ALLEGHENY OPHTHALMOLOGY ASSOCIATES

WELCOME TO OUR OFFICE!

1. PATIENT'S NAME: ______________________ MARITAL STATUS: M S W D

   ADDRESS: ______________________ CITY & ZIP: ______________________

   HOME PHONE: ______________________ BUSINESS PHONE: ______________________

   CELL #: ______________________

   SOCIAL SECURITY NO: ______________ BIRTHDATE: __________ AGE: _____ SEX: M F

2. GUARANTOR–(IF CHILD):______________________ RELATIONSHIP ______________________

   PHONE______________________ WORK PHONE ______________________

   ADDRESS: ______________________ CITY & ZIP ______________________

   BIRTHDATE: __________ SS # ______________OTHER INFO______________

3. NAME OF NEAREST RELATIVE NOT LIVING WITH YOU & PHONE #______________________

4. MAY WE CONTACT YOU BY PHONE OR MAIL TO, CONFIRM, GIVE TEST RESULTS, ETC. Y N

5. EMPLOYER NAME & ADDRESS ______________________

____

6. IS PATIENT A STUDENT: Y N

7. FAMILY DR.: ______________________ PHONE: __________

   ADDRESS: ______________________

8. INSURANCE INFORMATION: PLEASE INCLUDE ALL LETTERS & NUMBERS

____

9. POLICY HOLDER NAME ______________________BIRTHDATE ______________________

10. VISION COVERAGE?: Y N /NAME OF CARRIER ______________________

    VISION INS, ID # ______________________ GROUP #______________________

PLEASE BRING ALL INSURANCE CARDS WITH YOU SO WE CAN MAKE COPIES!

INSURANCE AUTHORIZATION & ASSIGNMENT **PLEASE READ AND SIGN**

I hereby authorize Michael B. Sigal, MD, Dr. Scott L. Portnoy, MD, or Michael A. Alunni, MD to release information to carriers concerning my illness and treatment. I hereby assign to the Physicians all payments for medical services by them to myself or my dependents. I understand that I am responsible for payment to this office within the stated policy. I understand that I am responsible for the refraction fee (checking of glasses) which insurance does not cover and copays and deductibles and non-covered charges.

* * * SIGNATURE ______________________________________ DATE ______________

11. IS THIS A WORK RELATED INJURY? Y N / IF YES, PLEASE FILL IN THE FOLLOWING:
    DID YOU FILE AN INJURY REPORT? Y N DATE OF INJURY ______________________

    COMPANY NAME:______________________

    ADDRESS:______________________

    PHONE: ______________________

SIGNATURE ON FILE

_________________________________ _________________________________

BENEFICIARY'S NAME (PRINT) MEDICARE IDENTIFICATION NO.

1. MEDICARE / OR EQUIVALENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO DRS. SIGAL, PORTNOY, AND ALUNNI FOR SERVICES FURNISHED ME BY DRS. SIGAL, PORTNOY, AND ALUNNI. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO 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 HCFA 1500 FORM OF ELSEWHERE ON THE OTHER APPROVED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURER OR AGENCY SHOWN.

DRS. SIGAL, PORTNOY, AND ALUNNI, ACCEPTS THE CHARGE DETERMINATION OF THE MEDICARE CARRIER. DRS. SIGAL, PORTNOY, AND ALUNNI, AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

_________________________________ _________________________________

SIGNATURE DATE

2. MEDIGAP

IF A MEDIGAP POLICY OR OTHER HEALTH INSURANCE IS INDICATED IN ITEM 9 OF THE HCFA 1500 FORM OR ELSEWHERE ON THE 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 EITHER TO ME OR ON MY BEHALF TO DRS. SIGAL, PORTNOY, AND ALUNNI.

_________________________________ _________________________________

SIGNATURE DATE

3. OTHER INSURANCE

I HEREBY AUTHORIZE PAYMENT OF MY MEDICAL AND SURGICAL INSURANCE BENEFITS TO DRS. SIGAL, PORTNOY, AND ALUNNI. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IF CO-PAYMENTS AND/OR DEDUCTIBLES ARE DESIGNATED BY MY INSURANCE COMPANY OR HEALTH PLAN, I AGREE TO PAY THEM TO DRS. SIGAL, PORTNOY, AND ALUNNI. I AUTHORIZE DRS. SIGAL, PORTNOY, AND ALUNNI TO RELEASE ANY INFORMATION REQUIRED TO PROCESS ANY AND ALL CLAIMS FOR REIMBURSEMENT ON MY BEHALF. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

X_________________________________ _________________________________

SIGNATURE DATE

ALLEGHENY OPHTHALMOLOGY ASSOCIATES

NOTICE TO OUR PATIENTS

Thank you for choosing Allegheny Ophthalmology Associates as your eye care provider. We are committed to providing you with quality and affordable healthcare. The following financial policies have been established to avert payment and insurance miscommunication. Please read it carefully and feel free to ask us any questions you may have. **Please sign in the space provided that you agree and will comply with the policy.** A copy will be provided to you.

