BAYSTATE®
EYE
C·A·R·E
GROUP
OPHTHALMOLOGY

PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ / _____ / _____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER SSN: XXX-XX- _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: _____

(Please check the box to indicate your preferred means of communication)

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____ ☐ EMAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

I HEREBY AUTHORIZE THE DOCTORS AND/OR STAFF OF BAYSTATE EYE CARE GROUP TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING PEOPLE:

NAME: _____ NAME: _____

RELATIONSHIP: _____ RELATIONSHIP: _____

PHONE #: _____ PHONE #: _____

INSURANCE INFORMATION

IS YOUR VISIT RELATED TO A WORKERS' COMPENSATION OR MOTOR VEHICLE ACCIDENT? _____

IF YES, PLEASE SEE OTHER SIDE. →

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

OTHER INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **DRS. SEEFELD, BERGER, BOUVIER AND/OR BUDRI.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

NAME: _____

SIGN HERE: X _____ **DATE:** _____

OVER →

DID YOU HAVE AN INJURY?

DATE OF ACCIDENT / DESCRIPTION: _____

_____

NAME AND ADDRESS WHERE BILL SHOULD BE SENT: _____

ADDRESS: _____

CITY / STATE: _____ ZIP: _____

PHONE NUMBER: _____

IS THERE A CLAIM OR REFERENCE NUMBER? _____

ADJUSTER'S NAME: _____

Patient Name: _____ DATE: _____

Pharmacy Name & Address _____ Tel. # _____

MEDICAL HISTORY

CHECK ALL THAT APPLY

- ❑ DIABETES
- ❑ HEART ATTACK
- ❑ HIGH BLOOD PRESSURE
- ❑ STROKE / SHOCK
- ❑ PACEMAKER / DEFIBRILLATOR
- ❑ ASTHMA
- ❑ EMPHYSEMA
- ❑ LIVER DISEASE / JAUNDICE
- ❑ STOMACH ULCER
- ❑ **PACEMAKER**
- ❑ OTHER: _____
- ❑ _____
- ❑ ARTHRITIS
- ❑ CANCER / TUMOR
- ❑ THYROID DISEASE
- ❑ SEIZURES
- ❑ BLOOD CLOTS
- ❑ BLEEDING DISORDER
- ❑ TRANSFUSIONS
- ❑ AIDS / HIV POSITIVE / A B C
- ❑ KIDNEY STONES / DISEASE
- ❑ **LATEX ALLERGY**
- ❑ _____
- ❑ _____

FAMILY HISTORY

Among your blood relatives, is there a history of any of the following:

CHECK ALL THAT APPLY

- ❑ GLAUCOMA
- ❑ CATARACTS
- ❑ "LAZY EYE" OR MUSCLE IMBALANCE
- ❑ RETINAL DISEASE
- ❑ MACULAR DISEASE
- ❑ NIGHT BLINDNESS
- ❑ COLOR BLINDNESS
- ❑ UNEXPLAINED VISION LOSS
- ❑ DIABETES MELLITUS
- ❑ TUMOR OR CANCER
- ❑ HIGH BLOOD PRESSURE
- ❑ HEART DISEASE
- ❑ BLEEDING DISORDER

SOCIAL HISTORY

CHECK ALL THAT APPLY

- ❑ DO YOU DRINK ALCOHOL? HOW MUCH PER DAY? _____
- ❑ DO YOU SMOKE? HOW MUCH PER DAY? _____

When was the last time you used Aspirin in any form? _____

SIGN HERE: X _____

OVER →

VACCINES

CHECK ALL THAT APPLY	DATE
❑ FLU	_____
❑ PNEUMONIA	_____
❑ SHINGLES	_____

ALLERGIES

CHECK ALL THAT APPLY	PLEASE LIST
❑ FOOD	_____
❑ MEDICINE	_____

EYE MEDICATIONS

What eye medications are you using at present? Give name(s) and dosage:

_____

_____

_____

OTHER MEDICATIONS

What other medications are you using at present? Give name(s) and dosage:

