Todd O. Leventhal, M.D.
Berkeley Heights Eye Group
571 Central Ave, Suite 101
New Providence, NJ 07924
Ph: 908-464-4600
Fax: 908-464-4737
www.berkeleyheightseye.md

Patient Information

Last Name:	**First Name:**	**Circle One:** Mr./Mrs./Ms.
DOB:	**SSN:**	**Gender:**
Address:		**Apt:**
City:	**State:**	**Zip Code:**
Home Ph:	**Mobile Phone:**	
Email Address*:		

Please circle one for each of the questions below:

May we call and leave messages at any of the phone numbers listed above? Home / Mobile / No

May we text your mobile number listed above? Yes / No / Not Applicable

Would you like an invite to register for our Patient Portal? *(*email required*) Yes / No

Insurance Information

(Please hand your insurance cards to the front desk at the time of your visit.)

Primary Insurance:	**Policy Holder: Self / Other:**
Member ID:	**Group Number:**
Secondary Insurance:	**Policy Holder: Self / Other:**
Member ID:	**Group Number:**

Vision Insurance(circle one): VSP / Spectera	**Member ID *or* SSN:**

Emergency Contact

Name:	**Relationship to Patient:**
Home Ph:	**Mobile Ph:**

Primary Care Physician

Name:	**Ph:**
Full Address:	**Zip Code:**

Preferred Local/Mail Order Pharmacy

Name:	**Ph:**
Full Address:	**Zip Code:**

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Refractions and Contact Lens Examination Policy

****If you would like to opt out of a refraction or contact lens examination, please let the technicians know before the start of your comprehensive visit.****

The refraction test, also known as a vision test, is an examination which tests the patient's ability to see an object at a specific distance. The test involves looking through a device, a phoropter, to read letters or recognize symbols on a wall chart through lenses of differing strength, which are contained within the device. A refraction is performed as part of a routine eye exam which will help determine whether a patient needs a prescription for eyeglasses or contact lenses.

Medicare considers this a routine test and, therefore, does not approve it as a covered medical service. Unfortunately, since Medicare doesn't cover it, many commercial insurance companies follow suit and also consider it a non-covered service. Our office fee for a refraction is **$50.00**. In some specific instances, vision insurance plans will allow you to use your benefit(s) to pay for the refraction fee. If this applies, our office will submit the fee on your behalf. If after the submission of the claim, your insurance does not cover the service provided, you will be billed.

I ACCEPT:

Signature: _____ Date: _____

I DECLINE:

Signature: _____ Date: _____

If you are either a regular contact lens wearer, or you decide to opt for contact lens wear, it is very important that the lenses fit properly and comfortably and that you understand proper contact lens safety and hygiene. A contact lens exam will include both a comprehensive eye exam to check your overall eye health and a contact lens consultation and measurement to determine the proper lens fit.

This examination, like a refraction, is not recognized by Medicare, and many commercial insurances, as a medical service. Our office fee for a contact lens exam is **$60.00**. In some specific instances, vision insurance plans will allow you to use your annual benefit(s) to pay for the contact lens exam fee. If this applies, our office will submit the fee on your behalf. If after the submission of the claim, your insurance does not cover the service provided, you will be billed.

I ACCEPT:

Signature: _____ Date: _____

I DECLINE:

Signature: _____ Date: _____

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Please read each section below and sign where applicable.

ALL PATIENTS:

"I request that all payments of authorized medical benefits be made either directly to myself or on my behalf to *Berkeley Heights Eye Group, P.A.* for services provided to me by the physician or supplier. I authorize the release of any relevant personal medical information to the healthcare financing administration and associated agents, should the information be needed to determine benefits or the benefits payable for related services."

Signature: _____ Date: _____

MEDICARE PATIENTS ONLY:

"I request that all payments of authorized Medicare benefits be made either directly to myself, or on my behalf to *Berkeley Heights Eye Group, P.A.,* for services provided to me by the physician or supplier. I authorize the release of any relevant personal medical information to the healthcare financing administration and associated agents, should the information be needed to determine benefits or the benefits payable for related services."

Signature: _____ Date: _____

COLLECTIONS POLICY:

Berkeley Heights Eye Group, P.A. would like all patients to understand and acknowledge that while our staff will be diligent in the help of collections from insurance carrier(s) and other sources, it is ultimately the patient's financial responsibility for service(s) rendered unless arrangements have been previously discussed and arranged.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES: (PRINT FIRST AND LAST NAME ON THE LINE)

I, _____, have read and acknowledged the office's *Notice of Privacy Practices*, posted at the front desk, and consent to the stated terms and conditions.

HIPAA PRIVACY CONSENT:

The following individual(s) are people with whom we, *Berkeley Heights Eye Group, P.A.,* have permission to discuss anything related to your medical treatment and care:

Full Name:	
Ph:	**Relationship to Patient:**
Full Name:	
Ph:	**Relationship to Patient:**

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____