MEDICAL EYE
ASSOCIATES
DOCTORS SURGERY CENTER
AMERICAN OPTICAL

MONT J. CARTWRIGHT, M.D., F.A.A.C.S
Diplomate, American Board of Ophthalmology

WISSAM HADRI, D.O.
Doctor of Osteopathic Medicine

For Our Patients

We would like to thank you for giving us the opportunity to be your vision specialist. We are committed to providing you with high quality service. To perform at a level of excellence, we need to provide you with information about what we need from you.

We ask that you prepare for an estimated three (3) hour wait for your appointment.

During this time our technicians will be reviewing your medical history, performing dilations, tests, and meeting your doctor.

We thank you for your patience and understanding.

Sincerely,

Medical Eye Associates Management Team

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Welcome to Our Office

Today's Date: ______________________ Soc. Sec # ______________________

Patient's Name: ____________________________________/____________________

(First) (MI) (Last) (Preferred Name)

Marital Status: Single / Married / Divorced / Widowed

Date of Birth: ____/____/_______ Age: ________ Sex: F M

Address: ____

City, State and Zip Code: ______________________________________

Home#: (_______) _____________ Cell#: (_______) _____________ E-mail: ________________

Spouse's Name: ________________________________ Phone#:(_______) _____________

Employer: ________________________________ Work#: (_______) _____________

Have you been seen by another eye doctor? Yes / No For this similar condition? Yes / No

Referred By: ________________________________ Phone#:(_______) _____________

Family Physician Name: ________________________________ Phone#:(_______) _____________

Insurance Information

Principal Insurance Name: ______________________________________

Insurance Policy Holder's Name: ________________________ Date of Birth: ____/____/_______

Insurer's Social Security: ________________________ Member/Policy ID: _____________

Secondary Insurance Name: ______________________________________

Insurance Policy Holder's Name: ________________________ Date of Birth: ____/____/_______

Insurer's Social Security: ________________________ Member/Policy ID: _____________

Emergency Contact

In case of emergency, please contact: ________________________ Phone#:(_______) _____________

Relationship to you: _______________ Address: ______________________________

Name of family member NOT residing with you: ________________ Phone#:(_______) _____________

Relationship to you: _______________ Address: ______________________________

PLEASE NOTE: PAYMENT IS EXPECTED AT THE TIME OF SERVICE

- ☐ I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payments to Medical Eye Associates for any services rendered to me by any Medical Eye Associates provider.
- ☐ I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, coinsurance and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of the service provided.
- ☐ I authorize use of this form on all my insurance submissions. I understand **I am responsible** for my bill. I permit a copy of this authorization to be used in place of the original.
- ☐ I understand **I am subject to be charged a $50 (fifty dollars) cancellation/no show fee** for canceling my appointment without giving 24-hour notice.
- ☐ I understand **I am subject to be charged a $100 (one-hundred dollars) cancellation/no show fee** for canceling my laser appointment without giving 48-hour notice
- ☐ I understand **I am subject to be charged a $200 (two-hundred dollars) cancellation/no show fee** for canceling my laser or any surgical appointments without giving 24-hour notice.

______________________________________ ________________

Signature of Patient or Legal Guardian (Signature on file for payment authorization) Date

NOTE: ANY UNPAID BALANCES FROM PREVIOUS VISITS, OR NON-ALLOWED CHARGES/NON-COVERED SERVICES MUST BE PAID IN FULL TODAY. I request that authorized Medigap benefits (if applicable) be made on my behalf to Medical Eye Associates. I authorize Medical Eye associates to contact the State Ins. Commissioner on my behalf in which state my insurance company domiciles to collect their payment. SIGNING THIS FORM CERTIFIES YOUR AGREEIANCE WITH ALL THE STATEMENTS ABOVE. If you disagree with any statement, please discuss it with us before signing.

