PATIENT REGISTRATION

PATIENT NAME				Salutation	
Birthdate		Age		Birth State	
Sex				SS #	

CURRENT ADDRESS	
Address	

ADDRESS YOUR INSURANCE COMPANY HAS ON FILE	
Address	

COMMUNICATION					
Home Phone #		Work Phone #		Ext	
Cell Phone #		Carrier			
Email					

GOVERNMENT REQUIRED INFORMATION: Check one in EACH section	
Primary Language	☐ English ☐ Spanish ☐ French ☐ Other:
Race	☐ American Indian or Alaska Native Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race ☐ Decline to Answer
Ethnicity	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline to Answer

INFORMATION			
Marital Status		Special Needs	
Occupation		Employer	
PRIMARY CARE PHYSICIAN			
Name			
Address			
Phone			
Fax			

EMERGENCY CONTACT		
Name	Relationship	Phone #

PRIMARY INSURANCE					
Name		Group Name			
ID #		Group #			
Phone #					
Policy Holder		Birthdate		SS#	

SECONDARY INSURANCE					
Name		Group Name			
ID#		Group #			
Phone #					
Policy Holder		Birthdate		SS#	

Physician's release and agreement: I hereby authorize payment directly to Lisa Nath, MD of benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medical information required by my Insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the part who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. If I fail to pay any outstanding balances, I will also incur any charges associated with the collection of these fees.

I understand I will be responsible for any fees incurred because I did not provide accurate insurance information. This includes not getting authorizations when required.

Patient's Signature:______________________________ Date:______________

I have read a copy of the Lisa Nath, MD NOTICE OF PRIVACY PRACTICES in accordance with the new HIPPA regulations.

Patient's Signature:______________________________ Date:______________

Name: Acct #: Date of Birth:

PATIENT MEDICAL HISTORY

Please fill in the following as pertains to your present overall health:

REVIEW OF SYSTEMS	
Constitution/Gen Health - (fatigue, appetite changes, etc.)	
Cardiovascular – heart related	
Ears, Nose, Mouth, Throat	
Respiratory – lungs, bronchial, chest	
Gastrointestinal – stomach related	
Genitourinary – urinary, renal, kidney	
Musculoskeletal –muscles/bones	
Integumentary – skin disorders	
Neurological – nerve related	
Endocrine – Thyroid/Diabetic	
Hematologic/Lymphatic – blood cells	
Allergic/Immunologic	
Other:	
Other:	

If Diabetic, please fill in the following:

Self Monitor BloodSugar / HgbA1c	
HgbA1C and/or Blood Sugar (please circle)	
Date Taken:	
When Taken; i.e. post breakfast, fasting	
Value:	

List all general and eye surgeries:

PAST SURGERIES		
Name of Procedure:	Date of Surgery:	Surgeon:

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

PAST / PRESENT OCULAR HISTORY/PATIENT		
		Date Diagnosed
Glaucoma		
Cataracts		
Age-Related Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus		
Amblyopia		
Diabetes		
Dry Eye		
Refractive		
Other		

Please list any FAMILY Ocular History below:

PAST / PRESENT OCULAR HISTORY/ FAMILY		
i.e. Mother, Father, brother, sister, aunt, uncle, cousin, grandmother, grandfather		Date Diagnosed
Glaucoma		
Cataracts		
Age-Related Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus		
Amblyopia		
Cancer		
Heart Disease		
Diabetes		
Other		

SOCIAL HISTORY	
Drugs:	
Alcohol:	1. Socially 2. Heavy Drinker 3. Don't drink (Please circle choice)
Occupation:	
Hobbies:	
Other:	
Tobacco – If Smoker	How long?: How many packs/day?:
Smoking Status	1. Never smoker 2. Everyday smoker 3. Former Smoker (Please circle choice)

Please list any allergies you have:

ALLERGIES

NAME	Type: Medication/Seasonal/Food	Reaction	Severity: Mild/Mod/Severe

Please list any Systemic and/or Ocular medications you are currently taking:

Medications			
Name:	Dose:	Sig/Instructions	Tablet/Capsule/Drops

Lisa M. Nath MD
511 Lincoln Ave
Pittsburgh, PA 15202
Phone: 412-734-5022
Fax: 412-766-1316

Patient Name: ______________________

Patient's Date of Birth: ______________________

HIPAA Privacy Officer: Kellie Ament – Office Manager

HIPAA

STANDARD AUTHORIZATION of USE & DISCLOSURE of PROTECTED HEALTH INFORMATION (PHI)

Unless noted below, your healthcare information can be shared with all entities outlined in the Notice of Health Information Practices guidelines. A copy of the current HIPAA Policy is posted in the office. A copy can be given to you at your request.

