GENTILE RETINA

WORLD CLASS VISION & EYE CARE

Patient Information

First Name: Last Name:

Sex: Female / Male Date of Birth: Social Security #:

Street Address: Email Address:

City: State: Zip:

Home #: Work #: Cell #:

Emergency Contact: Relationship: Phone #:

Referring Physician: Primary Care Doctor:

Race: American Indian Asian African American Hispanic White Other:

Preferred Language: Marital Status: Single / Married / Widowed

Insurance Information

Primary Insurance:

Employer Name: Occupation:

Employer Address:

Policy ID #: Group #: Effective Date:

Policy Holders Name: Relationship to Patient:

Street Address:

City: State: Zip:

Sex: Female / Male Date of Birth:

Secondary Insurance:

Policy ID #: Group #: Effective Date:

Policy Holders Name: Relationship to Patient:

Street Address:

City: State: Zip:

Sex: Female / Male Date of Birth:

Signature: Date:

GENTILE RETINA
WORLD CLASS VISION & EYE CARE

Financial Policy Statement

Welcome to Gentile Retina. Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality service available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient or responsible party. You will be responsible for any balances not covered by your insurance.

Patient Signature: Date:

Authorizations and Assignments

Release of Information:
In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all the information and documentation regarding the services rendered to me by the Physicians which may be required for my insurer to reevaluate its decision to deny payment for such services.

Medicare- Release of Information and Assignment of Benefits (Medicare only-Part B Providers)
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

Insurance Network/Provider Notice Pursuant to NYS "Out of Network" Law
I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate, can be provided to me upon request, and may be posted in the office. I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though they may be employed by, contracted by, or affiliated with Mount Sinai Health System hospitals or facilities. I understand that I can determine the health plans participated in by physicians who are employed by, are contracted by, or are affiliated with Mount Sinai Health System hospitals or facilities by visiting http://www.mountsinai.org/patient-care/find-a-doctor . I also understand that I can determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting those facilities' web portals at www.mountsinaihealth.org/insuranceinfo I understand that laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services provided in connection with my care may not be billed by the Physicians, and may be billed separately by the laboratories/facilities/providers who provide those services (even if those services are provided by Mount Sinai Health System facilities, laboratories, or providers). I further understand that laboratories/facilities/providers who provide laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services may or may not be participating providers in my health care plan network, that I can obtain the contact information for any such laboratories/facilities/providers whose services may be needed in connection with my care from the Physicians, and that I can contact those laboratories/facilities/providers directly to obtain information regarding their health plan participation. I understand that if I elect or choose to obtain services from a provider who I know or who has been disclosed (in writing, on a website, and/or at the time my appointment was made) as not participating in my health plan network, I will be responsible for any and all charges billed by that provider to me. I further understand that if the Physicians do not participate in or with my health plan and/or network, the amount or estimated amount that the Physicians will bill for healthcare services can be made available to me in advance, upon request.

HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

Patient Signature: Date:

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Gout
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Hepatitis
- ❑ Stomach ulcers
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PAST SOCIAL HISTORY

❑ Never Smoked ❑ Former Smoker ❑ Current Smoker ❑ Every day Smoker ❑ Someday Smoker

❑ Never Drinks Alcohol ❑ Drinks Alcohol Socially

❑ History of Substance Abuse ❑ No History of Substance Abuse

FAMILY HISTORY

- ❑ Diabetes
- ❑ Macular Degeneration
- ❑ Cancer
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Cataract
- ❑ Glaucoma
- ❑ Retinal Detachment
- ❑ Blindness

PAST SURGICAL HISTORY

CURRENT EYE CONDITIONS

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug
Name of eye drops

Pharmacy Name: _____ **Phone:** _____

GENTILE RETINA
WORLD CLASS VISION & EYE CARE

HIPAA Notice of Privacy Practices

Privacy Consent

I understand that Gentile Retina, "Notice of Privacy Practices" provides how my health information will be used and disclosed. The "Patient Rights" section describes my rights under the law. I have the right to review the notice before signing this consent. I understand that this notice may change and that I can request a revised copy.

I understand that I have the right to request that we restrict how protected health information about me is disclosed for treatment, payment, or health care operations. I understand that Gentile Retina, is not required to agree to this restriction, but you will honor this agreement.

I acknowledge by signing this form I consent to your use and disclosure to protect health information about my treatment, payment, and health care operations. I have the right to revoke this consent in writing with my signature. However, this revocation shall not affect any disclosures Gentile Retina has already made in reliance prior to my consent. Gentile Retina provides this form to me to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Consent to Release Information

I acknowledge that by signing this form, I permit Gentile Retina, to release any information to the physician involved in my care. I consent that Gentile Retina, may call my house or designate locations and leave a message on voice mail or in person in reference to my appointment reminders and insurance items. In addition, Gentile Retina, may mail to my home appointment reminders and patient statements. I designate the following representative(s) who Gentile Retina can communicate with me on my behalf. If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.

Patient Name_____

Patient Signature_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____