EYE CARE & SURGERY

Arthur M. Cotliar, M.D. • Jeremy M. Cotliar, M.D. • Gabriel M. Ferreira, M.D.
Rajendra K. Bansal, M.D. • James F. Kelly, M.D. • Jessica L. Barest, M.D.
Rachelle Goller, O.D. • Kevin Rosin, O.D.

Dear Patient:

Thank you for taking time to schedule an appointment at one of our offices. Please fill out the enclosed forms and bring the forms with you on the day of your appointment. In addition, please bring with you the following:

- Current insurance card(s)
- Referral from primary care Doctor (if required by the insurance company)
- Picture ID

Please plan to spend approximately 2 1/2 hours in our office. Again, we thank you for allowing us to participate in your eye care.

Sincerely,

Arthur M. Cotliar, M.D. & Staff

Harkness Eye Institute • 635 West 165th Street • Suite 370 • New York, NY 10032
New York Eyewear • 130 Fort Washington Avenue • Suite 1M • New York • NY 10032
Eye Care & Surgery • 880 River Avenue • Main Floor • Bronx • NY 10452
(212) 568-2600 • (212) 305-2241
Fax (212) 568-0097 • (212) 305-3266
www.drcotliar.com

Updated: 12/01/2016 FC

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REGISTRATION FORM

Last Name: ____________________________**First Name:** _______________________ **DOB:**_________________

Address: ____**Apt #:** ____________________________

City: ______________________ **State:** ___________________________ **Zip Code:** ______________________

Home Phone: _______________________ **Mobile Phone:** ____

Or best contact number _________________________________ **Marital Status:** __________________________

Social Security Number: __________________ **Gender:** ___________________

Mother's first Name: _________________________ **Father's first Name:** ______________________________

If Minor: Mother's Date of Birth:_______________ **Father's Date of Birth:** ____________________________

Referred by (Name, Address, Phone) ____

Primary Care Provider (PCP): ____________________________ **Phone Number:** ___________________________

E-mail Address: ____

☐ I agree to receive email and text message communications from Eye Care and Surgery

Pharmacy Name: ______________________________ **Phone:** _______________________________________

Emergency Contact: _____________________________ **Emergency Contact Phone:** ______________________

INSURANCE INFORMATION

Primary insurance: ____

Subscriber's name **Policy Number** **Relationship to patient**

SSN#: ___________________ **Secondary Insurance:** ____

Do You Have a Vision Plan? ☐Yes ☐ **No** **If yes, which one**: __________________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Eye Care and Surgery or insurance company to release any information required to process my claims.	
Patient / Parent / Guardian signature:	**Date:**

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PATIENT CONSENT FORM

Our Notice of Privacy Practices Provides Information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this consent, in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides his form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of privacy Policies.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent.

This consent was signed by: ____
(Patient / parent / Guardian Signature)

Relationship to patient (if other than patient): ____

Date: ____________________

In front of ____
(Office representative)

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HIPAA PATIENT COMMUNICATION FORM

• **Family and Friends**. It is the office policy Eye Care & Surgery not to release confidential medical information regarding your treatment to family members or friends, except for (I) parental/legal guardian. (II) other persons authorized by patient, (III) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that person is entitled to receive information regarding your treatment, (IV) in emergency situations, or (V) other as otherwise permitted by the Health Insurance Act of 1996(HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate below, so that we best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care; (if you wish to add names later on, please confirm this in writing or call our office).

Spouse: ______________________________ ________ **DOB:** __________ **Yes** ________ **No**

Parent: ______________________________ ________ **DOB:** ___________ **Yes** ________ **No**

Other: ______________________________ ________ **DOB:** ___________ **Yes** ________ **No**

______________________________ ________ **DOB:** ___________ **Yes** ________ **No**

• **Alternative communications**. You are entitled to specify alternatives, reasonable means of communications; if you do not wish to be contacted by us in a certain way. I hereby request the following means of contact only: ___________

____

____

PRINT NAME: ____

Patient / Parent / Guardian Signature:____

Date: ________________________

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PATIENT INSURANCE RELEASE FORM

Last Name: _________________________ **First Name:** __________________________ **DOB:** ___________

Address: ____ **Apt #:** _________________

City: ____________________**State:** _______________________ **Zip Code**: ___________________________

Home phone (___)______-__________ **Mobile phone:** (___) _____-________________________________

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits; for services on each and every claim to be submitted for myself and or dependents. This signature will bind me as though the undersigned had personally signed the particular claim.

