

Bannett Eye Centers, P.A., Wills Eye Institute affiliate

Custom Cataract Surgery, Advanced Implant Technology, Diabetic Retinopathy and Macular Degeneration Treatment Center, Laser Surgery, Glaucoma, Dry Eye Care, Comprehensive Eye Care

With offices at:

**620 N. Broad Street
Woodbury, NJ 08096**

Phone: (856)853-5554

Fax: (856)853-5650

Gregg A. Bennett, D.O.

Board Certified Ophthalmologic Surgeon
Fellow, American Academy of Ophthalmology

Kara Della Torre, M.D.

Board Certified Ophthalmologic Surgeon
Medical Retina Specialist

Dear Patient:

Welcome To Our Practice!

In an effort to efficiently serve you, we are sending you these papers prior to your appointment. **PLEASE BE SURE ALL PAPERS ARE FILLED OUT AND SIGNED BEFORE YOUR APPOINTMENT.**

You will need to bring the following to your appointment:

- Paperwork we mailed you
- All insurance cards
- Referrals – if you do not have a required referral, you will need to reschedule
- Copay, if your insurance requires
- Medication list **AND ALL OF YOUR EYE MEDICATIONS IN A PLASTIC BAGGIE.** *Please also bring your pharmacy insurance "formulary" list booklet in case you need a prescription sent in.*

Please note that **one of our doctors is allergic to fragrance**, so we ask that you please refrain from wearing perfume, cologne, or scented lotions on the day of your exam. **Also, since your eyes will be dilated for the exam, we recommend that you have someone drive you home, as the dilating drops can compromise your vision.** We also recommend that you bring sunglasses with you for comfort from sun glare.

PLEASE BE AWARE THAT WE DO NOT DO CONTACT LENS FITTINGS. We will be happy to refer you to an optometrist should you wish to get contacts.

If you have Medicare and need a refraction**, there will be a \$50 charge which you should be prepared to pay at your visit. **REFRACTIONS ARE NOT COVERED BY MEDICARE.** If you have a secondary insurance that covers refractions, we will refund your payment after your secondary pays. If your secondary insurance follows Medicare guidelines, they will NOT pay for refraction because Medicare does not pay for refraction.

****NEW COVID PROTOCOLS: WE MUST TALK TO YOU THE DAY BEFORE YOUR APPOINTMENT TO ENTER THIS DATA INTO OUR COMPUTER AND DO OUR COVID PRESCREEN. WITHOUT THIS CONVERSATION, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.****

Bannett Eye Centers, P.A.

Last Name: _____ First Name: _____ Mid. In _____
Dr/Mr/Ms/Miss/Mrs (circle one) Date of Birth: _____ Sex: M F
Marital Status: Single Married Divorced/Widow(er)
Home Address _____ Apt#: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) ____-____ Cell Phone: (____) - ____ - ____
Email: _____@_____ Social Security #: _____ --- _____ --- _____
Occupation: _____ Retired: Yes ___ No ___
Work Phone#: (____) _____ Present Employer: _____
Employer's Address: _____
Referred By: _____
Name of Family Physician: _____ Phone#: (____) ____-____
Physician's Address: _____
Optometrist: _____ Phone#: (____) ____-____
Name of Spouse/Parent: _____ Date of Birth: _____
Spouse or Parent's Social Security #: _____ --- _____ --- _____
Spouse's Employer: _____ Retired: Yes No

PRIMARY INSURANCE:

Insurance Name: _____
ID#: _____ Group # _____
Subscribers Name (If Different from patient): _____
Relationship to Patient: Self Spouse Child Other (check one)
Subscriber's Address (If Different from patient): _____
Subscriber's Date of Birth: _____ Subscriber's Social Security#: _____ --- _____ --- _____
Phone#: _____ Retired: Yes No

SECONDARY INSURANCE:

Secondary Insurance Name: _____
ID#: _____ Group#: _____
Subscribers Name (If Different from patient): _____
Relationship to Patient: Self Spouse Child Other (check one)
Subscriber's Address (If Different from patient): _____
Subscriber's Date of Birth: _____ Subscriber's Social Security#: _____ --- _____ --- _____
Phone#: _____ Retired: Yes No

PATIENT OR AUTHORIZED SIGNATURE:

ALL INSURANCE: I authorize the release of any medical information necessary to process this claim and request payment of benefits to Bannett Eye Centers. I understand I am financially responsible for all fees and will be billed for any balance & deductible my insurance does not cover.

