

## Siepser Laser Eyecare REGISTRATION FORM

(Please Print)

Today's date:				Being Seen By:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former/Maiden Name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: (    )		
<b>Chose Office because/Referred to office by (please check one box):</b>				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
<b>Family Physician (first and last name):</b>							
<b>Address:</b>							
<b>Phone Number:</b>							

INSURANCE INFORMATION								
<i><b>(Please give your insurance card to the receptionist.)</b></i>								
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: (    )		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:	Employer:		Employer address:			Employer phone no.: (    )		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> Medicare		<input type="checkbox"/> BlueCross	<input type="checkbox"/> Keystone		<input type="checkbox"/> Aetna	<input type="checkbox"/> Cigna
<input type="checkbox"/> Rail Road Medicare	<input type="checkbox"/> Elder Health		<input type="checkbox"/> United Health Care	<input type="checkbox"/> Worker's Comp		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:			<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Surgical Eye Care, LTD, t/a Siepser Laser Eye Care or insurance company to release any information required to process my claims.</p>				

# MEDICAL HISTORY

*Past Medical History and Review of Symptoms: (Check-mark if you had problems with or are presently complaining of any of the following)*

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Lower Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Skin Diseases
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Gall Bladder Disease	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Colitis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Head or Neck Radiation	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Headache	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Gout
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Alcohol Abuse

*Do you take any Medications: (Prescription, Over-the-counter, Vitamins, Herbs, etc?) YES or NO*  
*If YES, please list name of medications: (You may provide your own list.)*

<b>Drug</b>	<b>Drug</b>
<b>Drug</b>	<b>Drug</b>
<b>Drug</b>	<b>Drug</b>
<b>Drug</b>	<b>Drug</b>

**ALLERGIES TO ANY MEDICATIONS? :** (Please list) **YES or NO**


**Family History: (Please list any illness parents, grandparents, siblings have had).**

<b>ILLNESS</b>	<b>FAMILY MEMBER</b>
<b>AGE</b>	
Cancer (describe type)	
Hypertension (high blood pressure)	
Heart Disease	
Diabetes	
Strokes	
Mental Disease	
Drug and Alcohol Addiction	
Glaucoma	
Bleeding Diseases	
Other:	

**Please List and Supply the Dates of:**

<b>Operations</b>	<b>Hospitalizations other than surgery</b>

The above information is true to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL POLICY

### POLICY STATEMENT

We would like to thank you for choosing Surgical Eye Care, LTD, t/a Siepser Laser EyeCare and allowing us to provide your healthcare needs. The policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients.

Care delivered by this facility will be administered regardless of race, color, creed, social status, natural origin, handicap or sex.

We are committed to provide you with the best care possible. In order to accomplish this we need your assistance in reading and understanding the financial responsibility and our payment policy.

Initials \_\_\_\_\_

### RESPONSIBILITY FOR THE BILL

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the office will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the office in effect at the present time.

Initials \_\_\_\_\_

### REFERRALS

If your insurance plan requires a referral, it is your responsibility to have your referral submitted by your Primary Care Physician ***before*** your visit. You will not be seen if you do not have a referral. Please remember that your insurance company issues these regulations.

Initials \_\_\_\_\_

### POINT OF SERVICE COLLECTION

Payment is due at the time the service(s) are rendered. We accept cash, checks, Visa, Master Card, American Express and Discover. We will be happy to file verified insurance on your behalf. Co-pays are due at the time of service, remember this is part of the contract you have with your insurance company.

Initials \_\_\_\_\_

### REFRACTION POLICY

A "Refraction" is a procedure necessary for our physicians to evaluate your vision and/or write you a glasses prescription. Unfortunately, Medicare and most other insurance plans do not cover this procedure. **We do not bill your insurance for this refraction fee.** The cost of the refraction is \$47.00 and will be added to the medical portion of your visit. Please accept our apologies for the inconvenience this may cause and let us know if you need any clarification of the policy.

Initials \_\_\_\_\_

**I acknowledge that I have read and understand to the best of my knowledge the above outlined policies.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Steven B. Siepser, M.D., F.A.C.S.  
Daniel Merrick Kane, M.D.  
Christine Chung, M.D.  
Eris P. Jordan, OD



## NOTICE OF PRIVACY PRACTICES

By Signing below, I acknowledge that I have read and received Surgical Eye Care, LTD, t/a Siepser Laser Eye Care's **Notice of Privacy Practices** and authorize Surgical Eye Care, LTD, t/a Siepser Laser Eye Care to use, access and disclose my health information in the manner described in the notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

860 E. Swedesford Rd Wayne, PA 19087 (610) 265-2020 Fax: (610) 337-2348  
633 W. Germantown Pike, Plymouth Meeting, PA 19462 (484) 804-2600 Fax: (610) 279-3414



## **REFRACTION POLICY**

### **1. What is a refraction?**

Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

### **2. Why is it sometimes necessary?**

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A Refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription. As you can see a refraction is an essential part of an eye exam, however, Medicare and most insurance DO NOT cover it.

### **3. Will I be notified in advance if I need it?**

Yes, ONLY a technician or the physician is qualified to tell you if this procedure is necessary. They will let you know if this procedure is necessary BEFORE it is done. You will be given the option to accept or decline this service.

***IMPORTANT: If you decline we may not be able to determine the cause for your decrease in vision.***

### **4. How much is it?**

Our office policy is to charge **\$47.00** for this procedure in addition to the office visit co-pay and/or deductible. ***This is due at the time services are rendered.*** We will bill your insurance according to the individual contracted fee schedules. However, if your insurance pays the fee we will gladly refund you this prepaid **\$47.00** amount once we receive notice from your insurance.

***NOTE: This fee is due and payable whether or not you receive a written glasses prescription.***

***Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and new prescription will not be given. However, the fee covers the technician's time and effort in achieving this process.***

### ACKNOWLEDGEMENT

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 co-pay and deductible are separate from, and not included in, the refraction fee.

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Patient signature (Parent for minor)

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Date

Witness Signature

Date