METROPOLITAN EYE CARE

Scott B. Pomerantz, M.D.
Thomas J. LoPresti, O.D
Lori R. Kaplan, O.D.
523 Forest Avenue
Paramus, NJ 07652
Tel. (201) 262-5070
Fax (201) 262-5333

Please Complete and Sign Where Indicated

Patient Information:

Last Name:_____ First Name: _____

Street Address: _____City: _____State:_____ Zip Code_____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Ext: _____

Cell Phone: (_____)_____-_____ Email address: _____ Sex: M F

Date of Birth: _____/_____/_____ Age: _____ Soc. Sec. No.: _____-_____-_____

Occupation: _____ Employer: _____

Employer Address: _____

Is the Patient a Student? Yes No If YES, Name of School: _____

Patient's Status: Single Married Separated Divorced Widowed

If you circled married, please complete Spouse's Information below:

Spouse's Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Soc. Security No.: _____-_____-_____

Is Spouse Currently Working? Yes No

Employer: _____ Employer Address: _____

Work Phone: (_____)_____-_____ Ext.: _____

How did you hear about our practice? (Name of person) _____

Emergency contact: (Give the name of the nearest relative or of a close friend not living with you).

Name: _____ Home Phone: (_____) _____-_____

Relationship: _____ City: _____ State: _____

Who is the Patient's Primary Care Physician?

Name: _____

Address:_____ Phone Number: (_____)_____

METROPOLITAN EYE CARE

Comprehensive Patient History (1 of 2)

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

Review of Systems

Do You Have?	**Yes**	**No**
Decreased vision……..	☐	☐
Flashes……...	☐	☐
Abnormal sensitivity to light…….	☐	☐
Halos around lights……	☐	☐
Problems with glare……..	☐	☐
Red eye……..	☐	☐
Eye discomfort……..	☐	☐
Eye dryness……...	☐	☐
Eye itching……..	☐	☐
Pressure in or behind the eye…	☐	☐
Tearing of the eyes……	☐	☐
Discharge……	☐	☐
Crusting or red eyelids……	☐	☐
Double vision……..	☐	☐
Headaches……	☐	☐
Jagged lines in vision…….	☐	☐
Distortion of vision……..……	☐	☐

Other illnesses:_____

_____

Other surgeries: _____

_____

Past Medical History

Have you ever had?	**Yes**	**No**
Eye surgery……	☐	☐
Eye injury……	☐	☐
Serious eye infection……	☐	☐
Lazy eye……..	☐	☐
Droopy eyelid……	☐	☐
Corneal disease……	☐	☐
Cataract……	☐	☐
Retinal disorder……..	☐	☐
Eye tumor……	☐	☐
Eye turning in or out……..	☐	☐
Diabetes……	☐	☐
High blood pressure……..	☐	☐
Heart disease……	☐	☐
Lung disease……..	☐	☐
Neurological disease……	☐	☐
Thyroid disease……..	☐	☐
Migraine……	☐	☐
Lupus……	☐	☐
Asthma……	☐	☐
Stroke……..	☐	☐
Glaucoma……	☐	☐
Cancer……	☐	☐
Cholesterol……	☐	☐

Comprehensive Patient History (2 of 2)

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

Family History	**Yes**	**No**
Cataracts……	☐	☐
Macular Degeneration……..	☐	☐
Blindness……...	☐	☐
Retinal Detachment……..……	☐	☐
Glaucoma……..	☐	☐
Do you wear contact lenses?…….	☐	☐

If so, please provide any information you may have:

Soft Gas Perm. Toric

Disposable Extended wear

Name of Contact Lenses:

Present Prescription:

Base Curve (B.C.)

Diameter (Dia.)

Social history	**Yes**	**No**
Do you smoke……	☐	☐
Are you pregnant…… …	☐	☐
Do you use a computer often… ...	☐	☐
Do you consume alcohol……. .	☐	☐
Other eye disorders…… ..	☐	☐
Do you wear glasses…… …….	☐	☐

If so, what purpose: Distance Reading Bifocal

Progressive (Varilux) Trifocal Half /reader

List Allergies to medications if any:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Present Medication List: Dosage Freq.

Are you taking Flomax? Yes No

1. _____/_____/_____
2. _____/_____/_____
3. _____/_____/_____
4. _____/_____/_____
5. _____/_____/_____
6. _____/_____/_____
7. _____/_____/_____

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PAYMENT FOR SERVICES

In order to avoid misunderstanding regarding our payment policy, we ask that you read and sign below.

It is your responsibility to know the provisions of your insurance plan.