The following are persons/organizations to which my information ***may*** be shared with (ie: Spouse, children, caretaker, etc.)

* ____

__ Entire Patient Record __Office Notes __Testing Results/Notes __Procedure Notes __Financial History (Up to 3 years)

* ____

__ Entire Patient Record __Office Notes __Testing Results/Notes __Procedure Notes __Financial History (Up to 3 years)

* ____

__ Entire Patient Record __Office Notes __Testing Results/Notes __Procedure Notes __Financial History (Up to 3 years)

My signature below indicates that I, ______________________________, am requesting that the above named entites have access to the PHI that is indicated under their name. Please note that regular email is unsecure and it is possible for your PHI to be compromised during transmission from our practice. Because of this, we will not release your PHI via email.

- This authorization will expire 365 days from your signature below. You or your personal representative (or another individual(s) of legal entity authorized to do so by court order or law) must submit a new authorization after the expiration date to continue the authorization.
- You or your personal representative (or another individual(s) of legal entity authorized to do so by court order or law) have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice.
- This practice places no condition to sign this authorization on the deliver of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.
- You or your personal representative (or another individual(s) of legal entity authorized to do so by court order or law) have a right to receive a copy of this signed authorization at your request.

The following is my Personal Representative:

Name: ______________________________ Phone #: ______________________

______________________________ ______________________________
Printed Name of Patient Patient's Signature

______________ ______________________________ ______________________
Date Signature of Patient Representative Relationship to Patient

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER THE DATE ON THIS SIGNED FORM UNLESS REVOKED OR TEMINATED EARLIER BY THE PATIENT OR THE PATIENT'S REPRESENTATIVE.

Lisa M. Nath MD
511 Lincoln Ave
Pittsburgh, PA 15202
Phone: 412-734-5022
Fax: 412-766-1316

Lisa M. Nath, MD, LLC Patient Policies and Procedures

Due to increasing costs & decreasing reimbursements, the following policies had to be placed. We thank you for understanding. As always, we look forward to giving you the best care possible.

- Lisa M. Nath, MD, LLC will bill the insurance company/companies you have indicated that you are a member of for your visit today, provided we participate with those companies.
- Insurance cards **must be presented** at the time of service. If you do not have your insurance cards with you, you will be asked to reschedule your appointment.
- It is up to you to know if you need a referral for your visit and to obtain one. If your insurance company requires a referral for your visit and you do not have one, you will be asked to reschedule your appointment.
- The patient, or the Guarantor, is responsible for any co-pays, co-insurance, deductibles or non-covered services. Non-covered services may include Refraction charges for some insurances. **At this time, Medicare, Security Blue and Freedom Blue NEVER pay/cover a refraction.** A refraction may be necessary at today's exam in order for Dr. Nath to make a correct diagnosis. **Co-payments *and* non-covered services are always due at the time of service.** ***In some instances you may also be asked to pay for any co-insurance or deductibles at the time of service as well.*** If you do not have the funds to pay for these services, it will be up to the discretion of Lisa M. Nath, MD, LLC as to whether you will be asked to reschedule your appointment or to be billed for these charges.
- Monies collected at the time of service are applied to your account. All services are billed to your insurance/s (providing we participate). If your insurance company covers the services that you have already paid for, you will be sent a refund of any overpayment.
- Physicians release & agreement: I hereby authorize payment directly to Lisa Nath, MD of benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medical information required by my Insurance carrier(s). A copy of this authorization may be used in Lieu of the original. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the part who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. If I fail to pay any outstanding balances, I will also incur any charges associated with the collection of these fees. I also understand that I will be responsible for any fees incurred because I did not provide accurate insurance information. This includes not getting authorizations when required.
- If you are here for a contact lens evaluation, you will be asked to pay for your fit today. Once the fit is submitted to your insurance, you will be refunded if your benefit covers this service.
- When you make an appointment, it is expected that you keep it. If you cannot keep your appointment, please give us at least 24 hours' notice of cancellation. Any appointments canceled under 24 hours may be subject to a $25 Cancellation Fee. If you do not show up for a scheduled appointment and you did not call to cancel or reschedule, you ***will be*** charged a $25 No Show Fee.
- We accept cash, checks, credit cards, debit cards, health savings accounts and Care Credit. We do not accept post-dated checks.
- All returned checks are subject to a $25 NSF fee.

Patient's Signature (or person authorized to sign for patient) ______________________

Date ______________________