WOODCLIFF LAKE OPHTHALMOLOGY, LLP.

Mary Mendelsohn, MD, FAAO
Alyson G. Yashar, MD, FAAO
Anne Marie Alino, MD, FAAO
577 Chestnut Ridge Road
Woodcliff Lake, NJ 07677
Tel. (201) 782-1700 Fax (201) 782-1749

We want to welcome you to our office and thank you for choosing us to provide you with your eye care needs.

Please complete the enclosed forms and bring them with you along with your insurance card(s) and referral form if needed.

Please bring the following:

1. Insurance Cards
2. Referral if needed
3. List all medications that you are currently taking.
4. Current eyeglasses.
5. If you are a contact lens wearer, we will need you to provide any information regarding your lenses; brand, power, base curve, diameter.

A parent or legal guardian must accompany patients under the age of 18. If this is not possible, please provide a letter authorizing medical treatment.

Anyone in a wheelchair must have someone accompany them for the complete visit.

Thank You!

We look forward to meeting you.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Woodcliff Lake Ophthalmology
577 Chestnut Ridge Road
Woodcliff Lake, NJ 07677

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy Practices and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions. I you agree then you are bound to abide by such restrictions.

Please give us the name of the person that you would allow us to release confidential information to, such as test results, billing questions or treatment.

Name: _____ Phone Number: _____ Relationship: _____

Print Name (or responsible party if minor): _____ Relationship to patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do as documented below:

Date:	Initials:	Reason:

WOODCLIFF LAKE OPHTHALMOLOGY, LLP
FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. We participate with Medicare and MOST major insurance plans. We DO NOT participate with Medicaid or with any vision plans.

It is very important that you, the patient, come into our office with all of the required documentation and be fully aware of how your plan works prior to the time of your scheduled appointment. You may be billed for any uncovered services. You, the patient, are the policyholder and it is your responsibility to know your insurance plan.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ASK TO SCAN YOUR INSURANCE CARD(S) FOR YOUR FILE.

Appointments – 24-hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.

Referrals – If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **you will be required to sign a financial waiver**. It is then your responsibility to provide us with a referral within 48 hours of the date of your visit or you will be personally responsible for that day's services.

Co-Payments – By law we **MUST** collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay that co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

Our of Network Plans – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to our office with the Explanation of Benefit and the Private Insurance Authorization for Assignment of Benefit/Information Release. I, the undersigned, authorize payment of medical benefits to Woodcliff Lake Ophthalmology, LLP for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims of benefits.

Self-Pay Patients – Payment is expected at the time of service unless other financial agreements have been made prior to your visit.

Medicare – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on file: I request that payment of authorized Medicare benefits be made on my behalf to Woodcliff Lake Ophthalmology, LLP for any services furnished to me. I authorize any holder of medical information about me to be released to CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

Divorced/Separated Parents of Minor Patients – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Woodcliff Lake Ophthalmology, LLP will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account if a balance is unpaid after 30 days, there will be a $10 billing charge added each 3-day billing cycle until the balance is completely paid. Any balance left unpaid for 90 days, without attempts at resolution, will be considered delinquent and may be submitted to a collection agency. If you are having a financial hardship. Please speak with the billing office, and we will make every effort to set up an acceptable payment plan with you. Should it become necessary for us to use an outside agency to collect payment, you will be additionally responsible for whatever charges we may incur. Submission of your account to a collection agency may adversely affect your credit rating.

WE DO NOT PARTICIPATE WITH ANY VISION PLANS
WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____

Responsible Party's Signature: _____ Date: _____

Print Name: _____ Relationship: _____

WOODCLIFF LAKE OPHTHALMOLOGY, LLP.

LAST NAME:_____FIRST:_____ MI_____

Address:_____ APT:_____

City:_____ State:_____ Zip code:_____

Home Phone: ( )_____ Work Phone: ( )_____

Cell: ( ) _____ Email:_____

Preferred Method of Contact (Circle one): HOME WORK CELL EMAIL

Date of Birth: _____/_____/_____ Age: _____ SS#:_____

Marital Status (circle): Single Married Divorced Widowed

Referring Physician Name:_____

Employment: Occupation: _____

Employer Name and Address: _____

If under 18, please complete:
Responsible Party Last Name:_____ First Name:_____

Address:_____City:_____ State:_____Zip Code:_____

Home:_____Cell:_____EMAIL:_____

Are you a fulltime student? YES NO Name of School:_____State:_____

If you are married, please complete spouse information:

Spouse Name: _____DOB:____/_____/_____ SS#_____

Employer Name and Address:_____

Spouse Work Phone: ( ) _____ Cell:_____

Primary Care Physician:_____ Telephone:_____

Pharmacy Name:_____Phone:_____ City:_____ZIP:_____

Insurance Information:

Name of Insurance:_____ Member ID:_____

Guarantor:_____DOB:_____Relationship:_____

Reason for office visit: □ Routine Eye Exam □ Need New Glasses □ Medical or Surgical Problem
□ Interested in Contact Lenses □ Referred by Medical Physician

Emergency Contact Information

Name: _____ Phone No. ( ) _____ - _____

Address: _____ Relationship: _____

Review of Systems:

Please check off if you have:

