Adirondack Eye Physicians & Surgeons P.C./ Bay Optical, Inc

PATIENT REGISTRATION (under Affordable Care Act)

Patient Name: _____ **Date of Birth:** _____ **Sex:** ○ Male ○ Female
First Middle Last

Address: _____

Phone Numbers: Home _____ **Work:** _____ **Cell:** _____

Email Address: _____

Social Security Number: _____ **Marital Status:** _____ **Birth State:** _____

Occupation: _____ **Employer:** _____

Primary Insurance: _____ **Policy Holder:** _____ **DOB:** _____

Secondary Insurance: _____ **Policy Holder:** _____ **DOB** _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

How you wish to be notified for reminders/messages (circle one or more):

☐ Mailing address ☐ Home Phone ☐ Work Phone ☐ Cell Phone

GOVERNMENT REQUIRED INFORMATION
Check One in EACH Section

Primary Language	○ English ○ Spanish ○ French ○ Other: _____
Race	○ American Indian or Alaska Native Asian ○ Black or African American ○ Other Race ○ Native Hawaiian or other Pacific Islander ○ White ○ Decline to Answer
Ethnicity	○ Not Hispanic or Latino ○ Hispanic or Latino ○ Unknown ○ Decline to Answer

HIPPA PRIVACY STATEMENT

Physician's release and agreement: I hereby authorize payment directly to Adirondack Eye Physicians & Surgeons/Bay Optical, Inc of benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medical information required by my Insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the part who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. If I fail to pay any outstanding balances, I will also incur an charges associated with the collection of these fees.

I understand I will be responsible for any fees incurred because I did not provide accurate insurance information. This includes not getting authorizations when required.

I have read a copy of the Adirondack Eye Physicians & Surgeons/Bay Optical, Inc **NOTICE OF PRIVACY PRACTICES** in accordance with HIPPA regulations. A copy of this notice will be provided to me upon request.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

Below, I have listed individual(s) that are authorized to receive my Protected Health Information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____ _____
Name Relationship Phone number

_____ _____ _____
Name Relationship Phone number

Adirondack Eye Physicians & Bay Optical, Inc.

MEDICAL REVIEW

Name: _____ **Date of Birth:** _____ **Date:** _____

Last Eye Exam: _____ **By:** _____

Primary Care Physician: _____ **Last Visit:** _____

COMPLAINT
Why are you here today?

PERSONAL MEDICAL HISTORY – Please check all that apply	
General Health	
Cardiovascular	◯Heart Disease ◯High Blood Pressure ◯Cholesterol ◯Other:
Ears, Nose, Mouth, Throat	
Respiratory	◯Asthma ◯Emphysema ◯COPD ◯Other:
Gastrointestinal	◯GERD ◯Colitis ◯IBS ◯Other:
Genitourinary	◯Kidney Disease ◯Other:
Musculoskeletal	◯Arthritis ◯Fibromyalgia ◯Other:
Integumentary (skin conditions)	◯Dermatitis ◯Eczema ◯Rosacea ◯Other:
Neurological	◯MS ◯Stroke ◯Migraines ◯Seizures ◯Other:
Psychiatric	◯Depression ◯Anxiety ◯Bipolar ◯Other:
Endocrine	◯Diabetes ◯Hypothyroidism ◯Other:
Hematologic/Lymphatic	◯Hepatitis ◯Other:
Allergic/Immunologic	◯HIV/AIDS ◯Seasonal Allergies ◯Other:
Other	

PERSONAL OCULAR HISTORY– Please check all that apply						
Glaucoma	O					
Cataracts	O					
Macular Degeneration	O					
Retinal Disease	O					
Blindness	O					
Eye Injury	O					
Eye Surgery	O					
Strabismus (eye turn)	O					
Amblyopia (lazy eye)	O					
Dry Eye	O					
Do you wear glasses?	Yes	No	How Often:	Distance	Reading	Both
Do you wear contacts?	Yes ◯	No ◯	Brand: _____		Hours per day: _____	
Are you interested in wearing contacts?	Yes ◯	No ◯	Maybe			
Are you interested in	Yes ◯	No ◯	Maybe			

PERSONAL OCULAR HISTORY– Please check all that apply	
LASIK Surgery?	

