NORTHWEST EYE ASSOCIATES

Sparta Eye Associates ⌖ Blairstown Eye Associates ⌖ Califon Eye Associates ⌖ Stanhope Eye Associates ⌖ Branchville Eye Associates

Please complete BOTH SIDES of this PATIENT HISTORY FORM

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____ Gender: ❑ M / ❑ F

Social Security Number: _____ Marital Status: _____ Spouse Name: _____

Mailing Address: _____ City, State, Zip: _____ _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-MAIL ADDRESS: _____
(Parent's email if under 18) *(please write clearly)*

Patient's Employer (or School) _____ Occupation (or Grade) _____

Hobbies and Sports: _____

Name of Parent or Guardian (If patient under 18): _____

Last Medical Exam: _____ Family Doctor: _____ Pharmacy: _____

Last Eye Exam: _____ Previous Eye Dr. _____

GUARANTOR (if different than patient)

Name: _____ Relationship to Patient: _____

Mailing Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone: _____

How did you find us? ❑ Google Search ❑ Facebook ❑ Insurance Directory ❑ Newspaper ❑ Friend/Family ❑ Mailer
*Please check **all** that apply* ❑ Our Website ❑ Another Website: _____ ❑ Product Directory ❑ Sign/Location
and circle the main source ❑ Doctor or Other Professional: _____ ❑ Other: _____

VISION INSURANCE (eyeglasses, contact lenses)

Insurance Company Name and Address: _____

I.D.# _____ Group Name: _____ Group Number: _____

Subscriber Name: _____ Subscriber SSN: _____ Subscriber Date of Birth: _____

MEDICAL INSURANCE (medical eye conditions)

Insurance Company Name and Address: _____

I.D.# _____ Group Name: _____ Group Number: _____

Subscriber Name: _____ Subscriber SSN: _____ Subscriber Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name and Address: _____

I.D.# _____ Group Name: _____ Group Number: _____

Subscriber Name: _____ Subscriber SSN: _____ Subscriber Date of Birth: _____

Do you currently wear glasses? ❑ Yes ❑ No Are you planning to get new glasses today? ❑ Yes ❑ No
Do you wear contact lenses? ❑ Yes ❑ No (if no, are you interested in contact lenses? ❑ Yes ❑ No)
Would you like more information on LASIK and Refractive Surgery for nearsightedness? ❑ Yes ❑ No ❑ N/A

PLEASE COMPLETE SECOND SIDE

Current Ocular Symptoms

Name: _____ **Date:** _____

❑ Y ❑ N - Blurred Vision ❑ Y ❑ N - Eye Ache ❑ Y ❑ N - Eye Discharge ❑ Y ❑ N - Glare / Light Sensitivity
❑ Y ❑ N - Eye Strain ❑ Y ❑ N - Eye Itching ❑ Y ❑ N - Eye or Lid Swelling ❑ Y ❑ N - Double Vision
❑ Y ❑ N - Redness ❑ Y ❑ N - Eye Burning ❑ Y ❑ N - Distorted Vision ❑ Y ❑ N - Glaucoma
❑ Y ❑ N - Eye Pain ❑ Y ❑ N - Eye Dryness ❑ Y ❑ N - Floaters in Vision ❑ Y ❑ N - Cataract
❑ Y ❑ N - Eye Irritation ❑ Y ❑ N - Excess Tearing ❑ Y ❑ N - Flashes in Vision ❑ Y ❑ N - Retinal Disease

❑ Y ❑ N - Sensation of Not Feeling Grounded ❑ Y ❑ N - Loss of Balance or Dizziness ❑ Y ❑ N - Veering off When Walking
❑ Y ❑ N - Bothered by Movement Around You ❑ Y ❑ N - Bothered in Crowded Environments

Any Other Reasons for Visit: _____

Current Eye Conditions ❑ None

Date of Onset	Condition *(ocular)*

Allergies ❑ None

Allergy *(medications and environmental*	Reaction

Family History ❑ None

Disease	Family Members	Onset Age
Cataracts		
Glaucoma		
Retinal Disease		
Macular Degeneration		
Diabetes		
Other		