If I have Medicare or any other insurance, I request that the payment of the authorized Medicare or other insurance benefits be made either to me or on my behalf to the above named physician and his associates for any services furnished either to me by that physician or his associates. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents or any private carrier requesting any information needed to determine these benefits or any payments be made and authorizes release or medical information necessary to pay the claim.

If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Non-covered include services such as refraction, contact lens service. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

____

Patient / Parent / Guardian Signature

Date: ___________________________

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NON- COVERED SERVICES

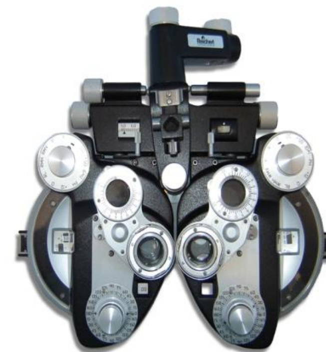
Optomap

Optomap
DILATION-FREE EYE EXAM*
Optomap is an ultra widefield image of the inside of the eye that allows for better visualization of the retina. This aids in the diagnoses of macular degeneration, glaucoma, retinal holes, retinal detachments and diabetic retinopathy without the need for dilation for most patients. Medicare and other insurances do not cover the $10.00 charge for this service. This charge is due from the patient at the time of the eye exam.
Do you accept these terms?
Please Circle: YES NO
Cost: $10.00
Initials: _______
* Except for cataract evaluations /only available at Harkness Eye Institute.

Biophotonic Scanner S3

S3 Biophotonic scanner is a cutting edge testing tool that non-invasively measures the antioxidant level in living tissue, providing an immediate indication of a person's overall antioxidant status.
Everyone can instantly know their own vitamin status, which can alert patients regarding the need to make improvements to their diet and lifestyle. In ophthalmology this is particularly important for eye health. We can recommend special multivitamins for better absorption in the body. Medicare and other insurance do not cover the $20.00 charge for this scan which is due from the patient at the time of the eye exam.
Do you accept these terms?
Please circle: YES NO
Cost: $20.00
Initials: _____

Refraction



The **refraction** is an eye exam that measures a person's prescription for eyeglasses.

Refraction is a non-covered service by Medicare, and most commercial and Medicaid plans. You are responsible to pay for the refraction.
The **refraction** fee is $35.00, which is collected at the time of service, in addition to any co-payment your plan may require. If you choose to have your prescription filled in our optical, we will apply the $35.00 fee to the cost of your eyeglasses.
Do you accept these terms?
Please circle: YES NO
Cost: $35.00
Initials: _____

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CONFIDENTIAL MEDICAL QUESTIONNAIRE

Last Name: ______________________ **First Name:** ________________________ **DOB:** ________________

PAST OCULAR HISTORY:
Previous History of Eye treatment or Exams:
____
____

Do you have any problems with the following areas? If yes, check mark

Eyes:

	Yes	No
Decreased vision at distance………	☐	☐
Decreased vision at near………..…	☐	☐
Distorted vision…..……………….	☐	☐
Flashing Lights………………………	☐	☐
Floaters……………………………….	☐	☐
Glare/light sensitivity………………	☐	☐
Night blindness…..…………………	☐	☐
Pain or soreness…..…………………	☐	☐
Styles or Chalazion…………….....	☐	☐
Cataracts……………..…………..…	☐	☐
Glaucoma…………………………..…	☐	☐
Retinal disorder…..…………….....…	☐	☐
Strabismus (crossed eyes)…………..	☐	☐
Chronic infection of eye or lid……...	☐	☐

Cardiovascular:

