LIOC LONG ISLAND OPHTHALMIC CONCEPTS
TRANSFORMING EYECARE

BELLMORE	GREAT NECK	HUNTINGTON	LITTLE NECK
2450 Merrick Road	560 Northern Boulevard	158 Main Street	54-44 Little Neck Pkwy
Bellmore, NY 11710	Great Neck, NY 11020	Huntington, NY 11743	Little Neck, NY 11362

PATIENT REGISTRATION

PATIENT NAME: _____ DATE: _____
Last First Middle

ADDRESS: _____
Street City State Zip Code

SS #: _____ DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE MARRIAGE STATUS:_____

HOME PHONE #: _____ BUSINESS PHONE #: _____CELL #_____

EMAIL: _____

RACE: ☐ Native American ☐ Asian ☐ African American ☐ Caucasian ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

OCCUPATION: _____ EMPLOYER'S NAME: _____

Pharmacy:_____

NATURE OF COMPLAINT: _____ **DATE OF ONSET**: _____

NAME, ADDRESS, TEL # OF PRIMARY PHYSICIAN: _____

_____

WHO REFERRED YOU TO OUR OFFICE? _____

IN CASE OF EMERGENCY PLEASE NOTIFY: _____ PHONE: _____Relationship:_____

MOTHER'S NAME: _____ FATHER'S NAME: _____

NAME OF INSURANCE_____POLICY HOLDER NAME_____

POLICY ID #: _____ GROUP #: _____ PLAN #: _____

POLICY HOLDER SS # _____ DATE OF BIRTH: _____RELATIONSHIP:_____

INSURANCE SECONDARY

NAME OF INSURANCE_____POLICY HOLDER NAME_____

POLICY ID #: _____ GROUP #: _____ PLAN #: _____

POLICY HOLDER SS # _____ DATE OF BIRTH: _____RELATIONSHIP:_____

IF AUTO RELATED: FILE # _____ WRITTEN REPORT FILED? _____

IF WORK RELATED: CARR. CASE # _____ WCB # _____

INSURANCE PAYMENT ORDER:

I authorize my insurance company to pay directly to George Tung, MD, all benefits due to me. This policy was in full force and effect at the time of treatment. I understand that I am financially responsible for all balances remaining after payment of possible insurance benefits and that, should it become necessary, any and all reasonable collection/attorney fees will be added to the patient's bill. I permit a copy of this authorization to be used in place of the original.

Legal Signature_____ Date_____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize George Tung, MD, to furnish information to my insurance carriers and to other physicians who may become involved in my care, concerning illness and treatments received by me. I permit a copy of this authorization to be used in place of the original.

Legal Signature_____ Date_____

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New Patient Medical History Questionnaire

revised 07/21/2017

George Tung, MD

☐ 2450 Merrick Rd, Bellmore, NY 11710
☐ 560 Northern Blvd, Great Neck, NY 11020
☐ 158 Main St, Huntington, NY 11743
☐ 54-44 Little Neck Pkwy #3, Little Neck, NY 11362

Name _____ Date _____

Date of birth _____ Name of primary care physician _____

Date of last eye exam _____ Date of last medical exam _____

Have you seen an ophthalmologist before? ☐ yes, date of last visit _____ ☐ no

Name of ophthalmologist seen _____

Current medications (list all prescribed and over-the-counter medications you are now taking and their dosages, including eye drops, birth control pills, diuretics or water pills, blood pressure or heart medications) _____

Please circle any of the following you are currently taking: **High risk medication that require Visual Fields:** plaquenil, Topamax, epilepsy meds, amiodarone, flomax, tamoxifen, prednisone, interferon, viagra

Do you have allergies to any medications: ☐ yes ☐ no Are you allergic to Latex? ☐ yes ☐ no

If YES, list the medications: _____

List all major illnesses (glaucoma, diabetes, blood pressure, heart attack, stent placement, etc.) or injuries (concussion, etc.): _____

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

Have you ever been diagnosed with cancer? ☐ yes ☐ no Dates of diagnosis and treatment received: _____

Do you currently have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (glaucoma, cataract, retinal disease)	☐	☐	
Loss of vision	☐	☐	
Blurred vision	☐	☐	
Fluctuating vision	☐	☐	
Distorted vision (halos)	☐	☐	
Loss of side vision	☐	☐	
Double vision	☐	☐	
Dryness	☐	☐	
Mucous discharge	☐	☐	
Redness/Swollen	☐	☐	
Sandy or gritty feeling	☐	☐	
Itching	☐	☐	
Burning	☐	☐	
Foreign body sensation	☐	☐	
Excess tearing/watering	☐	☐	
Glare/light-sensitivity	☐	☐	
Eye pain or soreness	☐	☐	
Infection of eye or lid (blepharitis, stye)	☐	☐	
Tired eyes	☐	☐	
Crossed eyes, lazy eye	☐	☐	