_____

_____

_____

Are you currently being treated for MRSA? _____

Have you ever been treated for MRSA in the past? _____

Are you colonized with MRSA? _____

If yes, how were you treated? _____

SURGERY / LASER / INJURIES

CHECK ALL THAT APPLY	DATE
❑ EYE SURGERY	_____
❑ OTHER SURGERY	_____

OVER →

Baystate Eye Care Group - Financial Policy

Dr. Steven Berger, M.D., Dr. William Seefeld, M.D.
Dr. J. Peter Bouvier, M.D., Dr. Kimberly Budri, O.D.

Dear valued patient, Thank you for choosing Baystate Eye Care Group to serve all your eyecare needs. We are committed to building and maintaining a successful physician-patient relationship with you and your family. Your clear understanding of our updated financial policy is vital to our professional relationship. Payment for services, arriving for your scheduled appointment on time and communication are also part of that relationship.

Co-Pay, Co-Insurance and Deductibles

If your insurance company sets a designated co-pay **we are required to collect your co-pay at the time of service.** We gladly accept cash, personal checks and most major credit cards. We ask that you pay your co-pay at each visit as well as any applicable deductibles, fees for non-covered services and any other cost shares that you may incur. **If you are unable to pay at the time of service a $10 statement fee will also be added to your account.**

Cancellations and Missed Appointments

Specialists are in high demand due to the multitude and various eye diseases and disorders affecting people every day. We strive to be available to those who need our services as quickly as possible. Missed appointments limit our availability to serve all of our patients in a timely manner. Patients who miss an appointment or cancel with less than a 48-hour notice will be charged a **$25 cancellation fee***. If an appointment is missed a second time, without 48-hour notice, **a fee of $50 will be charged**. Any cancellation fees incurred must be paid prior to scheduling subsequent services.

In order for us to provide you with the best possible care, keeping your scheduled appointments is crucial. If an appointment is missed for the third time, without 48-hour notice, we will assume you wish to discontinue your eyecare and will not schedule any future appointments in our office.

***Please note: If you miss a *first-time* appointment at this practice and/or you have *been referred to us by another physician* and do not call to cancel/reschedule with at least a 48-hour notice, we will be unable to schedule another appointment and your referring physician will be notified.**

Remember we are here to help all our patients

Your clear understanding of the policies described above is important. We also realize that ***your time is very important*** and this matters to us as well. Occasionally, in order to address emergency situations and/or provide particular patients with certain unexpected individualized care, wait times in our main lobby can be longer than expected. Please be assured that ALL patients are relevant to us and if you experience a delay and are unable to wait, we will gladly reschedule your appointment at the earliest convenient time for you.

.....

_____ I have read and understand the updated financial policy of Baystate Eye Care Group and also understand that Baystate Eye Care Group reserves the right to change any and all fees at any time.

_____ I understand that I will be billed for any missed appointments for which I have not given 48 hours' notice and I agree to pay the cancellation fee/s.

Patient Signature **X**_____ Date _____

Parent/Guardian Signature **X**_____ (if patient is a minor)

BAYSTATE EYE CARE GROUP

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Baystate Eye Care Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Baystate Eye Care Group's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Baystate Eye Care Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, Jeff Curtin, at 275 Bicentennial Highway, Springfield, MA 01118.

With this consent, Baystate Eye Care Group may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Baystate Eye Care Group may mail to my home or other alternative location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Baystate Eye Care Group may e-mail to my home or other alternative location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Baystate Eye Care Group restrict how it uses or discloses my PHI to carry out TPO.

However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I have received your Notice of Privacy Practices. By signing this form, I am consenting to Baystate Eye Care Group's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

_____ _____ /_____ /_____

Patient's Name Date

_____

Signature of Patient or Legal Guardian

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices and Patient Consent, but was unable to do so as documented.

Date: _____ /_____ /_____ Initials: _____

Patient Refused to Sign _____ Communications Barrier _____ Other _____