Patient Information

PERSONAL INFORMATION (Please Print)

Name ____ Date _________________

Date of Birth ______________ Age ______☐ M / ☐ F Social Security last 4 digits ___________

Address ____

Street Apt# City State Zip

Phone: Home (____) __________ Work (____) ___________ Mobile (____) _______________

Email _____________________ Occupation ____________________________________

Employer ___________________ Address: _____________________________________

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Widowed ☐ Divorced

Spouse/Partner Name _______________________ Spouse/Partner Phone (____) ______________

Employer ____

Referred by: ☐ Friend/Relative _____________________ ☐ Doctor ______________________

Name Name

☐ Other _________________________

Pharmacy Name: ____________________ **Address:** ________________ **Phone:** _______________

Complete if under 18 years or a student

Parent _____________________________ Employer ____________________________

Address ____ Phone (____) _______________

Parent _____________________________ Employer ____________________________

Address ____ Phone (____) _______________

INSURANCE INFORMATION

☐ Medical Insurance ____

ID# _____________________________ Group #______________________________

☐ Medicare #__________________________ Secondary Insurance __________________

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____________________________ Relationship ______________ DOB ___________

Who to notify in emergency.

Name ______________________________________ Relationship _______________________

Address ____

Street City State Zip

Home Phone (____) __________________ Work Phone (____) _________________________

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to Dr. Hilla Steinberg and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _________________________________ Date ________________

MEDICAL HISTORY QUESTIONNAIRE

NAME: ____ **DATE:** _______________

Date of **last eye exam** ____

List any **medications** you currently take (prescription and over the counter): ____________________

____

Do you have allergies to any medications? **YES** **NO**

If YES, list the medications: ____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): ____

List any surgeries you have had (cataract, tonsillectomy, appendectomy): ______________________

	YES	NO	DETAILS
GENERAL / CONSTITUTIONAL (fever, weight loss, other) RECENT			
EARS, NOSE, THROAT (stuffy nose, earache, cough, dry mouth, etc.) RECENT			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.) RECENT			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.) RECENT			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY **M** = mother **F** = father **S** = sibling **GP** = grandparent

Disease	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Hypertension			

Heart Disease			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: ______________________

Do you drive?	YES	NO	
Do you have visual difficulty when driving?	YES	NO	
Do you have problems with night vision?	YES	NO	
Have you ever tried to wear contact lenses?	YES	NO	
Do you currently wear contact lenses?	YES	NO	If YES, how long? ___________________
Do you currently wear glasses?	YES	NO	If YES, how long have you had your current prescription? ___________________________

Do you drink alcohol?	YES	NO	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	YES	NO	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Are you interested in consulting on the following **skin rejuvenation** procedures?

Botox (erase lines and wrinkles) Yes _____ No _____

Botox (underarm treatment to finally get
rid of sweaty armpits-for teenagers and adults!) Yes_____ No______

Juvederm Filler (smooth wrinkles and folds) Yes _____ No _____

Opus Plasma skin Resurfacing treatment Yes_____ No_____
(Improves texture, tightens and tones
Target area: Face, Neck, Chest, Hands)

Kybella (FDA approved injectable treatment Yes _____ No _____
used to improve the appearance and profile
of moderate to severe fat below the chin).

Dr. Hilla Steinberg's Signature: ____________________ Date: ____________

Acknowledgement of Receipt of Privacy Notice

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may not be used and disclosed by the facility listed at the beginning of this notice, and how I may obtain access to and control this information.

For **PATIENT** to **COMPLETE**:

Patient Name: ____

Signature of Patient: ____________________________________Date: ______________

If Applicable, Personal Representative's Name: ________________________________

Description of Personal Representative's Authority: ____________________________

Signature of Personal Representative: _________________________Date: ___________

For **OFFICE** to **COMPLETE:**

I have been given the Notice of Privacy Practices to the Patient, and the Patient:
[ ] Signed
[ ] Refused to sign
[ ] Was unable to sign because ____

Dr. Hilla Steinberg's Representative:

Signature: ____

Date: ____

Assignment of Benefits and Release of Billing Information Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Hilla Steinberg medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Hilla Steinberg to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Dr. Hilla Steinberg on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Referral

I also understand and acknowledge that attaining referral is the responsibility of the patient. If required by my plan, I understand that it is my responsibility to obtain the referral from my Primary Care Physician and present prior to my visit. Referrals must be provided before appointment or I may not be seen or I may pay for service in full and submit claim to my carrier.
If a claim is denied due to missing invalid referral, I am responsible for a $300 claim denial administration fee and any applicable charges for services/treatment.

________________________________ ________________________

Patient/Responsible Party Signature Date

____
(Patient's full name)

CONTACT LENS SERVICES AND FEES

Contact Lens Fittings:

There is a **$195.00 fee** for spherical contact lens update fitting, **$375.00 fee** for astigmatism contact lens update fitting, and **$400** for multifocal and mono-vision contact lens update fitting. Please be aware that this fee is **collected at the time of service**. The **fee varies** from the type of contact lens update fitting that is required. If you are not satisfied with the fit, you have 30 days to notify the practice and be refitted.

Patient Acknowledgement

I have read the above information and understand that contact lens prescription update exam is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in contact lens prescription update fee.

____ __________________
Patient Signature (or Parent for Minor) Date

NO SHOW FEE

I have been notified that if I do not show up for the scheduled appointment or the appointment is cancelled less than 24 hours before my scheduled visit, I will be charge **$110 fee**.

____ __________________
Patient Signature (or Parent for Minor) Date

CREDIT CARD ON FILE POLICY

At Hilla Steinberg MD, we require keeping your credit or debit card on file as a method of payment for delinquent balance but for which you are liable. You may choose to either:

1. **Complete this form.**
2. **Allow us to store a credit card in the system.**
3. **OR: Cover the cost of the exam as a self-pay patient ($425 plus the cost of the diagnostic tests if performed). The claim than will be filled with your insurance. Once your health plan covers the cost of the visit, you will be refunded**.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Hilla Steinberg MD to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard

Credit Card Number ____

Expiration Date _____ / _____ Security code ___________

Cardholder Name ____

Signature ____

Billing Address ____

City _____________________ State_______ Zip ___________

I, the undersigned, authorize and request Hilla Steinberg MD to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Hilla Steinberg MD.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a notification to Hilla Steinberg MD in writing and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: ___________________________________ Date: _____ / _____ / _____

REFRACTION EXAMINATION

Dear Patient:

Medicare and many insurance carriers require the refraction portion of our examination fee to be billed separately from the medical portion. Medicare and most other health insurance carriers will not cover this fee because they consider the refraction a **"ROUTINE NON-COVERED SERVICE"**. In most instances, the cost of this must be paid for by our patients.

If your health insurance has a clause to cover routine eye care, this refraction fee will be covered. Please check with your insurance carrier.

The fee for this refraction portion of your examination is **$105.00** and includes the following:

1. Measurement of your vision with your current prescription.
2. Computerized Automated Refraction if needed.
3. Quantitative measurement of the best prescription to give you the most accurate and comfortable vision possible. (REFRACTION)
4. Determination of your distance, and when appropriate, near vision with the newly measured prescription.
5. When requested, a written prescription for glasses for your use or records.

This entire procedure is necessary to judge if new glasses are to be prescribed or if your current prescription still serves you well. We hope this helps to clarify any questions you may have.

Print patient's name: ____

Patient Signature: ______________________________________ Date:________________________