(over) (over) (over) (over)

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Medical History Questionnaire (page 2)

GEORGE TUNG, MD
2450 Merrick Rd, Bellmore, NY 11710
560 Northern Blvd, Great Neck, NY 11020
158 Main St, Huntington, NY 11743
54-44 Little Neck Pkwy #3, Little Neck, NY 11362

Name

	YES	NO	Explanation of Problem
EARS, NOSE, THROAT (sinus, ear infection, chronic cough, dry mouth)			
CARDIOVASCULAR (heart, vessels)			
RESPIRATORY (asthma, emphysema)			
GASTROINTETINAL (stomach ulcers)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (arthritis)			
SKIN (acne, rosacea, skin cancer)			
NEUROLOGICAL (headaches)			
PSYCHIATRIC (stress, anxiety, depression)			
ENDOCRINE (diabetes, thyroid)			
BLOOD, LYMPH (anemia)			
ALLERGIC, IMMUNOLOGIC (hay fever)			

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

	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation _____

Education (high school, vocational school, college degree) _____

Marital Status (married, divorced, single, widowed) _____

Living Arrangements _____

Do you drive? ☐ yes ☐ no

Do you have visual difficulty when driving? ☐ yes ☐ no

Do you have problems with night vision? ☐ yes ☐ no

Do you wear eyeglasses? ☐ yes ☐ no

When was last Rx filled? _____ Where made? _____

Do you wear contact lenses? ☐ yes ☐ no If YES, hard ☐ soft ☐ daily ☐ extended ☐

How long have you worn contact lenses? _____ What brand do you wear? _____

Where do you get your contact lenses from? _____ _____

Do you drink alcohol? ☐ yes ☐ no If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? ☐ yes ☐ no If YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

Signature of Patient or Other (if other, please indicate relation) MD initials

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BELLMORE
2450 Merrick Road
Bellmore, NY 11710
(516) 783-0300

GREAT NECK
560 Northern Boulevard
Great Neck, NY 11020
(516) 504-2020

HUNTINGTON
158 Main Street
Huntington, NY 11743
(631) 427-1690

LITTLE NECK
54-44 Little Neck Pkwy
Little Neck, NY 11362
(718) 428-9393

Refraction

(Prescription for eye glasses)

To provide you with a comprehensive and complete exam, refraction is a necessary part of an ophthalmic examination. **Refraction is the prescription for eye glasses**. The fee for this diagnostic service is $90 and is **due at time of visit**. Unfortunately, Medicare and most commercial insurance carriers do not deem this service medically necessary and, therefore, consider it a non-covered service. Therefore, the financial responsibility falls upon you. The fee will only apply if performed.

I have read the above and agree that if a refraction is performed, I am financially responsible for this service. Do you wish to get the refraction performed today?

☐ Yes ☐ No ☐ Not Sure

X_____ _____

Patient Signature Date

Revised 5/15/18

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, as well as mail a reminder post card regarding an upcoming appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature: _____Date_____

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FINANCIAL POLICY

Dear Patients:

Thank you for choosing our Practice to provide your ophthalmologic needs. We will do our best to provide you with the finest possible medical care and attentive patient services. In order to prevent any misunderstanding concerning the responsibility of payment for medical and surgical care, the following information is necessary for you to read and understand prior to being seen.

The patient or the guarantor is responsible for payment at the time services are rendered. The only exception is if our doctor is a participating provider. In this case, we will accept the insurance payment as payment in full ONLY after all deductibles have been met and all co-pays and coinsurance have been paid.

If your insurance carrier requires a referral from your primary care physician, the referral must be presented prior to being seen by the doctor. Failure to provide all the necessary information may require you to reschedule your appointment. It is your responsibility to keep track of the referral expiration date and the number of visits given by your primary care physician.

MEDICARE: Dr. Tung is a Medicare Participating provider. Medicare will pay 80% of the approved charges AFTER YOUR YEARLY DEDUCTIBLE HAS BEEN MET. According to Federal Law, You are required to pay your deductible and the 20% balance if you do not have a secondary insurance carrier that will cover this cost.

HMO/PPO COVERAGE: If you have insurance through a company that our doctor has contracted with, we will require a copy of your insurance card, and **payment of any copays are due at the time of service.**

NON COVERED SERVICES: Some services we render may not be covered by your insurance carrier. Your signature below indicates that you have advised our doctor to proceed with the service and that you assume full responsibility for payment. These services may include (but are not limited to), contact lenses, refractions which may be needed to determine if any medical, optical or surgical treatment may be needed.

I HAVE READ THE ABOVE AND AGREE THAT I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES.

_____ _____

Signature of Patient or Guarantor Date

_____ _____

Signature or Responsibility Party (Guardian/Parent) Date