__Blurred vision

__Loss of vision

__Reduced side vision

__Flashes of light

__Floaters

__Abnormal sensitivity to light

__Halos around the eye

__Problems with glare

__Foreign body sensation

__Eye irritation

__Eye dryness

__Eye itching

__Pressure in or around the eye

__Tearing

__Discharge

__Crusting or red eyelids

__Double vision

__Headache

__Sandy or gritty eyes

__Night vision deficiency

__Tired eyes

__Swelling

__Recurrent infection

__Inability to wear contact lenses

Past Medical History:

Please check off if you ever had:

__Eye surgery

__Eye injury

__Serious eye infection

__Lazy eye

__Eye turning in or out

__Droopy eyelid

__Corneal disease

__Cataract

__Retinal disorder

ENT:

__Sinusitis

__Ringing in ears

Neurological disease:

__Headaches

__Migraines

__ **Psychiatric:**

__ **Endocrine:**

__ **Heart:**

__ **Abdominal:**

__ **Hematologic:** *(bleeding clotting difficulty)*

__ **Vascular:**

__ **Musculoskeletal:**

__ **GYN:**

__ **Genitourinary:** *(Bladder/kidneys)*

__ **Other:**

Social History

Do you drink? __Yes __No If yes, how much? _____

Do you smoke? __ Yes __No If yes, how much? _____

Present Medications: dosage and frequency

_____ _____ _____

_____ _____ _____

Allergies to Medications:

_____

Medical History:

Medical Conditions: (Please circle any that apply): Diabetes, Hypothyroidism, Coronary Artery Disease, High Blood Pressure, High Cholesterol, Asthma, Allergies, Cancer, OTHER: _____

Ocular History:

Do you drive? □ Yes □ No **Do you have difficulty with distance or near vision?** □Yes □No

Do you wear glasses? □ Yes □ No **If yes, how old is your current pair?**_____

If yes, what type? Distance Reading Bifocal Progressive Trifocal Half

Do you wear contact lenses? □ Yes □ No **If yes, how old is your current pair?**_____

What type of contacts do you wear? SOFT RGP Toric Multifocal Dailies Extend Wear

Do you sleep in your lenses? □ Yes □ No **Cleaning solution:**_____

Brand of contact lenses:_____

	RIGHT EYE	LEFT EYE
Present Prescription:	_____	_____
Base Curve (B.C.):	_____	_____
Diameter (DIA.):	_____	_____

Family History

□ **Cataracts. Who:**_____
□ **Macular Degeneration. Who:**_____
□ **Diabetes. Who:**_____
□ **Blindness. Who:**_____
□ **Glaucoma. Who:**_____
□ **Retinal Detachment. Who:**_____
□ **Lazy Eye. Who:**_____
□ **Crossed Eye. Who:**_____

SIGNATURE RELEASE: I HAVE READ THE OFFICE POLICY AND I UNDERSTAND THAT, REGARDLESS OF MY INSURANCE STATUS, I AM RESPONSIBLE FOR PROFESSIONAL SERVICES RENDERED TO ME OR MY DEPENDENT. I AUTHORIZE YOU TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY FOR THE PURPOSE OF PROCESSING CLAIMS. I UNDERSTAND THAT THIS IS MY RESPONSIBILITY TO BE FAMILIAR WITH MY INSURANCE COMPANY POLICIES.

I UNDERSTAND THAT MEDICARE AND OTHER INSURANCE COMPANIES MAY CONSIDER A ROUTINE EYE EXAM AND REFRACTION (PROCEDURE DONE BY THE DOCTOR TO CHECK YOUR PRESCRIPTION) AS NON-COVERED PROCEDURES. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR THESE PROCEDURES AT TODAY'S VISIT.

PATIENT SIGNATURE:_____ **DATE:**_____

DOCTOR'S SIGNATURE:_____ **DATE:**_____

WOODCLIFF LAKE OPHTHALMOLOGY, LLP.

MARY MENDELSOHN, MD, FAAO
Comprehensive Eye Care & Medical Retina
Diabetic Eye Care & Laser Eye Surgery

ALYSON G. YASHAR, MD, FAAO
Comprehensive Eye Care, Cataract Surgery,
Botox, Lid Surgery & Neuro-Ophthalmology

ANNE MARIE ALINO, MD, FAAO
Comprehensive Eye Care, Cataracts,
Glaucoma, Macular Degeneration

NO SHOW, RESCHEDULE & CANCELLATION POLICY

Woodcliff Lake Ophthalmology enforces a formal policy regarding patients that do not show up for their scheduled appointments ("no show"), patients who call to cancel their appointment less than 24 hours prior to their appointment time ("late cancellations") or patients that call to reschedule their appointment less than 24 hours prior to the appointment time ("late rescheduled appointments").

We hereby notify and reserve the right to charge a fee to our patients who are "no shows", "late cancellations" or "late reschedules" with less than a 24 hour notice according to the following fee schedule:

First occurrence:	Patient will be charged a $25.00 fee.
Second occurrence:	Patient will be charged a $35.00 fee.
Third occurrence:	Patient will be charged a $50.00 fee.

PATIENT MAY BE CHARGED A FULL PRICE OF THE SCHEDULED OFFICE VISIT FOR ANY ADDITIONAL NO SHOW, LATE CANCELLATION OR LATE RESCHEDULED APPOINTMENT AFTER THE THIRD OCCURRENCE.

If you have any questions pertaining to this policy, please contact our billing office from Monday – Friday, from 9:00 a.m. to 5:00 p.m. 201-782-1700.

Patient Name DOB

Signature Date Witnessed