EYENAMICS NY

ROBERT ROTHSTEIN, M.D.
Ophthalmologist

KIM STAIMAN ROTHSTEIN, O.D.
Optometrist

110-45 Queens Blvd, Suite AA, Forest Hills, New York 11375
Phone (718) 261-2727 • Fax (718) 261-5302

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____

Date of birth: _____ / _____ / _____ Social Security Number: _____

Gender (check one): **Male: _____ Female: _____**

Address: _____

Apt#: _____ City: _____ State: _____ Zip Code: _____

Home phone number: (_____) _____ - _____ Cell phone number: (_____) _____ - _____

Email address: _____

Marital Status (check the one that applies):

Single: _____ Married: _____ Divorced(a): _____ Separated(a): _____Other: _____

Patient Employers: _____

Occupation: _____ Phone: _____

How did you hear about our office? _____

Referred by a doctor? (name) _____

Doctor's address: _____ _____

Telephone number (doctor): (_____) _____ - _____

What is the reason for your visit:

_____

Insurance Plan: _____

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Pharmacy information:

Pharmacy name and address: _____

Telephone number (pharmacy): (_____) _____ - _____

Patient's primary care physician information:

Last Name: _____ First Name: _____

Office address: _____

Telephone number (physician): (_____) _____ - _____

IN CASE OF EMERGENCY

Who may we contact in case of an emergency?

Name: _____ Relationship: _____

Telephone number (emergency contact): (_____) _____ - _____

_____

PATIENT DISCLOSURE

The information provided is true to the best of my knowledge. I consent to examination and treatment by the personnel at **EYENAMICS NY.** I authorize my insurance benefits to be paid directly to the physician. I understand that because these services are performed for me. I am financially responsible for the bill and any balance incurred whether or not it is paid by my insurance carried. I am responsible for necessary physician referrals and co-payments at the time of the visit. I also authorize **EYENAMICS NY** to release any information required to process my claims to my insurance carriers or its intermediaries to the Health Care Financing Administration and its agent for Medicare Claims.

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INDIVIDUAL CONSENT

CONSENT TO USE OR DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

PATIENT'S NAME: _____

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain on time your written consent before we treat you, obtain payment for our services, and conduct health care operations of the center. Please read carefully the information below before signing this form.

CONSENT: By signing this consent form, you will permit **EYENAMICS NY** and its staff to use your protected health information for treatment, payment, and normal business operations within the facility. You also permit the facility and its staff to share your information with other persons or organizations outside of the facility that perform payment activities and business operations jointly with the facility.

NOTICE OF PRIVACY PRACTICES: We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail, and we encourage you to read it. We want you to know, however, that the Notice of Privacy Practices is subject to change. If it is changed, you may obtain a copy of the revised notice by calling the office at (718) 261-2727 or asking for a copy on your next visit.

RESTRICTING USE AND DISCLOSURE: You have the right to ask us to restrict the use or disclosure of your protected health information. **EYENAMICS NY** is not required to agree to this restriction, but if it does, it will be bound by this agreement unless the information is needed to provide you with emergency treatment or comply with the law.

REVOKING CONSENT: You have the right to revoke this consent at any time, except to the extent the center has already taken action based upon your consent. For example, if you revoke consent after the center has provided you with treatment, the center will be permitted to use or disclose your protected health information to bill for treatment. To revoke this consent, please write to **EYENAMICS NY.**

By signing this consent form, I hereby authorize **EYENAMICS NY** and its providers to use and disclose my personal health information, as necessary, for the purpose of obtaining medical treatment, facilitating payment for sure treatment, and for normal business operations.

X_____ _____

Patient/Guardian Signature **Date**

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CANCELLATION POLICIES

1. CANCELLATION/NO SHOW POLICY FOR A ROUTINE APPOINTMENT

We understand that there are times when you miss an appointment due to an emergency or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting an appointment.

If an appointment is not canceled at least **24 hours** in advance, you will be charged **forty dollars ($40.00)**; This will not be covered by your insurance company, it will be billed directly to you.

2. CANCELLATION/NO SHOW POLICY FOR SURGERIES

Due to the large block time needed for surgeries and the amount of work that goes into scheduling a surgery, last minute cancellation can cause problems and added expenses for the office.

If surgery is not canceled at least 2 **week** in advance, you will be charged **one hundred fifty dollars ($150.00)**. This will not be covered by your insurance company; it will be billed directly to you.

By signing this consent form, you agree to the cancellation and no-show policies from this office.

X_____ _____

Patient/Guardian Signature **Date**

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REFRACTION FEE

Dear Patients,

Please be advised that all types of refractions are not generally covered by insurance companies, since we **DO NOT ACCEPT VISION PLANS**. There are two forms of refraction, a general refraction and a prism refraction. A general refraction is the determination of one's eyeglasses prescription. The fee for a **GENERAL REFRACTION** is $85.00. A prism refraction is a special type of refraction performed when a patient has double vision. The price for a **PRISM REFRACTION** ranges from $150-$250 depending on the complexity. Most insurance companies **DO NOT** cover these services. Refractions need to be paid in full on the day of the service. By signing this form, you acknowledge that **IF** you opt to have a refraction, you agree to pay the fee on the day of service it is performed.

Thank you.