Current Medications ❑ None

Rx Date	Medication	Condition Treated

Height: _____ **Weight:** _____

Female Patients - Are you pregnant or nursing? ❑ Y ❑ N

Patient's Surgical History ❑ None

Please include ALL Eye Surgeries and Major General Surgeries

Surgical Procedure	Date	Eye	Surgeon

Tobacco Usage:
❑ Never Smoked ❑ Current Smoker ❑ Former Smoker

Current or past problems (Review of Systems) *If YES please explain*

General Health (Fever, Weight Loss)	❑ Y ❑ N	
Ear/Nose/Throat	❑ Y ❑ N	
Heart / Blood Pressure	❑ Y ❑ N	
Lungs	❑ Y ❑ N	
Stomach/Bowel	❑ Y ❑ N	
Kidney/Genital/Urinary/	❑ Y ❑ N	
Arthritis/Muscles/Joints/Bones	❑ Y ❑ N	
Skin/Rashes/Lumps	❑ Y ❑ N	
Neurological/Headaches/Seizures	❑ Y ❑ N	
Psychological/Psychiatric	❑ Y ❑ N	
Endocrine/Thyroid/Diabetes	❑ Y ❑ N	
Lymph/Blood/Bleeding /	❑ Y ❑ N	
Allergic/Immunologic	❑ Y ❑ N	

MEDICAL INSURANCE AND VISION PLAN POLICIES

ABOUT INSURANCE CLAIM SUBMISSIONS AND DEDUCTIBLES

- Many medical plans, like Medicare, have annual deductibles that patients must meet before insurance begins to pay. Eligibility, coverage, co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. Unfortunately, we have no control over these terms and amounts.
- Our participation in your medical insurance or vision plan does not necessarily mean that your specific coverage will pay for the visit. Each plan is different, and we do not know what charges will be covered or what your insurance company will tell us to bill you. You, the insured, will be ultimately responsible for payment of any charges not covered by your plan.
- For insurance plans where we are participating providers, all deductibles, co-pays and non-covered services are due at the time of service. For patient without coverage or having insurance plans where we are NOT participating providers, payment in full is expected at the time of service. We will provide all necessary information needed for you to submit a claim for any allowable reimbursement.
- Please check your managed care plan when making the appointment and bring any necessary referral forms on the day of the exam to avoid your insurance company from denying your claim.
- If you have both medical insurance and a vision plan it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- All prior outstanding family balances are expected to be paid before receiving additional services.

NON-COVERED SERVICES

Insurance plans have required us to itemize certain specific procedures of the eye exam as separate fees. Many medical and vision plans exclude these from coverage and require patients to pay for them out-of-pocket. Among these are:

- **REFRACTION - $48.00** – This part of your eye exam determines whether you can be helped with a new eyeglass prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information we use to assess your eyes. Unfortunately, Medicare and many other medical insurance plans usually do not consider refraction a covered medical service. However, vision plans usually do cover refraction fees.
- **ANNUAL CONTACT LENS EXAM - $58.00** –If you wear contact lenses you will need additional testing which is required by insurance companies to be itemized separately from the general eye exam fee. Contact lenses are prescribed medical devices which sit on the surface of the eye. Federal and NJ laws and regulations require contact lens prescriptions to expire. The Annual Contact Lens Exam allows us to safely renew your contact lens prescription and includes biomicroscopic examination of the contact lens on the eye to check the lens fit and to look for any adverse effects from contact lens wear on the cornea, conjunctiva and eyelid tissues; Contact lens refraction to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions); and review new lens designs and material options that may improve comfort and/or health.

Non-covered fees are collected at the time of service in addition to any co-payment your plan may require. Should your plan ultimately pay us for either service, we will reimburse you accordingly.

I have read the above information and understand these insurance and vision plan policies.

Signature _____ Printed Name_____ Date_____

Additional Information Required by Federal Law

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Contact lenses, glasses, vision therapy equipment, medications or special testing may be recommended as a result of your examination. The cost of those interventions can vary and can impact the total cost of care. Any material costs will be disclosed prior to ordering to allow you to make an informed decision. This Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. HHS charges a $25 fee to use their dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, ask questions or get more information about your right to a Good Faith Estimate or the dispute process, go to www.cms.gov/nosurprises or call 1-800-985-3059. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it should you need it if you are billed a higher amount.

Northwest Eye Associates TIN: 22-2780791

- Sparta Eye Associates - 117 Sparta Ave Sparta NJ 07871 - 973.729.9199
- Blairstown Eye Associates - 174 Route 94 Blairstown NJ 07825 - 908.362.8257
- Califon Eye Associates - 438 County Road 513 Califon NJ 07830 - 908.362.9211
- Stanhope Eye Associates - 145 Route 183 Stanhope NJ 07874 - 973.347.8877
- Branchville Eye Associates - 200 Route 206 Branchville NJ 07826 - 973.948.7272

Jeffrey F. Clauss, OD (NPI:1871573709 LIC:27OA004120)
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www.EyesNJ.com

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Patient Name: _____

Visual Lifestyle Questions

Let us know how you're using your eyes, to help us give you the best personalized recommendations to optimize your vision.

