

PLEASE COMPLETE THE ENTIRE FORM (NO BLANKS PLEASE!) 2/2012
INSURANCE COVERAGE **MUST BE VERIFIED PRIOR TO THE EXAMINATION**
PLEASE PRESENT A COPY OF YOUR INSURANCE CARD & PHOTO ID TO THE RECEPTIONIST, THANK YOU

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED; WE ACCEPT THE FOLLOWING FORMS OF PAYMENT!!
CASH/CHECK/VISA/MC/AMEX/DISCOVER/ DEBIT CARD

WHO SHOULD WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PATIENT INFORMATION: (PLEASE PRINT) _____ AGE _____

PATIENT LAST NAME: _____ MARITAL (please circle) STATUS: S M D W

FIRST NAME: _____ MIDDLE INITIAL: _____ DATE OF BIRTH: _____

ADDRESS: _____ SS#: _____

CITY: _____ EMPLOYED BY: _____

STATE: _____ OCCUPATION: _____

ZIP: _____ HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
PREFERRED COMMUNICATION: YES NO YES NO YES NO TEXTING YES NO

EMAIL: _____

I authorize the use of my email address for PATIENT COMMUNICATION only. (Your email address will not be released to any third parties.) Patient Initial's _____

DRIVER'S LICENSE#: _____ EXPIRES: _____ STATE: _____

_____ I understand that it is the patient's responsibility to notify the office of all insurance coverage prior to being seen by the doctor. I understand my benefits. Insurance will not be accepted after the fact and not all services are covered by your insurance.

*****MUST BE COMPLETED IN ORDER TO FILE INSURANCE - IF NOT COMPLETE WE ARE UNABLE TO FILE YOUR INSURANCE!!**

EMPLOYEE (INSURED OR POLICY HOLDER) INFORMATION

FULL NAME: _____ D.O.B.: _____

SS#: _____ HOME PHONE#: _____ WORK PHONE#: _____

EMPLOYER: _____ RELATIONSHIP: _____

MEDICAL/VISION INSURANCE CARRRIER: _____

IDENTIFICATION# AND GROUP#: _____

- ❖ I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.
- ❖ I authorize the release of any medical or other information necessary to process any insurance claim. I also authorize payment of medical benefits to Joel H. Goffman, M.D., P.A.
- ❖ I UNDERSTAND THAT MY INSURANCE BENEFITS MAY OR MAY NOT COVER ANY OR ALL SERVICES.
- ❖ I understand that any cancellation or NO-Show appointment given without 24-hour notice will result in a \$25.00 rescheduling fee.
- ❖ I AUTHORIZE THE RELEASE OF MY MEDICAL AND/OR FINANCIAL INFORMATION TO THE FOLLOWING INDIVIDUAL(S):
(OTHER THAN SELF - I.E. SPOUSE OR PARENTS)

Name(s) and relationship to patient - PARENTS, SPOUSE, CHILDREN OR ENTER NONE

X _____ X _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

ATTENTION ALL PATIENTS WHO ARE COVERED BY INSURANCE/MEDICARE

Dear Patient:

We are committed to providing you with the best possible care. If you have medical or vision insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

As a courtesy to my patients, my office will file with Medicare or your major medical or vision plan for our non-Medicare participants. However, **you are responsible for any unmet deductible, coinsurance or copays and any non-covered services at the time services are rendered.** In order for us to file your claim in a timely manner a copy of your Medicare and/or insurance card will be needed as well as your referral from your primary care physician, if you are a member. **For patients with secondary insurances we only file to your primary insurance carrier, you will need to file for reimbursement to your secondary insurance. Medicare patients, your secondary will be accepted only if Medicare forwards the claim to your secondary policy directly.**

For our Out-of-Network patients, you will be given an itemized receipt to file with your insurance company.

PLEASE READ AND INITIAL

****DIAGNOSTIC TEST SUCH AS TOPOGRAPHY, RETINAL PHOTOS AND OPTICAL COHERENCE TOMOGRAPHY – OCT (WHICH ARE RECOMMENDED BY DR. GOFFMAN FOR AN ACCURATE AND COMPLETE EXAMINATION), REFRACTIONS, CONTACT LENS SERVICES, CONTACT LENSES AND GLASSES ARE NOT COVERED BY YOUR MEDICAL OR VISION PLANS UNLESS MEDICALLY NECESSARY FOR CERTAIN DIAGNOSES.** In addition to your co-pay (if your visit is coverage by insurance), there will be additional charges for the services listed above which are not covered by your insurance. Refraction -\$50., Topography-\$25., Retinal Photos - \$35., OCT -\$50., Contact lens fits range from-\$340.-\$670. If you have any question, please ask the staff to clarify any charges prior to services being rendered.