Please sign below to acknowledge that you are aware of the refraction fee:

PRINT YOUR NAME: _____

SIGN YOUR NAME: _____

TODAY'S DATE: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Dr. Robert Rothstein, 110-45 Queens Blvd, Ste AA, Foret Hills, NY, 11375. PH# 718-26-2727 FAX# 718-261-5302

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ /_____/_____
Referring Doctor: _____Primary Care Physician: _____
Pharmacy & Location: _____
Race: ▢ American Indian or Alaska Native ▢ White ▢ Black or African American
▢ Native Hawaiian or Other Pacific Islander ▢ Asian ▢ Declined to Specify
Ethnicity: ▢ Hispanic or Latino ▢ Not Hispanic or Latino
Language: ▢ English ▢ Spanish ▢ Russian ▢ French

Allergies	Reaction	Severity
_____	_____	Mild/ Moderate/ Severe
_____	_____	Mild/ Moderate/ Severe
_____	_____	Mild/ Moderate/ Severe

PAST OCULAR HISTORY: (Please ONLY select those that apply) **▢ NOT APPLICABLE**

▢ Amblyopia (Lazy Eye) ▢ Diabetic Retinopathy ▢ Iritis/Uveitis
▢Astigmatism ▢ Dry Eye Syndrome ▢ Macular Degeneration
▢Cataracts ▢ Glaucoma ▢ Myopia (Nearsighted)
▢Corneal Disorder ▢ Hyperopia (Farsighted) ▢ Retinal Detachment

OCULAR SURGERIES: (Please ONLY select those that apply) **▢ NOT APPLICABLE**

▢ Blepharoplasty (Lid Surgery) ▢ Glaucoma Surgery ▢ Strabismus (Eye Muscle Surgery)
▢ Cataract Surgery ▢ Laser Retinal Surgery
▢ Refractive Surgery ▢ Vitrectomy ▢ Corneal Transplant
▢ LASIK ▢ Trabeculectomy ▢ YAG Laser Capsulotomy
▢ Punctal Plugs ▢ Other: _____

CURRENT EYE MEDICATIONS (eye drops or tablets/pills for eyes): **▢ NOT APPLICABLE**

_____ _____ _____

_____ _____ _____

OTHER MEDICAL HISTORY: **▢ NOT APPLICABLE**

▢ Anemia ▢ Congestive Heart Failure ▢ Hepatitis
▢ Herpes ▢ Liver Disease ▢ Lupus
▢ Arrhythmia ▢ Rheumatoid Arthritis ▢ Stroke
▢ Asthma ▢ Diabetes (Type 1 or Type 2) ▢ Fibromyalgia
▢ Migraine ▢ High Blood Pressure ▢ Heart Attack
▢ Cancer ▢ Thyroid Disease ▢ Arthritis
▢ High Cholesterol ▢ COPD ▢ Headaches
▢ HIV/AIDS ▢ Multiple Sclerosis ▢ Kidney Disease
▢ Polymyalgia ▢ Hearing Loss ▢ Psychiatric Disorder
▢ Other:_____

GENERAL SURGERIES/PROCEDURES: **▢ NOT APPLICABLE**

_____ _____ _____

ALL OTHER SYSTEMIC MEDICATIONS (please indicate all current medications)

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY (please indicate relationship) ▢ **No History** ▢ **History Unknown**

▢ Blindness ▢ Glaucoma ▢ Cataracts ▢ Macular Degeneration
▢ Heart Disease ▢ Retinal Disease ▢ Cancer ▢ High Blood Pressure
▢ Stroke ▢ Diabetes ▢ Amblyopia ▢ Other: _____

SOCIAL HISTORY (Please ONLY select those that apply)

Smoking: ▢ Daily Smoker ▢ Some Day Smoker ▢ Former Smoker ▢ Never Smoked
Alcohol Use: ▢ Yes ▢ No
If yes, how much and how often? _____
Drug Use: ▢ Yes ▢ No
If yes, which and how long? _____

REVIEW OF SYSTEMS (Please ONLY select all those that apply)

Eyes:
▢ Previous Surgery
▢ Contact Lens
▢ Pain
▢ Double Vision
▢ Glaucoma
▢ Cataracts
▢ Floaters
▢ Flashes
▢ Dry Eyes
▢ Macular Degeneration

Musculo-Skeletal:
▢ Stiffness
▢ Arthritis
▢ Joint Pain/Swelling

Constitutional:
▢ Fatigue/Weakness
▢ Fever
▢ Weight Gain/Loss

Respiratory:
▢ Cough
▢ Congestion
▢ Wheezing
▢ Asthma

Psychiatric:
▢ Anxiety/ Depression
▢ Mood Swings
▢ Difficulty Sleeping

Endocrine:
▢ Fingernail Changes
▢ Increased Thirst
▢ Increase Urination
▢ Increased Urination
▢ Increased Sweating

Genitourinary:
▢ Pain/Difficulty
▢ Blood in Urine
▢ History of Kidney Stones

Blood/Lymph Nodes:
▢ Easy Bruising
▢ Gums Bleed Easy
▢ Prolonged Bleeding
▢ Heavy Aspirin Use

Skin:
▢ Rash/Sores
▢ Lesions
▢ Hives/Eczema
▢ Tremors

Immunologic:
▢ Hives
▢ Itching
▢ Runny Nose
▢ Sinus Pressure

Gastrointestinal:
▢ Heartburn
▢ Nausea/Vomiting
▢ Jaundice/Hepatitis

Ear, Nose and Throat (Ent):
▢ Hard of Hearing
▢ Ringing in Ears
▢ Vertigo

Neurological:
▢ Seizures
▢ Weakness/Paralysis
▢ Numbness

Cardiovascular:
▢ Chest Pain
▢ Dizziness
▢ Fainting Spells
▢ Shortness of Breath
▢ Irregular Heart Beats

X_____ _____

Patient/Guardian Signature **Date**