Todd O. Leventhal, M.D.

BERKELEY HEIGHTS EYE GROUP
571 Central Avenue, Suite 101
New Providence, NJ 07974
Phone: (908) 464 - 4600 ■ Fax: (908) 464 – 4737
www.berkeleyheightseye.md

Patient Information: **Date:** _____

Name: _____ Date of Birth: _____

Mr. __ Mrs. __ Ms. __ Gender: _____ Social Security No.: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Would you like to receive text messages? **Y / N**

Would you like to register for our patient portal? **Y / N**

May we leave messages on number(s) listed above? **Y / N**

Email address: _____

Language: _____

Insurance Information:

Primary Insurance: _____

Member/Subscriber ID: _____ Group Number: _____

Secondary Insurance: _____

Member/Subscriber ID: _____ Group Number: _____

VISION Insurance **(CIRCLE ONE):** 1. VSP 2. EyeMed (excluding Aetna) 3. Spectera (UHC)

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Individual(s) to be contacted IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PRIMARY MEDICAL CARE PHYSICIAN: **Does not apply:** ____

Name: _____ Telephone No.: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Fax No.: _____

PREFERRED LOCAL PHARMACY AND/OR MAIL ORDER PHARMACY:

Name: _____ Telephone No.: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Fax No.: _____

Allergies & their reactions: *No Known Drug Allergies:* ____

_____

Medication(s): *See Attached List Provided:* ____

_____

_____

_____

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Medicare Patients Only (PLEASE READ & SIGN BELOW):

"I request that payment of authorized Medicare benefits to be made either to myself or on my behalf of the Berkeley Heights Eye Group, P.A., for services rendered to me by the physician or supplier. I authorize any holder of medical information about me to be released to the healthcare financing administration and its agents with any information needed to determine these benefits or the benefits payable for related services."

Signature: _____ Date: _____

All Patients (PLEASE READ & SIGN BELOW):

"I request that payment of authorized medical benefits to be made either to myself or on my behalf of the Berkeley Heights Eye Group, P.A., for services rendered to me by the physician or supplier. I authorize any holder of medical information about me to be released to the healthcare financing administration and its agents with any information needed to determine these benefits or the benefits payable for related services."

Signature: _____ Date: _____

Notice of Privacy Practices Consent Form (PLEASE READ & SIGN BELOW):

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

HIPPA Privacy Consent Form (PLEASE READ & SIGN BELOW):

The following individual(s) are people with whom we are able to discuss anything related to your medical care:

Name: _____ Telephone Number: _____

Relationship to you: _____

Name: _____ Telephone Number: _____

Relationship to you: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

The Berkeley Heights Eye Group, PA., would like all patients to understand that while our staff will be helping with collections from insurance carrier(s) and other sources, it is ultimately the patient's financial responsibility for service(s) rendered unless previous arrangements have been made.

Signature: _____ Date: _____

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Refraction Policy

One of the most important parts of your eye exam today is the refraction. The refraction exam is the part of the exam by which we determine whether you can be helped in anyway by a new set of glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess the health of your eyes and look out for new/existing problems.

The refraction is a NON-COVERED SERVICE by Medicare and many other insurance plans.

These plans consider refraction as a "Vision" service, not a "Medical" service. Our office fee for the refraction is $50.00. If after submission of the medical claim to your insurance plan(s) does not cover the service rendered, then you will be billed.

I ACCEPT:

Signature: _____ Date: _____

I DECLINE:

Signature: _____ Date: _____

For All Contact Lens Wearers:

Ongoing use of contact lenses requires an annual examination of your eyes to ensure that your eye is healthy enough to continue wearing contact lenses. This assessment is a non – covered service. This is referred to as a contact lens exam fee, which is $60 dollars. This is separate from the refraction and the remainder of your eye examination. In some specific instances, some vision plans allow you to use some of your annual benefit(s) to pay for the contact lens exam fee. The office will submit the fee in these cases.

I ACCEPT:

Signature: _____ Date: _____