PLEASE INITIAL _____

Laser vision correction is **not** covered by insurance.

Normal processing time takes 4-6 weeks for most insurance companies. We will make every attempt to work with your insurance company should they require additional information to process your claim. However, if your insurance company fails to make a payment within a reasonable length of time, issues a denial notice, and or goes into receivership, the balance will then be billed to you directly. A reasonable length of time is considered to approximately 5-6 weeks. We must emphasize that, as a medical care provider, my relationship is with you, not your insurance company. While filing of insurance is a **courtesy** we extend to my patients, all charges are your responsibility from the date the services are rendered.

I agree to assume any financial obligation involved in the full payment of services, which include all outstanding balances not covered by Medicare and/or my insurance company. I authorize any holder of medical information to release to the Social Security Administration or its intermediaries or carriers, or to the billing agents of the insurance companies listed on my patient information record, or to my employer or worker's compensation carrier. Any information needed for this insurance or Medicare claim to be processed.

Patient Signature or Responsible Party

Date

NOTE TO MEDICARE PATIENTS:

My office accepts Medicare assignment. Medicare will send the payment directly to Joel H Goffman, M.D., P.A. Under terms of the assignment, the allowable charges are accepted by this office and are considered as the total charge. However, Medicare will only pay 80% of the allowable charge. This means the beneficiaries (patients) will be required to pay any unmet deductible (which is \$162.00 starting in 2011 and coinsurance of 20%). *Eye examinations performed for the purpose of prescribing, fitting, or changing eyeglasses, and/or contact lenses are not covered by Medicare. Medicare and most insurance companies do not cover PRK, Lasik or the Presbyopic correcting implant for refractive/ cataract surgery.*

Patient Social History:

Use of Tobacco:

NEVER Smoked

Former Smoker _____yrs

Current Smoker ____Packs/day ____Yrs

Current Smokeless Tobacco User ____cans/day ____yrs

Use of Alcohol:

Never

Rarely

Moderate

Daily

Have you had a blood transfusion?

YES

NO

Family Medical History: Does anyone in your family have any of the following medical condition? NONE

FAMILY MEMBER	DIABETES	GLAUCOMA	MACULAR DEGENERATION	HYPERTENSION	OTHER CONDITIONS
MOTHER					
FATHER					
SISTER					
BROTHER					
MATERNAL GRANDMOTHER					
MATERNAL GRANDFATHER					
PATERNAL GRANDMOTHER					
PATERNAL GRANDFATHER					

REVIEW OF SYSTEMS: Please indicate any personal history below: NONE

Cardiovascular

High Blood Pressure

Stroke

Cholesterol

Mitral Valve Prolapse

Congestive Hrt Disease

Constitutional Symptoms

Good general health

Cranial\Facial

Hearing Loss

Sinus problems

Endocrine

Diabetes

Thyroid Disorder

Renal Disease

Gout

Gastrointestinal

Hepatitis

Acid Reflux

Cancer - colon

Cancer - Liver

Tuberculosis

Genitourinary

Menopause

Prostate Disorder

Kidney Stones

Prostate Cancer

Hematologic/Lymphatic

Blood Clots

Leg/Muscle Cramps

Anemia

Bleeding/Bruising

Immunologic

Sjorgen's Syndrome

Sarcoidosis

Herpes Zoster

Shingles

Integumentary\Skin

Psoriasis

Lupus

Raynaud's Disease

Rosacea

Musculoskeletal

Difficulty walking

Rheumatoid Arthritis

Arthritis

Osteoporosis

Neurological

Vertigo

Migraines

Parkinson's

Headaches

Psychiatric

Alzheimer's

Insomnia

Memory Loss

Depression

Respiratory

Asthma

COPD

Emphysema

Cancer - Lung

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr. Goffman of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient or Guardian if Minor

Date

Signature of Doctor

Date