NIGHTINGALE
EYE ASSOCIATES

211 Central Park West, Suite 1E
New York, NY 10024
T: 212-877-7188
F: 212-877-3912
www.nightingale-eyes.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION				
Patient's Name (Last, First, Middle):			Today's Date: / /	
Email Address:		Date of Birth: / /	Age:	Sex: ☐ M ☐ F
Street Address:	Apt:	Home Phone: ( )	Cell Phone: ( )	
City:		State:	Zip:	
Occupation:		Employer:		
Emergency Contact:		Relation:	Emergency Contact Phone #: ( )	
GUARANTOR – PERSON RESPONSIBLE (IF DIFFERENT THAN ABOVE)				
Name (Last, First, Middle):		Date of Birth: / /	Sex: ☐ M ☐ F	
Street Address:	Apt:	City:	State:	Zip:
Relationship to Patient:		Home Phone: ( )	Cell Phone: ( )	
INSURANCE INFORMATION				
Primary Insurance & ID#:		Secondary Insurance & ID#:		
PHARMACY				
Name:		Phone:		
Street Address:		City:	State:	Zip:
PRIMARY CARE PHYSICIAN (PCP)				
Name:	Address:	Phone: ( )		
OPTOMETRIST (OD) / OPTICAL				
Name:	Address:	Phone: ( )		
HOW WERE YOU REFERRED?				
☐ Doctor (please specify):	☐ Family/Friend (please specify):	☐ Other (please specify):		

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REFRACTION POLICY

A refraction is the test that is done to give you a prescription for glasses or to update your current prescription. **A refraction must be performed if you wish to get a new prescription for glasses.** Medicare, and most other major insurance companies, consider refraction a non-covered service to be billed by physicians themselves. If you desire to have a refraction performed, the **refraction fee is $100**. This charge is collected at the time of service along with any additional co-payments, co-insurances or deductibles. Kindly let the staff know of your decision by selecting the appropriate box below.

For contact lens wearers. If you would like to update your contact lens prescription and have the information including the brand name, base curve and power of each eye, Dr. Andrew B. Nightingale and/or Dr. Jeffrey D. Nightingale will be able to give you the updated prescription. The cost of a refraction of both eyeglasses and contact lens is $150.

- ☐ Yes, I would like a refraction to receive a prescription for glasses and/or contacts. I understand that I will be charged $100 (glasses alone) or $150 (glasses and contacts) and payment is due today.

- ☐ No, please do not include a refraction in the exam today.

CONTACT LENS FITTING

If you do not wear contact lenses currently and are interested in wearing them, or if the doctor recommends a new type of contact lens, a contact lens fitting is required. A contact lens fitting is a separate charge with a separate fee schedule (available at the front desk) depending on the contact lens type.

ACKNOWLEDGMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copayment is separate from and not included in the refraction fee.

Print Name: _____

Signature: _____ Date: _____

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CANCELLATION AND NO SHOW POLICY AGREEMENT

Our practice is committed to providing all of our patients with exceptional care. When patients cancel without giving enough notice, they prevent other patients from being seen.

We understand that situations arise in which you must cancel your appointment. It is requested that if you must cancel your appointment you **provide more than 24 hours notice**. To cancel a Monday appointment, please call our office by **2pm on the preceding Friday**. This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot. Office appointments that are cancelled with less than 24 hours notification will be charged a **$50.00 Cancellation Fee.**

Patients who do not show up for their appointment without a call to cancel an office appointment will be marked as a **No Show**. Patient will be charged a **$50.00 No Show Fee.**

Cancellation and No Show Fees are the sole responsibility of the patient and must be paid in full prior to the patient's next appointment.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

Print Name: _____

Signature: _____ Date: _____

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PAYMENT POLICY

- Our office participates with most insurance companies but each plan may vary by employer and insured. **PLEASE KNOW YOUR PLAN**. **Co-payments are due and payable at the time of your office visit**. If you have a deductible that has not been met, we require a deposit towards your deductible. Once your insurance company has processed the claim, you will be billed for the remaining amount according to the Explanation of Benefits (EOB).
- If you are a member of an **HMO**, you are required by your plan to obtain a referral prior to your visit with us. If your plan requires a referral and you have not obtained one, your examination may need to be rescheduled.

I authorize the release of information to determine eligibility for payment and/or to obtain reimbursement. I understand that if my account is not paid directly, I am responsible for the full amount and may be charged all costs associated with collections of the amount due. I authorize the release of any medical information necessary to process claims and the release of payment to Dr. Andrew B. Nightingale and/or Dr. Jeffrey D. Nightingale.

AGREEMENT OF RESPONSIBILITY

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices.

Initial: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to my insurance company. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Initial: _____

Print Name: _____
Signature: _____ Date: _____

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MEDICAL HISTORY

Name: _____ Date: _____

What is the reason for your visit?

_____

Do you have a history of any of the following eye conditions?

- ☐ Cataract
- ☐ LASIK/PRK/SMILE
- ☐ Glaucoma
- ☐ Retinal detachment
- ☐ Dry eye/Blepharitis
- ☐ Macular degeneration
- ☐ Diabetic retinopathy
- ☐ Crossed eyes (strabismus)
- ☐ Lazy eye (amblyopia)
- ☐ Retinal tear/detachment
- ☐ Eye trauma
- ☐ Uveitis

Please list any other eye conditions:

_____

Do you have a history of any eye surgeries, lasers or procedures? ☐ Yes ☐ No

If yes, please list: _____

Family history of eye disease: _____

Please indicate if you have ever had any of the following medical conditions:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Irregular heart beat
- ☐ Bleeding disorder
- ☐ Stroke
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Rheumatologic disease
- ☐ Cancer
- ☐ Psychiatric disorder
- ☐ Seizure disorder
- ☐ Neurological condition
- ☐ HIV

List any other health conditions and history of surgeries:

_____

_____

List or attach your current medications:

_____ _____
_____ _____
_____ _____
_____ _____

List your current eye drops:

_____
_____
_____
_____

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please list: _____