



ROTHCHILD EYE INSTITUTE

PLEASE COMPLETE ALL PAGES (PLEASE PRINT)

Patient Name:			
Address: Include City, State and Zip Code			
Home Phone No.	Date of Birth	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number:		Driver's License No.:	
Patient Employer:		Employer's Phone Number:	
Employer's Address:			
Referring Doctor:		Insurance Name:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Who referred you to this office?	
Payment is due when services are rendered. All copays, balance, and deductibles will be collected at time of service.			
How will you be paying today? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card			
PLEASE COMPLETE IF THE PATIENT IS NOT THE INSURANCE POLICY HOLDER			
Insurer:	Last Name:	First Name:	
Address: Include City, State and Zip Code		Date of Birth:	
Phone No.:		Social Security No.:	
Responsible Party Employer:		Driver's License No.:	
Employer Phone No.:			
IF YOU HAVE NO INSURANCE, PLEASE FILL OUT THE BOTTOM PORTION			
<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian			
Responsible Party Last Name:		First Name:	
Address: Include City, State and Zip Code		Date of Birth:	
Phone No.:		Social Security No.:	
Responsible Party Employer:			
Employer's Phone No.:		Driver's License No.:	
IF YOU ARE COVERED BY INSURANCE, PLEASE PRESENT YOUR CARD AND REFERRAL			

AUTHORIZATION: I hereby authorize the physician indicated above to furnish to Insurance Carriers concerning this illness, and hereby irrevocably assign to the Doctor all payment for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance and any collection fees that may be incurred.

Patient, Parent or Guardian Signature

Date

Eye History Information

Do you now have or have you ever had any of the following? Check yes or no. If yes, circle which eye was affected and for approximately how long.

Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____
Detached Retina	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____
Blindness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____
Cataracts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____
Floaters	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____
Light Flashes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____
Eye Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____
Partial Vision Blurred or Decreased Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Right Eye	Left Eye	Both Eyes	_____

Have you had previous eye surgery? Yes No

If yes, give type of surgery, which eye, and date. _____

Please state reason for coming to see us. Give date problem started. _____

Has anyone in your family had:

Relationship

Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Detached Retina	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Cataracts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Medical History

Do you, or have you ever had any of the following? Check yes or no. If yes, please state approximately how long.

Heart Trouble	Yes ()	No ()	_____
Diabetes	Yes ()	No ()	_____
High Blood Pressure	Yes ()	No ()	_____
Lung Disease	Yes ()	No ()	_____
Bleeding Problems	Yes ()	No ()	_____
Arthritis	Yes ()	No ()	_____
Cancer	Yes ()	No ()	_____
Thyroid	Yes ()	No ()	_____
Hepatitis	Yes ()	No ()	_____
HIV/AIDS	Yes ()	No ()	_____

Please list all other medical problems: _____

Please list all medications you are presently taking, and for how long:

Medication	How long?
_____	_____
_____	_____
_____	_____

List any medications you are allergic to: _____

List all previous surgeries and the date.: (Do not list previous eye surgery here.)

Thank you for your cooperation!

LIFETIME AUTHORIZATION FORM

I request that payment of authorized insurance benefits to me or on my behalf be made to Eric J. Rothchild, M.D. for any services furnished to me by Dr. Rothchild. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

I understand that I am completely and legally responsible for any co-payment or deductible for any service billed on assignment.

SIGNATURE: _____

DATE: _____

WITNESS: _____

DATE: _____

Rothchild Eye Institute
16244 S. Military Trail
Suite #690
Delray Beach, FL 33484

Patient's Name:

Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Refraction (92015)

Because:

Not A Covered Service

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ 49.00**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Rothchild Eye Institute reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Rothchild Eye Institute.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Patient Account Number