prostate surgery, other surgery for cancer or any other surgery you can remember:

_____

_____

List all current medications (name and dose if possible) include oral, drops, ointments and prescription and non-prescription medication:

_____

_____

Please select the correct statement below:

I have medication allergies ☐ I have *NO* known medication allergies ☐

Please list all medication, food or other allergies and the type of reaction you have had:

_____

Please select below any diseases in which there is a family history:

Diabetes ☐ Glaucoma ☐ Cataract ☐

Hypertension ☐ Macular degeneration ☐ Cancer ☐ Type_____

Other_____

Please select the best answer about your smoking history:

Current every day smoker ☐ Current occasional smoker ☐

Former smoker ☐ Never smoked ☐ I don't know ☐

If you smoke about how many packs per day (circle the best choice):

5 or more 4 3 2 1 ½ less than ½

How many alcohol drinks do you consume in a week (circle the best choice):

More than 21 10-21 5-10 1-5 <1 0

Are you currently employed outside the home (select what applies):

NO ☐ YES ☐ If yes, what kind of job do you have? _____

Are you pregnant: Yes ☐ (how many weeks) _____ NO ☐

Are you planning pregnancy: YES ☐ NO ☐

Are you interested in **LASER VISION CORRECTION?** YES ☐ NO ☐

Are you interested in **BOTOX OR JUVEDERM?** YES ☐ NO ☐

Do you currently have any of the following (select all that apply):

Systemic: fever ☐ sudden weight loss or gain ☐ fatigue ☐

ENT: stuffy nose ☐ sinus problems ☐ dry mouth ☐ ear problem ☐

Heart: chest pains ☐ rapid heartbeat ☐

Respiratory: cough ☐ wheezing ☐ shortness of breath ☐

Gastrointestinal: nausea ☐ diarrhea ☐ heartburn ☐

Genitourinary: incontinence ☐ frequency of urination ☐ burning on urination ☐

Skin: rashes ☐ dryness of skin ☐

Muscle or joint: stiffness ☐ pains ☐ swollen joints ☐

Neurological: numbness ☐ weakness ☐ headaches ☐ paralysis ☐

Psychiatric: anxiety ☐ depression ☐ insomnia ☐

Endocrine: unusual intolerance to heat ☐ or to cold ☐

Hematologic: easy bruising ☐ anemia ☐

Allergic reactions: hay fever ☐ seasonal allergy ☐ hives ☐

Any other symptoms not mentioned above: _____

_____

Primary Physician: _____

Referred by _____

Gary S. Hirshfield, MD, FACS

BOARD CERTIFIED OPHTHALMOLOGIST • COMPREHENSIVE OPHTHALMOLOGY AND OPHTHALMIC SURGERY

OUR FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. *Ultimately, however, any and all financial liability rests with the patient.*

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. **A refractive examination is not a covered service by most insurance companies, including Medicare. If a refraction is performed, you will be charged for this service.**

It is the patient's/parent's/guardian's responsibility to obtain the appropriate referral and pay all copays and balances at the time of service. There is a $15.00 billing fee for all services not paid for at the time of visit. There is a $15.00 cancellation fee for appointments that are missed but not cancelled within 4 hours of the scheduled time. All returned checks will be assessed a $35.00 fee and a $15.00 billing fee for rebilling. If your account becomes delinquent at any point besides the original amount owed, you will also be responsible for any additional fees charged by the credit agency.

On occasion the staff at HEA may help you in obtaining a referral however we are not responsible for this. If a referral is not obtained and cannot be obtained before the visit you will have the choice of rescheduling the visit or paying the full fee at the time of the visit.

I have read and understand the above financial policy.

_____ _____

Signature of patient/guardian/parent Date

_____ _____

Printed name of patient Date

176-60 UNION TURNPIKE . SUITE 110 . FRESH MEADOWS . NY 11366 . PHONE: (718) 460-1200 . FAX: (718) 461-2135

Gary S. Hirshfield, MD, FACS

BOARD CERTIFIED OPHTHALMOLOGIST • COMPREHENSIVE OPHTHALMOLOGY AND OPHTHALMIC SURGERY

REFRACTION POLICY

A refraction is an examination that determines the best possible glasses or other possible optical device to give the patient the best possible vision. This test takes time and precision and requires the full cooperation of the patient. It is required to be performed if a prescription for glasses is needed by the patient.

Most insurance does not cover the refraction test. Our fee for this test is $85.00, however, if you pay at the time of service the fee will be discounted to $25.00. We will make every effort to bill the insurance company and if they do pay, your fee will be refunded immediately.

AGREEMENT

I acknowledge and agree to the policy as described above.

Patient _____ Date _____

176-60 UNION TURNPIKE . SUITE 110 . FRESH MEADOWS . NY 11366 . PHONE: (718) 460-1200 . FAX: (718) 461-2135

GARY S HIRSHFIELD, M.D.,P.C.

HIRSHFIELD EYE ASSOCIATES

Patient Acknowledgement
And Consent for Use and Disclosure of Protected Health Information

I, the undersigned, acknowledge receipt of the currently effective Notice of Privacy Practices.

This Consent for Use and Disclosure of Protected Health Information includes some, but not all, of the provisions of the Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices Eff. 10/01/2014 prior to signing this consent. **Gary S. Hirshfield, M.D., P.C.** 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 **Gary S. Hirshfield, M.D., P.C.** With this consent, **Gary S. Hirshfield, M.D., P.C.** 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 test results, among others.

I hereby give my consent for **Gary S. Hirshfield, M.D., P.C.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Additionally, my information may be used to determine if I am a candidate for any research studies being conducted at **Gary S. Hirshfield, M.D., P.C.** under the supervision of **Gary S. Hirshfield, M.D** The Notice of Privacy Practices provided by **Gary S. Hirshfield, M.D., P.C.** describes such uses and disclosures more completely.

With this consent, **Gary S. Hirshfield, M.D., P.C.** 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." As well as the use of my email address to contact me in regards to changes in business hours, appointment information, promotional offers and the introduction of new services provided by the Practice.

I have the right to request that **Gary S. Hirshfield, M.D., P.C.** restrict how it uses or discloses my PHI to carry out TPO for which I must submit my written request the HIPAA Compliance Officer.

By signing this form, I am consenting to allow **Gary S. Hirshfield, M.D., P.C.** to use and disclose my PHI for research activities performed by Touchstone Clinical Research, LLC.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Gary S. Hirshfield, M.D., P.C.** may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name Print Name of Legal Guardian, if applicable

SIGNATURE ON FILE

Beneficiary Name (print) Medicare Number

1. MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to **Dr. Gary S. Hirshfield**, for services furnished me by **Dr. Gary S. Hirshfield**. 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 to related services.

I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claims forms, my signature authorizes releasing the information to the insurer or agency shown.

Dr. Gary S. Hirshfield accepts 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 deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature Date

2. MEDIGAP

If a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to **Dr. Gary S. Hirshfield.**

Beneficiary Signature Date

3. OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to **Dr. Gary S. Hirshfield**.
I understand I am financially responsible for any changes whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Dr. Gary S. Hirshfield**. I authorize **Dr. Gary S. Hirshfield** to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Beneficiary Signature Date