

## 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: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGN HERE: **X** \_\_\_\_\_

Checking this box confirms  
your signature.

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

- |  |  |
|--|--|
| <input type="checkbox"/> DIABETES                  | <input type="checkbox"/> ARTHRITIS                   |
| <input type="checkbox"/> HEART ATTACK              | <input type="checkbox"/> CANCER / TUMOR              |
| <input type="checkbox"/> HIGH BLOOD PRESSURE       | <input type="checkbox"/> THYROID DISEASE             |
| <input type="checkbox"/> STROKE / SHOCK            | <input type="checkbox"/> SEIZURES                    |
| <input type="checkbox"/> PACEMAKER / DEFIBRILLATOR | <input type="checkbox"/> BLOOD CLOTS                 |
| <input type="checkbox"/> ASTHMA                    | <input type="checkbox"/> BLEEDING DISORDER           |
| <input type="checkbox"/> EMPHYSEMA                 | <input type="checkbox"/> TRANSFUSIONS                |
| <input type="checkbox"/> LIVER DISEASE / JAUNDICE  | <input type="checkbox"/> AIDS / HIV POSITIVE / A B C |
| <input type="checkbox"/> STOMACH ULCER             | <input type="checkbox"/> KIDNEY STONES / DISEASE     |
| <input type="checkbox"/> <b>PACEMAKER</b>          | <input type="checkbox"/> <b>LATEX ALLERGY</b>        |
| <input type="checkbox"/> OTHER: _____              | <input type="checkbox"/> _____                       |
| <input type="checkbox"/> _____                     | <input type="checkbox"/> _____                       |

**FAMILY HISTORY**

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

 CHECK ALL THAT APPLY

- |  |  |
|--|--|
| <input type="checkbox"/> GLAUCOMA                          | <input type="checkbox"/> COLOR BLINDNESS         |
| <input type="checkbox"/> CATARACTS                         | <input type="checkbox"/> UNEXPLAINED VISION LOSS |
| <input type="checkbox"/> "LAZY EYE" OR<br>MUSCLE IMBALANCE | <input type="checkbox"/> DIABETES MELLITUS       |
| <input type="checkbox"/> RETINAL DISEASE                   | <input type="checkbox"/> TUMOR OR CANCER         |
| <input type="checkbox"/> MACULAR DISEASE                   | <input type="checkbox"/> HIGH BLOOD PRESSURE     |
| <input type="checkbox"/> NIGHT BLINDNESS                   | <input type="checkbox"/> HEART DISEASE           |
|  | <input type="checkbox"/> BLEEDING DISORDER       |

**SOCIAL HISTORY**

 CHECK ALL THAT APPLY

- |  |                         |
|--|-------------------------|
| <input type="checkbox"/> DO YOU DRINK ALCOHOL? | HOW MUCH PER DAY? _____ |
| <input type="checkbox"/> DO YOU SMOKE?         | HOW MUCH PER DAY? _____ |

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

**SIGN HERE: X** \_\_\_\_\_

Checking this box confirms your signature.

**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

\_\_\_\_\_

\_\_\_\_\_

# 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)

Checking this box confirms your signature.

**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

Checking this box confirms  
your signature.

**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 \_\_\_\_\_