

New Patient Information

Name (First, M.I., Last): _____

Date of Birth: _____

Sex: Male/Female

Marital Status: S M W D

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Social Security Number: _____

How did you hear about our office? _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder Date of Birth: _____

Policy Holder Social Security Number: _____

Policy Holder Social Security Number:

Policy #: _____ Policy#: _____

Group Number: _____ Group Number: _____

Address: _____ Address: _____

Patient Name

Date

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (*print*) _____

Medicare Number _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Amit Chokshi, MD, for services furnished me by Amit Chokshi, MD. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Amit Chokshi, MD accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Amit Chokshi, MD, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Amit Chokshi, MD may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Amit Chokshi, MD for reimbursement for services rendered, and (2) any health care provider for continued patient care. Amit Chokshi, MD may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Amit Chokshi, MD maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Amit Chokshi, MD has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Amit Chokshi, MD if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Amit Chokshi, MD's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Amit Chokshi, MD to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Amit Chokshi, MD, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Amit Chokshi, MD for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Amit Chokshi, MD. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Amit Chokshi, MD. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party _____

Date _____

Amit R. Chokshi M.D. P.A

Dilation

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses or dark sunglass inserts. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or that you wait until your eyes return to normal so that you can drive safely.

Refraction

A refraction is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. A refraction is NOT a covered service by Medicare or most insurance plans. These plans consider a refraction a "vision" service not a "medical" service. Medicare's benefit policy (100.02, Section 90) states: "Routine physical checkups; eyeglasses, contact lenses and eye examinations for the prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and whatever purpose performed; hearing aids; and immunizations are not covered." We will NOT file the charge for a refraction with a health insurance plan unless we know that your plan covers the refraction charge. Our office fee for a refraction is \$40.00 and this fee is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly. Cataract exams must have a refraction.

Communication Release

I hereby give permission to Dr.'s Chokshi, Coluccelli and Habashi office staff to notify me by telephone of the following:

Yes _____ No _____ Appointment reminder by either a personal or recorded message.

Yes _____ No _____ A message to call the office for test results.
(NOTE: at no time will actual test results be left by message)

Yes _____ No _____ I authorize the office of Amit Chokshi M.D., P.A to release medical information to my family physician.

Please list below any individuals that are authorized to receive information on your account
(EX: APPOINTMENTS, MEDICAL INFO, BILLING, OR PRESCRIPTIONS) _____

(EMERGENCY CONTACT PERSON)

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

Patient's Name (Printed)

Date

Patient's Signature (Legally Responsible Adult for minor)

Relationship to Patient

Amit R. Chokshi, M.D.
Office Financial Policy

Dear Patient:

Thank you for choosing Dr. Chokshi for your eye care needs. Our main concern is that you, our patient, receive the proper care needed to restore your health. We hope that you understand that our financial policy is necessary to maintain the vital health of our practice. Therefore, we have instituted the following policy. We ask that you read and sign our financial policy prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, check, and for your convenience, Master Card/Visa/Discover/AMEX credit cards. We will be happy to process insurance as long as you provide us with your **most** current insurance card and accurate information for filing. We currently participate in Medicare and most managed care plans. If you are covered under an HMO policy, you must have a referral from your primary care physician in order to see our physician. For that reason, you must make sure that we are listed as providers under your insurance plan. We must emphasize the following:

1. Not all services are covered as benefits with all insurance companies. Any charges not paid by your insurance company are solely **YOUR RESPONSIBILITY**: such as refraction (the process of determining your eyeglass prescription) **\$40.00**. We will file your claim with your insurance company as a courtesy. It is not our obligation. If your insurance company does not pay your balance within 45 days, we ask that you contact your insurance company to help expedite payment to us.
2. If your insurance company does not pay in full within **60** days, we ask that you pay the balance due in cash, check, or credit card. Remember, ultimately you are the responsible party for services rendered.
3. Co-payments and deductibles are due at the time services are rendered. It is unlawful for us to waive co-pays or deductibles.
4. If you belong to an HMO or POS plan, you must have a referral form with you **each** and **every** time you arrive for an office visit. Some referrals may include several visits. If you do not obtain a referral, you are responsible for the payment, which is due at the time of service.
5. Returned checks will be subject to a **\$25.00** check fee.
6. All balances older than **90** days will be reviewed and turned over to our collection department for payment or will be sent directly to legal course for resolution. In the event of a defaulted account, you will be responsible for any collection and/or legal fees.
7. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that we may assist you in the management of your account. Again, thank you for choosing us for your eye care needs. We appreciate the opportunity to serve you.
8. Due to the increase in no show appointments, there is now a **\$25.00** no show fee if you do not keep your appointment and did not give the office a 24 hour notice.
9. If you do not have a form of payment today for your office visit, you will be charged **\$10.00** for a billing processing fee.
10. If you have a change in your insurance and do not update it with the receptionist, you will be charged **\$20.00** to refile with your correct insurance.

Patient Signature: _____ Date: _____

By my signature, I indicate that I have read this policy and agree to its provisions.