X _____ Date: _____

MEDICARE ONLY: I request payment of authorized Medicare benefits be made to Bannett Eye Centers for any services furnished me by that physician. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/____ Date: ____/____/____
Primary Care Physician: _____ Referring Dr. _____
Email address: _____@_____ Local Pharmacy: _____
Location(street & city) _____ Phone # _____
Mail Order Pharmacy: _____

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White or Caucasian Other _____ Unknown

Ethnicity: Hispanic Not Hispanic

Preferred Language: English French Italian Japanese Portuguese Russian Spanish

Allergies: _____ **Reaction:** _____ **Severity:** mild / moderate / severe

_____ mild / moderate / severe
_____ mild / moderate / severe

Past Ocular Health (please check all that apply):

- Overall Healthy Diabetic Retinopathy Iritis Optic Neuritis
 - Amblyopia (Lazy eye) Dry Eye Keratitis Sicca Retinal Detach
 - Cataracts Glaucoma Macular Degeneration Retinal Disease
 - Conjunctivitis Injury/Trauma Uveitis
- Other _____

Ocular Surgeries: (Please mark all that apply)

- No prior ocular surgery Foreign Body Removal Punctal Plugs Yag Capsulotomy
 - Blepharoplasty Glaucoma Surgery Retinal Laser (Rt eye Lt eye)
 - Cataract Surgery (Rt eye Lt eye) Intravitreal Injections Vitrectomy Strabismus surgery
 - Laser surgery for glaucoma Radial Keratotomy Corneal Transplant PRK/LASIK (refractive surgery)
- Other _____

Current Eye Medications: (Please list)

Systemic Illnesses that currently have or have had in the past:

- Acid Reflux Carotid Artery disease Heart Attack Lupus
- Ankylosing Spondylitis Congestive Heart Failure Heart Disease Migraine
- Anxiety Disorders COPD Hepatitis Multiple Sclerosis
- Arrhythmia Deep Vein Thrombosis High Blood Pressure Rheumatoid Arthritis
- Arthritis Depression High Cholesterol Seasonal allergies
- Asthma Diabetes HIV/AIDS Stroke/TIA
- Auto Immune Disease Gastric ulcers Kidney Disease Thyroid Disease
- Cancer Headache

Active Infections for which you are being treated:

Other _____

Major Surgeries: (Please list)

Patient Name: _____ **Date of birth:** _____

Current Medications: (Please list, or reference a list you provide to us)

Family History (Indicate relation as maternal grandmother/father, paternal grandmother/father, parent, sibling, or child):

<u>Disease</u>	<u>Relation</u>	<u>Living or Deceased</u>	<u>Approx. Age at Onset</u>
<input type="checkbox"/> Arthritis	_____	_____	_____
<input type="checkbox"/> Blindness	_____	_____	_____
<input type="checkbox"/> Cancer	_____	_____	_____
<input type="checkbox"/> Cataract	_____	_____	_____
<input type="checkbox"/> Glaucoma	_____	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____	_____
<input type="checkbox"/> Kidney Disease	_____	_____	_____
<input type="checkbox"/> Lazy Eye	_____	_____	_____
<input type="checkbox"/> Macular Degeneration	_____	_____	_____
<input type="checkbox"/> Multiple Sclerosis	_____	_____	_____
<input type="checkbox"/> Retinal Disease	_____	_____	_____
<input type="checkbox"/> Stroke	_____	_____	_____
<input type="checkbox"/> Tuberculosis	_____	_____	_____
Other	_____		

Social History: (Please mark all that apply)