SOCIAL HISTORY	
Occupation	
Do you work on a computer?	Yes◯ No ◯ Hours per Day: _____
Alcohol	Type: _____ How Often: _____
Smoking Status	◯Never Smoker ◯Former Smoker ◯Current Smoker - Packs per Day _____
Recreational Drugs	◯Marijuana ◯ Other:

FAMILY HISTORY – Please specify relationship	
Glaucoma	
Cataracts	
Macular Degeneration	
Retinal Disease	
Other Disease	
Blindness	
Strabismus (eye turn)	
Amblyopia (lazy eye)	
Diabetes	
Cancer	
Heart Disease	
Stroke	

ALLERGIES – Please list all allergies		

MEDICATIONS – Please list all medications including eye drops			
Name of Medication	Dose	Name of Medication	Dose

Welcome to the office of:

Brenda M. Dobie, O.D. **Nicole Gaibrois,O.D.**

Important information for patient review:

- **Your insurance is a contract between you and your insurance company. You are ultimately responsible for payment regardless of your insurance's determination.**
- **Knowledge of benefits and eligibility are your responsibility. All insurance plans are unique. Our staff may not have the specific information for your plan available to them on your visit.**
- **Insurance Referrals for medical visits are your responsibility. All referrals must be obtained prior to your appointment. If referrals are not received in a timely manner after your initial visit you are responsible for all charges.**
- **Insurance claims cannot be backdated. All services and orders are billed on the appointment date.**
- **All co-pays are due at time of service. If not paid, a $10.00 service fee will be applied to your account.**
- **Full payment is required for all eyeglass and contact lens orders. If we participate with your insurance company for hardware or contacts, our billing department will assist you. You are responsible for any non-covered items and any difference in fees above and beyond your insurance company's allowable amount.**
- **All lenses are custom made. Canceled orders will be subject to a 45% cancellation/restocking fee & must be done within 30 days. Not responsible for the accuracy of prescriptions filled by other providers.**
- **Customer's Own Frame Liability. Customer assumes liability for any frame breakage to any previously owned frame when lenses only are purchased or adjustments made. Frames become fragile/brittle. Lenses purchased will only fit into same frame/size.**
- **Orders over 3 months old and not picked up will be considered abandoned and payment forfeited.**
- **Refractions are considered routine. A refraction is the part of the exam where the doctor determines your prescription. This service may not be covered by your insurance. If you do not have routine coverage this charge is your responsibility.**
- **Pupilary Distance (PD) is not part of an eye exam and is not given to patients due to liability.**
- **An adult is required to accompany all children to their appointments. The adult accompanying the minor is responsible for payment of services regardless of the relationship or financial arrangement.**

By signing below, I authorize:

1. **This form will serve as a Lifetime Signature on File for my Account.**
2. **Payment from my insurance company for services rendered to be made payable to above doctors and we acknowledge that any overage in payment received from the insurance will be refunded to the appropriate entity.**
3. **I have read and/or understand the Notice of Privacy Practices and I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.**

Patient Name: _____

Patient Signature:_____ **Date:**_____

Bay Optical, Inc & Adirondack Eye Physicians

website: www.bayopticalgroup.com

PATIENT PORTAL

Take Charge of Your Healthcare!

Patients of Bay Optical can now communicate with our practice electronically through our PATIENT PORTAL. This allows you to have access to your medications, medical history and more. You will also be able to request prescription refills and message your provider.

To get started, we must have your email address. After your visit, you will receive an email from Bay Optical, Inc. with a link to the PATIENT PORTAL. The first time you access the portal you will be asked to enter your email address. You will then need to check your email again for an activation code that will be emailed to you separately from MySecureHealthData.com. Enter the activation code and your date of birth. You will then be asked to create a unique password and pick a security question and answer.

The website for the portal is: www.MySecureHealthData.com

Please check appropriate box: ◯ Enroll ◯ Decline ◯ Do not have email

Please fill in your email below. Tear off the bottom portion and return it to the receptionist so we can update your account and send you the link to your PATIENT PORTAL.

Print Name_____ Signature_____

Email: _____