Please give the receptionist your most updated INSURANCE card(s), LICENSE and **REFERRAL**, if your insurance company requires one for each office visit. All claims will be automatically submitted to your insurance company. Failure to provide our office with correct insurance information will result in a denial from your insurance company and you will ultimately be responsible for payment.

If you do not have insurance coverage or if the physician you are seeing does not participate with your insurance plan, you will be responsible for payment at the completion of your exam.

All co-pays and refraction fees are due at the time of service. If your insurance company determines there is any additional subscriber liability (including, but not limited to deductibles, co-insurances, and non-covered services) you will be responsible for that amount.

Please understand that your insurance card is not a guarantee of payment of any health care claim. Final determination will be made based on your eligibility and benefits at the time of processing.

Your signature below indicates that you have read and agree to our practice's payment for services policy.

(Patient Signature) _____ (Date) _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this form you acknowledge that you have received a copy of our condensed version of our Notice of Privacy Practices Summary. If you would like a full length Notice, one can be provided to you.

Please read the statements below. By checking each individual box, you are giving our office the authorization to release your medical information.

☐ **Medical benefits to the physician or supplier.** By checking this box, you are allowing your insurance company to pay us for your office visit.

☐ **Medical information necessary to process this claim and all future claims.** By checking this box, you are allowing us to send your insurance company any information needed in order to process your claim.

☐ **Medical claims to be submitted electronically if your insurance company requires it.**

☐ **Your Pharmacy**. By checking this box you are allowing us to call in or submit your eye medication(s) electronically to your pharmacy. (Medicare now requires electronic prescription submission).

☐ **Optician**. By checking this box, you are allowing us to give your eyeglass prescription to the optician of your choice.

☐ **Contact Lens Company**. By checking this box you are allowing us to give your contact lens prescription to the optician or contact lens company of your choice.

☐ Any other **physician** that requires information about you, such as your Primary Care Physician or any other Specialist.

X:_____ Date:_____
Signature

Please give us the name of a person that you would authorize us to release confidential information to, such as test results, billing questions or treatment.

Name:_____Relationship:_____Phone Number:_____

Scott B. Pomerantz, M.D.
Gayle A.Grossman, M.D
Thomas J. LoPresti, O.D.

523 Forest Avenue Paramus, NJ 07652 Tel. 201-262-5070

One of the most important parts of your eye exam today is the refraction. This is the part of the exam that will determine whether you can be helped in any way by new glasses or contact lenses. It is also how we determine the best possible visual acuity and function of your eye, which is essential information for us to have as we assess your eyes and look for problems. **It is NOT a covered service by Medicare and many other insurance plans.** These plans consider the refraction a "vision" service not a "medical" service. Our office fee for refraction is **$60.00** and unless your plan automatically covers the refraction charge, **this fee is collected at the time of service in addition to any co-payment your plan may require.**

Please decide whether you wish to have this service done by checking one of the boxes below.

□ I have vision coverage through **VSP (Vision Service Plan).**

□ I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee**.**

THIS FEE IS COLLECTED AT THE COMPLETION OF YOUR VISIT.

□ I decline the refraction service today. I understand that without the refraction, Dr. Pomerantz, Dr. Grossman or Dr. LoPresti may not be able to fully assess the health and function of my eyes.

If you decline the refraction, we will not be able to prescribe eyeglasses or contact lens prescriptions at this time.

Signature: _____Date:_____

Print Name:_____

SCOTT B. POMERANTZ, M.D.
PARAMUS PROFESSIONAL BUILDING
523 FOREST AVENUE
PARAMUS, NEW JERSEY 07652

TELEPHONE (201) 262-5070
FAX (201) 262-5333

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

This information is made available on request by a patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- For Worker's compensation programs
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- In emergency situations
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these right please see the detailed Notice of Privacy Practices that follows this summary.

NOTICE OF PRIVACY PRACTICES

This information is made available on request by a patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including physicians, PAs, RNs, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with our Practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- Medical Treatment. We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the Practice also may share medical information about you including your record(s), prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

- Payment. We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

- Health Care Operations. We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have

with medical information from other Practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

- Appointment and Patient Recall Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing or otherwise leaving a message on an answering machine, which could (potentially) be received or intercepted by others.

- Emergency Situations. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

- Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

    - to prevent or control disease, injury or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;

- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- Investigation and Government Activities. We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

The Office Administrator can be reached at this number (201) 262-5070.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

  To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

- Right to Amend. If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

  We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

  To request restrictions, you must make your request in writing. In your request, you indicate:

  - what information you want to limit;
  - whether you want to limit our use, disclosure or both; and
  - to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.