	Yes	No
Hypertension………………..…..	☐	☐
Heart attack……………….....…	☐	☐
Irregular heart beat…………..…	☐	☐
Pacemaker………………..……	☐	☐
Bypass graft…………….....….	☐	☐
Chest Pains…………………	☐	☐

Endocrine:

	Yes	No
High Blood Sugar………..…	☐	☐
Low Blood Sugar………..…	☐	☐
Diabetes…………………..…….	☐	☐
Insulin…………...….	☐	☐
Pills…………………	☐	☐
Thyroid disorder……………..….	☐	☐

Ear, Nose, Mouth and Throat

	Yes	No
Hearing Loss……………….……..…	☐	☐
Dizziness………………..………...	☐	☐
Sinus Congestion…...………………	☐	☐
Dry mouth/throat…………….…….	☐	☐

Neurological:

	Yes	No
Stroke…….………………..…….	☐	☐
Palsy……………………..………	☐	☐
Parkinson's Disease..…….	☐	☐
Migraine Headache…..…….	☐	☐
Blackout…….……………..….	☐	☐

Continue→→→

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General:

Cancer (where)……………………………………………….. …..……..……..……..……..……..……..
(When)………………………………………… …..……..……..……..……..……..……..……..……..

Gastrointestinal:

	Yes	No
Hepatitis…..………………....…	☐	☐
Gallstones…..……………..…..…	☐	☐
Diarrhea……………….….	☐	☐
Heartburn……………….……….…………..	☐	☐
Ulcers……………………....……	☐	☐

Musculoskeletal:

Arthritis (Where)…………..…… …..……..…
……………………………………………..……..

Hematological/Lymphatic:

	Yes	No
Abnormal Bleeding..……..….	☐	☐
Blood Disorders..…..……..….	☐	☐
Anemia…..…..……………....….	☐	☐
Sickle cell anemia…………..	☐	☐

Respiratory:

	Yes	No
Asthma…..……………..……....….	☐	☐
Bronchitis…..………………….….….	☐	☐
Emphysema………………………….….	☐	☐
Shortness of breath………………….	☐	☐
Tuberculosis……………………....….	☐	☐
Wheezing…..…………………….….....	☐	☐
Chronic cough………..……………	☐	☐

Genitourinary:

	Yes	No
Kidney Disorder……..……….....…	☐	☐
Herpes Simplex…..………………..…	☐	☐
Change in urination…………………	☐	☐

Skin:

	Yes	No
Eczema, psoriasis…..……..….	☐	☐
Rash…..…..……………....….	☐	☐
Dry Skin…..…..……....….	☐	☐
Skin Cancer...……..….	☐	☐

Psychiatric:

	Yes	No
Depression…..……….	☐	☐
Mood Swings………..	☐	☐

Allergy/Immunology:

	Yes	No
Seasonal allergies……....…	☐	☐
Anaphylactic reaction………	☐	☐
HIV……….………………	☐	☐

Do you smoke? How much?……………………………………………………… …..……..……..…
Do you Drink alcohol? How much?………………………………………………. …..……..……..…
Medications: (Please list current medications)………………………………….. …..……..……..…
………………………………………………………………………………………..……..……..……..…

Family History:

	Yes	No
Thyroid Disease.…….....…	☐	☐
Diabetes…..……………..…	☐	☐
Glaucoma…………………	☐	☐
Macular Degeneration………	☐	☐
High Blood Pressure………	☐	☐
Systemic Disease…………	☐	☐

Patient's Signature: ………………………………………………………………………..……..…
Doctor's Signature: ……………………………………….. **Date:** ……………….……..…

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Refraction Fee Policy

What is Refraction?

The refraction is an eye exam that measures a person's prescription for eyeglasses.

When does a patient pay for Refraction?

Refraction (CPT code 92015) is a Non-Covered service by Medicare, most Commercial and Medicaid plans. You are responsible to pay for the refraction.

What is the cost for Refraction?

The Refraction fee is $**35.00**. **This is collected at the time of service** in addition to any co-payment your plan may require. If you choose to have your prescription filled in our optical, we will apply the $35 fee to the cost of your eyeglasses.

Do you accept these terms?

Circle **Yes** **No**

Patient Signature _______________

Date ______________________

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