Westwood Ophthalmology Associates P.A.
300 Fairview Avenue
Westwood, NJ 07675

PATIENT REGISTRATION FORM

First Name	MI	Last Name	Age	Sex: ☐M ☐F
Home Address		Apt #	Marital Status: ☐S ☐M ☐D ☐W	
City		State / Zip	DOB	
Primary # ☐Home ☐Mobile		Secondary # ☐Home ☐Mobile	Work #	
SS#	Driver's License #	E-Mail Address		
Patient Employer Name, Address/Occupation				
Financially Responsible Persons Address (if different from patient)				
Is patient residing in a Skilled Nursing Facility / Rehabilitation Center? _____ Yes _____ No				
If yes, name and address of facility:			Phone #	
Emergency Contact Name	Relationship		Phone #	
Referring Physician			Phone #	
Primary Care Physician			Phone #	

IF PATIENT IS UNDER AGE 18 PLEASE COMPLETE (WHO IS RESPONSIBLE FOR THIS ACCOUNT)

Mother's Full Name	SS#	DOB	Home #	Cell #
Mother's Employer	Work Phone # and Ext		Home Address If Different Than Above	
Father's Full Name	SS#	DOB	Home #	Cell #
Father's Employer	Work Phone # and Ext		Home Address If Different Than Above	

INSURANCE INFORMATION: Irene A.Tran, OD is the ONLY doctor who participates in some vision plans. We will only submit claims for Dr. Tran's patients to vision plans. Please initial verifying that you acknowledge this statement.

NAME OF VISION PLAN: _____ **Patients Initials** _____

Primary Insurance	Policy Holder Name	DOB	Sex: ☐M ☐F
Address			
ID #	Group #	Effective Date	
Secondary Insurance	Policy Holder Name	DOB	Sex: ☐M ☐F
Address			
ID #	Group #	Effective Date	

FINANCIAL POLICY STATEMENT

Welcome to Westwood Ophthalmology Assoc., PA, we are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will submit your claim. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. Should your account be sent to a third party collector, you agree to pay an additional 30% of the balance or $50, whichever is greater. A return check fee of $35 will be assessed if your check is returned by your bank.

Patient's Signature **Date**

PATIENT AUTHORIZATION

I hereby authorize Westwood Ophthalmology Assoc., PA to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and or any other insurance company be made directly to Westwood Ophthalmology Assoc., PA. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare part B benefits.

Patient's Signature **Date**

I acknowledge that I have received the "Notice of Privacy Practice" from Westwood Ophthalmology Associates, P.A.

Print Patient's Name _____ Date _____

Signature of Patient and/or Legal Guardian _____

Print Legal Guardian's Name _____

Consent to Release Information:

By signing below, you permit Westwood Ophthalmology Associates, P.A. to release any medical information to the physicians involved in your care. You consent that this practice may call you at home or other designated locations and leave a message on your answering machine, voice mail or in person in reference to appointment reminders and insurance items. In addition, this practice may mail to your home appointment reminder cards and patient statements.

You designate the following representative(s) who Westwood Ophthalmology Associates, P.A. can communicate with on your behalf. If you do not designate anyone, the doctor will not be able to speak to anyone in your family regarding your medical condition.

Name	Relationship
Name	Relationship
Name	Relationship

Print Patient's Name _____ Date _____

Signature of Patient and/or Legal Guardian _____

Print Legal Guardian's Name _____

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 Westwood Ophthalmology, for services furnished me by Westwood Ophthalmology. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) 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. Westwood Ophthalmology 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 Westwood Ophthalmology, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Westwood Ophthalmology 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 Westwood Ophthalmology for reimbursement for services rendered, and (2) any health care provider for continued patient care. Westwood Ophthalmology 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 Westwood Ophthalmology 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 Westwood Ophthalmology 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 Westwood Ophthalmology if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Westwood Ophthalmology'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 Westwood Ophthalmology to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Westwood Ophthalmology, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Westwood Ophthalmology 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 Westwood Ophthalmology. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Westwood Ophthalmology. 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

OFFICE POLICY FOR ALL PATIENTS

For the benefit of our patients the doctors of Westwood Ophthalmology Associates have enrolled in numerous health insurance programs. Please be advised that we do not participate in any "vision" plans. Such plans do not cover medical services rendered by our physicians. Ophthalmologists are medical doctors, highly trained physicians and eye surgeons whose professional services are typically covered under medical insurance plans. Unfortunately, due to the intricacies of the many different health insurance plan policies, and how frequently they change, it is simply not possible for us to keep up to date with the specific coverage of each individual patient's plan. It is ultimately the patient's responsibility to understand his or her insurance plan's policies with regard to eye care. Health insurance companies have been covering fewer services in recent years throughout medicine and passing the cost along to the patient. There may be portions of your exam today that are not covered by your insurance plan. You will be responsible for those charges. We know how confusing this can be, so we wanted to point out some common billing misunderstandings *before* your visit with one of our physicians:

"**Referrals:"** Some plans require that you obtain a referral from your primary care doctor before you see a specialist like one of our ophthalmologists, otherwise they won't pay for it. It is your responsibility to find out if a referral is necessary in your plan. You must have the necessary documentation at the time of your visit in order to be seen.