1. **Information:** We ask that you present your insurance card to us at every visit as proof of insurance coverage. We will also ask you to verify your current home address and phone number. If we do not have accurate information to bill for the services you receive during your visit with us, **you may be responsible for payment for all service provided.**

2. **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services:** You should be aware that some, or perhaps all, of the services you receive may not be covered by your insurance provider. You will be responsible for the cost of the services. If you are unsure if a service is covered by your policy, please contact your insurance with the number on the back of your card to verify. **It is the patient responsibility to know if you are eligible for benefits, including Vision Exam and glasses or contacts with your insurance.**

4. **Payment arrangements:** We offer monthly payment plans to assist you in paying unexpected balances. Please contact our Patient Account Representative for details at 724-224-4240 ext 333 or 311.

5. **Nonpayment:** Please be aware that if a balance remains unpaid, we will refer your account to a collection agency. Once your account is in collections, we reserve the right to discharge you as a patient.

6. **Form Completions:** Please allow up to two weeks for forms, ie; FMLA, drivers forms, work releases, school papers, etc. to be completed.

Our practice is committed to providing the best care to our patients. Thank you for understanding our payment policies. Please let us know if you have any questions or concerns.

I have read and understand the above payment policy and agree to abide by its guidelines.

NAME________________________________ DOB______________________

X____________________________________ DATE____________________

Patient's signature or responsible party

DATE ______________________________

PATIENT'S NAME ______________________

SEX: M_____ F_____

DATE OF BIRTH ______________ AGE _______

FAMILY DOCTOR ______________________

WHO REFERRED YOU TO OUR OFFICE?

____

GENERAL MEDICAL PROBLEMS	YES	NO
DIABETES		
TYPE (CIRCLE) 1	2	OTHER
HIGH BLOOD PRESSURE		
ARTHRITIS		
CONGESTIVE HEART FAILURE		
BRONCHITIS/EMPHYSEMA/ASTHMA		
STROKE		
HEART ATTACK		
THYROID PROBLEMS		
CANCER		
ULCER		
AIDS		
OTHER		
PAST EYE PROBLEMS	**YES**	**NO**
GLASSES		
CONTACTS		
RETINAL DETACHMENTS		
CATARACT		
GLAUCOMA		
IRITIS/UVEITIS		
TRAUMA		
PREVIOUS EYE SURGERY		
TYPE:		
REFRACTIVE SURGERY		
(CIRCLE) LASIK RK	PRK	
TURNED EYE		
LAZY EYE		
OTHER		
FAMILY HISTORY	**YES**	**NO**
GLAUCOMA		
CATARACT		
RETINAL DETACHMENTS		
LAZY EYE		
TURNED EYE		
MACULAR DEGENERATION		
OTHER		
SOCIAL HISTORY	**YES**	**NO**
SMOKE		
DRINK		
DO YOU DRIVE		

HOBBIES ___________________________

INTERESTS _________________________

ALLERGIES TO MEDICATIONS: PLEASE LIST _________

____

____

MEDICATIONS: PLEASE LIST ____________________

____

____

Please continue on other side

Occupation: ____

Surgical History ______________________________________

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Review of Systems

Do you currently have any of the following problems:

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	n	n	______________________
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	n	n	______________________
Heart problems (e.g., chest pain, irregular heart beat)	n	n	______________________
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	n	n	______________________
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	n	n	______________________
Urinary problems (e.g., pain or discomfort, blood in urine)	n	n	______________________
Skin problems (e.g., rashes, excessive dryness)	n	n	______________________
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	n	n	______________________
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	n	n	______________________
Psychiatric problems (e.g., depression, anxiety)	n	n	______________________

Where and when was your last eye exam ______________________________

____

Pharmacy Phone # ____

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

Dated Reviewed/Updated____________________tech__________

ALLEGHENY OPHTHALMOLOGY ASSOCIATES

2853 Freeport Road
Natrona Heights, PA 15065

PATIENT COMMUNICATION FORM
EXHIBIT O

A. Family and Friends. It is the office policy of Allegheny Ophthalmology not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse________________________________ yes____________ no____________

Parent________________________________ yes____________ no____________

Other_________________________________ yes____________ no____________

______________________________________ yes____________ no____________

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:____________________________

PRINTED NAME:____

Patient/Parent/Guardian Signature______________________________

DATE __________