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Advanced Notice of Patient Responsibility for Non-Covered Services

PLEASE NOTE: If a refraction test is needed to determine a prescription for your glasses, a fee of $40.00 is collected at the time of visit. This test is covered by vision insurance only. ***The refraction test is not covered by medical insurance.***

______________________________________ ______________
Patient Signature Date

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Eye Drops

In order to perform a thorough evaluation of the health of your eyes, it is sometimes necessary to dilate the pupils with eye drops. Please be advised of the potential for a significant decrease in vision after dilating drops and driving may be difficult.

______________________________________ ______________
Patient Signature Date

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Patient Information Disclosure

Authorization

Please list below the names of persons who are authorized to receive information from Medical Eye Associates, Doctors Surgery Center, and American Optical concerning your diagnoses, treatment, and prognosis for purposes other than treatment and payment. When authorized persons request healthcare information pertaining to you, they will be required to present a photo I.D. When authorized persons inquire via telephone, your name, date of birth and social security number will be verified. Authorized names shall remain on file until you request removal.

Name	**Relationship to Patient**

____
Patient Signature

____
Date

____
Patient Name

Acct#:_______________

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Assignment of Medical/Surgical Benefit
Authorization to release Medical Information

I,______________________________________hereby irrevocably assign and transfer payment of any and all medical benefits to which I may be entitled for services provided by Mont J. Cartwright, M.D. and Wissam Hadri, D.O. pursuant to contact of health insurance, group health insurance, Medicare, Medicaid, no fault automobile insurance, or any type or form of insurance whatsoever, and authorize payment of said benefits directly to the aforementioned physician and or supplier. This assignment shall be binding upon my heirs, executors and administrators.

I understand that I am financially responsible for any unpaid balance reflecting insurance deductibles, coinsurances and non-covered services.

I authorize to release, to my insurance company, of any medical or other information which may be necessary to process claims for services provided to me by the above-named physician and/or supplier.

I authorize the release of pertinent medical records to the physician who referred me, as well as to my primary care physician, upon request.

All photos taken are the property of Medical Eye Associates; they may be used for insurance authorizations, educational purposes, and medical publications. Original photos cannot be released. This authorization will certify that I give full consent to have photograph(s) taken, whether still or motion and to have said photograph(s) or portions thereof published. Photograph(s) taken for a specific purpose may be used for multiple purposes, including publications and advertising.

A photocopy for this authorization shall serve in the place and stead of this original.

____________________ ____

Date Patient’s or Authorized Person’s Signature

Witnessed By:____

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Insurance Terminology for Patients

Participating Provider:	Any doctor who agrees to accept the Medicare allowable (not the Medicare payment) as payment in full.
Medicare Allowable:	The amount Medicare allows for a particular charge which may be equal to or less than the doctor's charge.
Medicare Payment:	Medicare pays 80% of the allowable amount after the $257.00 deductible has been met.
Medicare Deductible:	Medicare requires that you pay the first $257.00 they have allowed for charges submitted on an annual basis.
Medicare Co-Payment:	What's left after Medicare pays their 80% of the allowable. You are responsible for the 20% balance due under co-payments.
Out-Of-Pocket Expense:	Medicare requires that you pay $257.00 deductible, plus 20% of the allowable amount.
Supplemental Insurance:	You may purchase a separate insurance policy that may pay your out-pocket expenses (Medicare deductible and co-payment) in part or in full, depending on the terms of your policy.

_______________________________________ ____________________

Patient Signature Date

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Dear patient,

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and the convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescription of your prescription to mail order pharmacies.

To implement this new program, we need to collect some information from you on the pharmacies of your choice. We will define one pharmacy as your main pharmacy; however, you may also provide information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone and fax) as any information provided will be helpful.

Patient Name:________________________________ Date of Birth: _____________

Main Pharmacy
Name (i.e. CVS, Walgreens, etc.):____
Street Name & City: ____
Phone:___________________________________ Fax:________________________

Additional Pharmacies
Name (i.e. CVS, Walgreens, etc.):____
Street Name & City: ____
Phone:___________________________________ Fax:________________________

Name (i.e. CVS, Walgreens, etc.):____
Street Name & City: ____
Phone:___________________________________ Fax:________________________

☐ Medco ☐ CareMark ☐ Express Scripts ☐ Pharmacare ☐ Other

Please list your allergies:____