"**Deductible:"** Under some plans the insurance coverage does not kick in until you have first spent a certain amount of money yourself, out-of-pocket, for doctor visits. This amount is called a "deductible" and can be as high as a few thousand dollars in some cases. If you have not yet met your plan's annual deductible for this calendar year, then you may be responsible for the entire bill. Many patients forget that when a new year begins the deductible begins again as well. Please check your plan so that you are not surprised.

"Co-Payment:" By now most patients are familiar with this policy imposed by many insurance plans. This is the portion of the exam fee that your plan expects you to pay. "Co-Pays" are expected at the time of service and may differ between a specialist and primary care doctor. Your insurance card often lists the exact amounts.

"**Well-Care Vision Coverage:"** Some plans will cover the cost of an annual eye exam whether or not a medical problem exists or is found on exam. This is typically called "well-care" coverage. Others will only pay the claim if a medical disorder is discovered. Find out what your plan says about this. Many plans do not consider the need for eyeglasses for distance or reading a medical disorder, so you may be responsible for the bill if you do not have well-care coverage. Likewise, "routine" or normal eye exams where no problem is found may not be covered without a "well-care" provision.

"**Refraction:"** This is a diagnostic test performed during most complete eye examinations and in some shorter visits to determine the optical state of the eye (near or far-sighted, astigmatic, presbyopic). Refractions are medically necessary to properly diagnose and treat eye disorders and are also the basis for prescribing glasses and contact lenses. Some health insurance companies inexplicably simply stopped paying for this test despite our strenuous objections. As it is a critical piece of medical information our physicians must continue to perform refractions when indicated. Your insurance company may be one of those that does not cover this test. Please check in advance.

"Pre-Existing Condition:" Some policies will not cover care related to a medical disorder that was diagnosed prior to the start of coverage with that particular company/plan. Check to see if such provisions apply to you.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY FOR ANY NON-COVERED SERVICES.

_____ _____

Patient Name Date

_____

Patient Signature / Guardian Signature

Westwood Ophthalmology Associates P.A.

PATRICK K. CHIN, MD
Comprehensive Ophthalmology
Cataract/IOL Surgery
LASIK Refractive Surgery

MICHAEL S. FLEISCHER, MD
Comprehensive Ophthalmology
Cataract/IOL Surgery
Diabetic Eye Care

GLEN M. BIANCHI, MD
Pediatric Ophthalmology
Adult Strabismus
Comprehensive Ophthalmology

JUNG S. LEE, MD
Comprehensive Ophthalmology
Cornea and External Diseases
Cataract/IOL Surgery
LASIK Refractive Surgery

JEFFREY S. KAIDEN, MD
Comprehensive Ophthalmology
Glaucoma Management

BRENDA PAGAN-DURAN, MD
Comprehensive Ophthalmology

JAMES KIRSZROT, MD
Comprehensive Ophthalmology
Oculoplastic Surgery

IRENE A.TRAN, OD
Comprehensive Eyecare
Contact Lens Specialist

Westwood Ophthalmology only participates with Spectera and your appointment must be with Dr. Irene Tran for your yearly eye examination in order to use your Spectera benefits.

_____ Your visits at Westwood Ophthalmology will be submitted to your medical insurance company only, unless you are scheduled with Dr. Tran for your yearly exam and are using **Spectera**.

_____ If you advise us that you have a vision plan other than **Spectera**, this visit will be submitted to your medical insurance. If your medical insurance advises us of any non-covered service (such as "refraction", but not limited to it), then you will be responsible for the billed services and we will not submit a claim to your vision plan because we do not participate in other vision plans.

Once again, we only participate in **Spectera** and your yearly appointment must be with Dr. Tran.

By signing this form, Westwood Ophthalmology has advised you that the only vision plan we participate in is **Spectera**; and if you have another vision plan, then you are going out of network with your vision plan and this bill will be your responsibility.

_____ _____

Patient Signature Date

_____

Patient Name