Smoking: current every day smoker current some day smoker former smoker never smoked
Circle applicable: cigarettes/pipe/cigar 1 pack/day 1/2 pack/day explain other quantities: _____

Alcohol Use: Yes No If yes, how much and how often? _____

Recreational Drug Use: Yes No If yes, what drug and how often? _____

Patient Name: _____ **Date of birth:** _____

Review of Systems:

Eyes

Previous Surgery

- Contact Lens
- Pain
- Double Vision
- Glaucoma
- Cataracts
- Macular Degeneration
- Dry Eyes
- Flashes
- Floaters

Ear, Nose, and Throat

- Hard of Hearing
- Ringing in Ears
- Vertigo

Cardiovascular

- Chest Pain
- Dizziness
- Fainting Spells
- Shortness of Breath
- Irregular Heart Beat
- Difficulty Lying Flat

Constitutional

- Fatigue / Weakness
- Fever
- Weight Gain / Loss

Respiratory

- Cough
- Congestion
- Wheezing
- Asthma

Gastrointestinal

- Heartburn
- Nausea / Vomiting
- Jaundice / Hepatitis

Genito-Urinary

- Pain / Difficulty
- Blood in Urine
- History of Kidney Stones
- History of STD's

Psychiatric

- Anxiety / Depression
- Mood Swings
- Difficulty Sleeping

Endocrine

- Increased Thirst
- Increased Hunger
- Increased Urination
- Increased Sweating
- Fingernail Changes

Blood / Lymphnodes

- Easy Bruising
- Gums Bleed Easy
- Prolonged Bleeding
- Heavy Aspirin Use

MusculoSkeletal

- Stiffness
- Arthritis
- Joint Pain / Swelling

Skin

- Rash / Sores
- Lesions
- Hives / Eczema

Neurological

- Seizures
- Weakness / Paralysis
- Numbness
- Tremors

Immunologic

- Hives
- Itching
- Runny Nose
- Sinus Pressure

Have you had 2 or more falls in the past year? ___Yes ___No

Have you had your flu vaccine this year? ___Yes ___No

Have you had your pneumonia vaccine this year? ___Yes ___No

****PLEASE BRING YOUR PHARMACY PLAN'S FORMULARY BOOKLET WITH YOU TO YOUR APPOINTMENT IN THE EVENT OUR DOCTOR NEEDS TO PRESCRIBE YOU MEDICATION.****

Name: _____ Date of Birth: _____

Do you currently have any problems in the following areas? If YES provide information:

EYES	YES	NO	
Loss of Vision			
Blurred Vision			
Distorted Vision (Halos)			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy/Gritty Feeling			
Itching			
Burning			
Foreign Body Sensation			
Excess Tearing/Watering			
Occasional Tearing			
Glare/Light Sensitivity			
Eye Pain/Soreness			
Sties/Chalazion			
Fluctuating Visual Acuity			

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Name: _____ Date of Birth: _____

SOCIAL HISTORY

Current Occupation: _____

	YES	NO	EXPLANATION
Do you drive?			
Do you have visual difficulty driving?			
Do you have a problem w/ night vision			
Have you ever tried wearing contacts?			
Do you currently wear glasses?			If yes, how long have you had current pair? _____
Have you ever had a blood transfusion?			
Have you ever been in contact with someone who had an STD			

History Reviewed: No Changes Additions as noted above

Physicians Signature: _____ Date: _____

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BANNETT EYE CENTERS, P.A. NOTICE OF PRIVACY

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you have received in our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice serves to inform you that we have a policy regarding the ways in which we may use and share medical information about you. This policy includes a description of your rights and certain duties that we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY:

1. To keep your medical information private
2. To make this notice available which describes our legal duties, privacy practices, and your rights regarding your medical information
3. To follow the terms of the notice that is now in effect

WE HAVE THE RIGHT TO:

1. Change our privacy policies and the terms of this notice at any time, provided that the changes are permitted by law
2. Make the changes in our privacy policies and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

NOTICE OF CHANGES TO PRIVACY POLICIES:

1. Before we make an important change to our privacy policies, we will change this notice and make the new notice available upon request

I understand that this serves only as an overview and a more detailed policy is available for my review upon my request

X_____ Date: _____

I do hereby give my permission to Bennett Eye Centers, P.A. to release *some* confidential medical information such as appointments, test results, medical prescriptions, refills and instructions, referral information, and billing questions to my immediate family members or other concerned individuals involved in my health care. All other medical information will not be discussed without my express permission. Information may be conveyed by phone, fax, or in person.