What is your current or most recent occupation? _____

What activities or hobbies do you engage in? (please check all that apply)

- ❑ Golfing
- ❑ Target Shooting / Hunting
- ❑ Work or Activities Above Eye Level or Overhead (such as mechanic, electrician, carpenter, plumber)
- ❑ Needlecrafts / Sewing / Model Building
- ❑ Piano or Other Musical Instruments (please specify _____)
- ❑ Fishing / Boating
- ❑ Home Workshop
- ❑ Competitive Sports (please specify _____)
- ❑ Other Visual Activities: _____

How many hours during an average day do you use a desktop computer? _____

During an average day, how many hours do you spend reading or doing close work? _____

Are you bothered by halos or glare during the day or from lights at night? ❑ Yes ❑ No

Have you ever felt your eyeglass lenses were too thick or heavy? ❑ Yes ❑ No

Questions for Students *(of all ages)*

Do you experience any of the following? Please rate each symptom on the following scale:

(0) Never (1) Not very often (2) Sometimes (3) Fairly Often (4) Always

Avoidance of reading or near vision tasks	
Feeling sleepy while reading or doing near work	
Losing concentration, or easily distracted when doing near work	
Eyes feel tired or uncomfortable when reading or doing near work	
Headaches after reading or doing near work	
Struggling with reading comprehension and remembering what was read	
Double vision when reading or doing near work	
Eyes feel painful, tense, or have a pulling sensation when doing near work	
Losing your place when reading, or having to reread lines of text over again	
Text blurring or going in and out of focus while reading	
Burning, itchy, or watery eyes with near work	
Poor handwriting, including sloping, trouble staying within lines	
Difficulty aligning numbers in columns	
Difficulty copying notes from a whiteboard/smartboard	
Holding books or near work very close to eyes	
Clumsiness and knocking things over	
TOTAL SCORE	0

A score of 16 or above could indicate an underlying visual dysfunction.

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Please read and sign in the 3 places below.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of our Notice of Privacy Practices.

1 _____ _____ _____

Patient or Authorized Agent Signature ***Date*** ***Print Name***

INSURANCE AUTHORIZATION AND PATIENT RESPONSIBILITY

I authorize the release of medical information necessary to process claims and assign medical benefits to myself or the named provider for professional services rendered.
I understand that I am responsible for confirming eligibility and provider participation under my insurance plan and providing a referral if it is required. I further understand and agree that any co-pays are due at the time of service and that I am fully responsible for any balances that my insurance does not cover.

INSURANCE SIGNATURE ON FILE

If I am covered under Medicare or other insurance, this will also serve as your file copy of my "Signature on File" for submitting Medicare and other insurance claims and accepting Medicare assignment on my behalf.

2 _____ _____ _____

Patient or Authorized Agent Signature ***Date*** ***Print Name***

_____ _____

Relation to Patient ***Source of Authority (if not patient)***

If we are participating providers, we will submit claims to your primary insurance carrier however patients are responsible for submissions to any secondary insurance. We will be happy to help you by providing any itemized documentation required.
PLEASE CONTACT YOUR INSURANCE COMPANY DIRECTLY FOR CONFIRMATION OF YOUR COVERAGE, ELIGIBILITY, DEDUCTABLES AND PLAN LIMITS.

PATIENT PROVIDED FRAMES AND LENSES WAIVER

I acknowledge that eyeglass frames can break when adjusted or during the insertion or removal of lenses. I recognize that eyeglass frames become increasingly fragile and more prone to possible damage as they age and that replacements may not be available for older styles and frames purchased from other sources.

Should I choose to present my existing frames or lenses for service I agree to do so at my own risk. I agree not to hold Northwest Eye Associates or the optical lab responsible for any breakage or damage to my own frame or lenses when replacing lenses or during frame adjustments or repairs. I also agree not to hold Northwest Eye Associates responsible for any loss of frames or lenses that I provide and that I am responsible for informing the office at the time of order should I wish to purchase shipping insurance. I also agree that this waiver will apply to all eyeglasses I provide for service, and it will remain in force without expiration unless it has been specifically rescinded in writing.

3 _____ _____ _____

Patient or Authorized Agent Signature ***Date*** ***Print Name***