

Date	Account #	Office #	Phone #	Referral #

**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address 1			Home Phone	Cell Phone		
Address 2			Work Phone	Email Address		
City	State	Zip Code	Employer	Occupation		
Emergency Contact			Pharmacy	Phone		

**Physician**

Primary Physician	Referring Physician, or name of person referring you.

**Medical Insurance**

	Name & Address	Policyholder Name	Relationship	Policy ID	Group ID
1					
2					
3					

**Guarantor (Person to be billed, if different than patient)**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address 1			Home Phone	Cell Phone		
Address 2			Work Phone	Email Address		
City	State	Zip Code	Employer	Occupation		

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly to , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered 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 my insurance submissions. I understand that payment is expected at the time of service. I also authorize the to charge any past due balance to my creditcard as they deem necessary.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	<p align="center"><b>Gary S. Hirshfield, MD, PC</b>                  176-60 Union Turnpike, Suite 110 Phone: 718-460-1200                  Fresh Meadows, NY 11366 Email</p>
X		

Please attach all pertinent insurance ID cards for photocopying.

PATIENT HISTORY RECORD(page 1)

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please answer all of the following questions concerning your medical status and history:**

1. Do you have any medical conditions(e.g.: diabetes, high blood pressure, heart disease, cancer, arthritis or any other)?

\_\_\_\_\_ Yes \_\_\_\_\_ NO If yes please list all conditions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever had any eye disease(e.g.: cataracts, glaucoma, retinal detachment, lazy eye or any other eye problem or eye surgery)?

\_\_\_\_\_ Yes \_\_\_\_\_ NO If yes please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Have you ever had any surgery?

\_\_\_\_\_ Yes \_\_\_\_\_ NO If yes please list type and date: \_\_\_\_\_

\_\_\_\_\_

4. Do you take any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

5. If you answered yes to number 4 above please list all medications including pills, drops, ointments, vitamins, herbal remedies, etc., including dose \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you have food or drug allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes please list: \_\_\_\_\_

\_\_\_\_\_

PATIENT HISTORY RECORD(page 2)

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**Review of systems(please answer all of the following):**

Do you currently have any of the following:

Fever, unexpected weight loss or gain, fatigue: \_\_\_\_\_yes\_\_\_\_\_no

Ear, nose and throat problems, such as hearing loss, sinus problems, sore throat:

\_\_\_\_\_yes\_\_\_\_\_no

Heart problems, such as chest pain, palpitations: \_\_\_\_\_yes\_\_\_\_\_no

Respiratory problems such as shortness of breath, wheezing, or coughing:

\_\_\_\_\_yes\_\_\_\_\_no

Gastrointestinal problems such as heartburn, abdominal pain, diarrhea or vomiting: \_\_\_\_\_yes\_\_\_\_\_no

Urinary problems such as incontinence, pain, burning or blood in urine:

\_\_\_\_\_yes\_\_\_\_\_no

Skin problems such as rashes, dryness: \_\_\_\_\_yes\_\_\_\_\_no

Musculoskeletal problems such as aches and pains, swollen joints etc.:

\_\_\_\_\_yes\_\_\_\_\_no

Neurological problems such as numbness, weakness, headaches, paralysis:

\_\_\_\_\_yes\_\_\_\_\_no

Psychiatric problems such as anxiety, depression, hallucinations:

\_\_\_\_\_yes\_\_\_\_\_no

**Please explain all yes answers to the above questions:**

\_\_\_\_\_  
\_\_\_\_\_

**Family and Social History:**

Do any diseases run in your family(such as diabetes, hypertension, cancer, glaucoma, macular degeneration or other diseases)? \_\_\_\_\_yes\_\_\_\_\_no

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? \_\_\_\_\_yes \_\_\_\_\_no If yes, how much? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_yes \_\_\_\_\_no If yes, how much? \_\_\_\_\_

If employed how many hours per week do you work? \_\_\_\_\_

**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 Hirshfield, for services furnished me by Dr. Gary 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 release 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 claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Dr. Gary Hirshfield accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered 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 Hirshfield.

Beneficiary Signature

Date

**3. OTHER INSURANCE**

I hereby authorize payment of my medical and surgical insurance benefits to Dr. G. Hirshfield. I understand I am financially responsible for any charges 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. G. Hirshfield. I authorize Dr. 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

**Consent for Purposes of Treatment, Payment and Healthcare Operations**

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I consent to the use or disclosure of my protected health information by **Gary s. Hirshfield, M.D.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Gary S. Hirshfield, M.D.. I understand that diagnosis or treatment of me by **Gary S. Hirshfield, M.D.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Gary S. Hirshfield, M.D.** is not required to agree to the restrictions that I may request. However, if **Gary S. Hirshfield, M.D.** agrees to a restriction that I request, the restriction is binding on Gary S. Hirshfield, M.D..

I have the right to revoke this consent, in writing, at any time, except to the extent that **Gary S. Hirshfield, M.D.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Gary S. Hirshfield's** Notice of Privacy Practices prior to signing this document. **Gary S. Hirshfield, M.D.** has provided the Notice of Privacy Practices to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Gary S. Hirshfield, M.D.**. The Notice of Privacy Practices for **Gary s. Hirshfield, M.D** is also provided **in the back billing office.** This Notice of Privacy Practices also describes my rights and **Gary S. Hirshfield's** duties with respect to my protected health information.

**Gary S. Hirshfield, M.D.** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority



Gary S. Hirshfield, MD, FACS

BOARD CERTIFIED OPHTHALMOLOGIST • COMPREHENSIVE OPHTHALMOLOGY AND OPHTHALMIC SURGERY

## PATIENT AGREEMENT

### REFRACTION CHARGES

A REFRACTION is a diagnostic test used to determine the patient's best ability to see. A refraction is the specific measurements of the refractive state of the eye. A series of lenses are presented to determine which prescription provides the sharpest and clearest vision.

This is an essential part of most ophthalmologic evaluations. This test is performed during your annual eye exam or if there has been a decrease in your vision since your last visit.

This test is necessary to perform in order for your physician to determine the best visual acuity which is needed to evaluate for possible eye diseases.

Occasionally the refraction is used as the basic information for prescribing glasses or other optical devices. However often times the refraction does not lead to prescription for glasses.

### **SOME INSURANCE COMPANIES, INCLUDING MEDICARE, DO NOT COVER THE REFRACTION TEST.**

The usual charge for this service is \$85.00. If my insurance does not cover this test, a time of service discount of 70% is offered. Therefore, if I pay today, my out of pocket expense is only \$25.00. If I am unable to pay today, my charge will be sent through the billing service and I will be billed.

Patient

Signature: \_\_\_\_\_ Date \_\_\_\_\_



### 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:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will be charged an additional **\$15.00 billing fee**. We accept cash, checks and all major credit cards for services.

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.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan with you. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **\$35.00** returned check fee.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I have read and understand the above financial policy.

\_\_\_\_\_  
Signature of patient/guardian/parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Date