X _____ Date: _____

PERMISSION TO LEAVE MESSAGES ON ANSWERING MACHINE OR VOICE MAIL _____ YES
_____ NO

WHAT YOU NEED TO KNOW ABOUT BILLING AND INSURANCE

Bannett Eye Centers, P.A. will be happy to submit an insurance claim form to your insurance for you for today's visit. If we participate with your particular insurance plan, our billing office will receive an Explanation of Benefits telling us what the allowable amount of the services are, how much the insurance company is paying, how much we have to write off, and what you owe. You will receive this same Explanation of Benefits ("EOB") in the mail.

If we do not participate with your particular insurance plan, we will still be happy to submit a claim form to your insurance, however, you will be responsible for all charges incurred. Because we do not participate with your plan, we may or may not receive an EOB, and your insurance company may pay you instead of us. You should receive an EOB.

EVERY PLAN IS DIFFERENT. Please do not expect us to know the details of your plan-that is your responsibility. WE STRONGLY ADVISE you call your insurance company prior to your appointment.

I _____ understand I will be financially responsible for the following:
(Print name here)

1. All charges which my participating insurance company applied to my **deductible, copay and coinsurance.**
2. All charges which are deemed "**non-covered**" by my plan.*
3. All charges for which I should have gotten a referral, but did not.
4. "**Routine eye care**" exams that are not covered under my plan.**
5. All charges, if I have a non-participating insurance plan/company or no insurance at all.
6. Not giving the office accurate and current insurance information. ***

***Refractions** are not covered by most insurance plans, including Medicare and Medicaid. A refraction is that part of the eye examination that determines whether you need prescription eyeglasses to improve your vision, or whether there has been a change in your glasses prescription since your last visit. When the technician asks you, "Which is better, one or two?," that is the refraction part of your office visit. A change in your vision can be caused by many things, ranging from natural aging, including the development of cataracts, to more serious eye diseases. While a refraction is usually only needed once a year, sometimes it may be necessary more frequently, especially if a patient notices and complains about a change in his/her vision. The objective information obtained from a refraction is **crucial** to assisting the doctor in his/her assessment of the health of your eyes. IF YOU DO NOT WISH TO HAVE A REFRACTION, PLEASE ADVISE THE OPHTHALMIC TECHNICIAN WHO WORKS YOU UP. You will need to sign a waiver stating that, by refusing a refraction, you understand that you are taking away this crucial piece of information from the doctor, which may impact on your exam. You should also be aware that, without a refraction, the doctor will be unable to update your eyeglasses prescription. Our current fee for a refraction is \$50.

Many insurances, including Medicare, will only allow you to see an ophthalmologist if you have a medical diagnosis, not a "routine eye care**" diagnosis. Examples of "routine eye care" diagnosis are myopia (near sightedness), hyperopia (far sightedness) and presbyopia (difficulty reading). You are required to know whether your plan covers "routine eye care" by an ophthalmologist.

***If you do not give us accurate and current insurance information, our claims will not be properly processed. Every insurance company has their own "timely filing" period – some as little as 90 days. If our claims are delayed because you give us the wrong information, you will be responsible for our bill.

Our Billing Policy

Payment is due at the time services are rendered. If there is a balance due on your account, we will send you a bill. We will send four bills before we send your account to our collections agency. If your account is turned over to a collection agency, you will also be responsible for

their fee. Your signature below indicates you have read and understood the information provided in this statement, and agree to pay your bill in a timely manner.

Patient/Responsible Party's signature

Date

BANNETT EYE CENTERS CANCELLATION POLICY:

PLEASE NOTE – WE HAVE MANY PATIENTS WHO HAVE BEEN WAITING A LONG TIME FOR APPOINTMENTS WITH OUR SPECIALISTS. IN CONSIDERATION OF THEM, AND OUR OWN STAFFING CONCERNS, WE WOULD APPRECIATE IT IF YOU NEED TO CANCEL YOUR APPOINTMENT YOU GIVE US AT LEAST 24 HOURS NOTICE.

At our discretion, APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE WILL INCUR A \$50 CANCELLATION CHARGE.

Signature: _____ Date: _____

Name of Patient/Responsible Party: _____

****PLEASE BRING YOUR PHARMACY PLAN'S FORMULARY BOOKLET WITH YOU TO YOUR APPOINTMENT IN THE EVENT OUR DOCTOR NEEDS TO PRESCRIBE YOU MEDICATION.****

Things you should know about your visit with our ophthalmologists:

YOU ARE SEEING A MEDICAL SPECIALIST.

YOUR EYES WILL BE DILATED. We recommend that you bring a driver and sunglasses with you to your appointment. Everybody reacts to dilating drops differently.

WE DO NOT DO CONTACT LENSES. We can recommend some wonderful optometrists to you who do fit contact lenses.

WE MAY NEED TO DO DIAGNOSTIC TESTING DURING YOUR APPOINTMENT. Your insurance may apply a coinsurance or deductible to the testing over and above your copay for the office visit.

YOU WILL PROBABLY BE REFRACTED. One of the most important parts of your eye exam is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. **It is NOT a covered service by Medicare and many other insurance plans.** These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is \$50 and, unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment/co-insurance your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly. If you are coming to us for a **cataract evaluation**, we WILL be doing a refraction, even if you had one recently at another provider's office. **Payment is due at the time of service.**

_____ 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 and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

_____ I decline the refraction service today. I understand that without the refraction, Dr. Bannett or Dr. Della Torre may not be able to fully assess the health and function of my eyes.

Name: _____ Date: _____

Date: _____

We need to know the following information in order to determine where to send your claim for our medical services.

- Do you have end stage renal disease? ____ Yes ____ No
If yes, is Medicare primary? ____ Yes ____ No ____ Unknown
If yes, when did Medicare become primary? ____/____/____
- Are you currently residing in a rehab facility after a hospitalization on a Medicare Part A stay? ____ Yes ____ No
If yes, please provide name of rehab facility and telephone number, if possible:

- Are you currently employed and 65 or older? ____ Yes ____ No
If yes, does your employer have less than 20 employees? ____ Yes ____ No
____ Unknown
Please provide name of employer, address and telephone number. If you have contact information regarding your employer's human resources department, please provide:

- Are you 65 or older or disabled and your spouse is currently employed? ____ Yes
____ No
Are you a dependant on your spouse's policy? ____ Yes ____ No
If so, does your spouse's employer have less than 20 employees? ____ Yes
____ No ____ Unknown
Please provide name of your spouse's employer, address and telephone number. If you have contact information regarding your spouse's employer's human resources department, please provide:

- Are you under 65 and disabled, have group health plan coverage based on your or a family member's current employment, and the employer has less than 100 employees?
____ Yes ____ No ____ Not applicable ____ Unknown

6. Are you currently in hospice care? ___ Yes ___ No

The information provided herein is true to the best of my knowledge. I authorize Bannett Eye Centers to contact the above-referenced entities for the purposes of determining accurate insurance information.

Patient Name: _____

Signature: _____

A. Notifier: Bannett Eye Centers, PA B. Patient Name: _____

C. Identifier Number: _____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. REFRACTION** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. REFRACTION** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
REFRACTION	NON-COVERED SERVICE	\$50

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. REFRACTION** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS:	Check only one box. We cannot choose a box for you.
<input type="checkbox"/>	OPTION 1. I want the D. REFRACTION listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/>	OPTION 2. I want the D. REFRACTION listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/>	OPTION 3. I don't want the D. REFRACTION listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information: none

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: _____	J. Date: _____
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