*Ronald S. Oser, M.D.*
*Marcie Oser Wertlieb, M.D.*
*Julie G. Gutmark, M.D.*
14201 Laurel Park Drive, Suite 208, Laurel, MD 20707
Phone 301 498-6616 Fax 301 498-8030

# PATIENT REGISTRATION
## PLEASE ANSWER ALL QUESTIONS COMPLETELY

**Personal Information:** **Today's Date** _____

**Name** _____ **Social Security #** _____/_____/_____

**Date of Birth** _____/_____/_____ **Age** _____ ☐ **Male** ☐ **Female**

**Address** _____ **Home Phone** _____

**City** _____ **ST** _____ **Zip** _____ **Work Phone** _____

**Marital Status:** Single Married Divorced Widowed **Cell Phone** _____
(Please circle your choice)

**Occupation** _____ **Email Address** _____

**Language** _____ **Ethnicity** _____ **Race** _____

**Referred by:**

**Physician Hospital Friend Relative Other** _____
(Please circle your choice)

**Primary Care Physician's Name** _____ **Number** _____

**Referring Physician's Name** _____ **Number** _____

**Insurance Information:**

| | |
|---|---|
| **Primary Insurance** _____ | **Secondary Insurance** _____ |
| **Policy #** _____ | **Policy #** _____ |
| **Group #** (if available) _____ | **Group #** (if available) _____ |
| **Relationship to policyholder:** Self Spouse Child (Please circle your choice) | **Relationship to policyholder:** Self Spouse Child (Please circle your choice) |
| **Policyholder's Name** _____ | **Policyholder's Name** _____ |
| **Policyholder's Birth date** _____ | **Policyholder's Birth date** _____ |

**I authorize payment of insurance benefits (including Medicare part B) directly to Ronald S. Oser, MD PA. I authorize the physician to release any information needed to process this claim. I also understand that I am responsible for all charges and treatment rendered by Ronald S. Oser, MD PA**

**Signature** _____ **Date** _____

Reason for Today's Visit? _____

## Ocular History:

Do you have a history of eye problems? ☐ Yes ☐ No

If Yes, what ?_____

Do you wear glasses? ☐ Yes ☐ No If Yes, how old are they? _____ Yrs

Purchased from? _____ Are you happy with them? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Purchased from? _____ Are you happy with them ☐ Yes ☐ No

If yes, do you know the prescription of your contacts

Contact lens brand _____ Base curve _____ Power right _____ left _____

## Present Health:

For what illnesses, if any, are you currently being treated (high blood pressure, heart disease, diabetes, arthritis, other) _____

_____

## Hospitalizations:

Please list your most recent hospitalizations, if any, below.

| Year | Operation/ Illness |
|---|---|
| | |
| | |

## Medications:

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list both prescription & over-the-counter medications _____

_____

_____

## Allergies:

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, which medications? _____

## Family and Personal History:

Do you have or has a close blood relative had:

Blindness ☐ Yes ☐ No Who? _____

Glaucoma ☐ Yes ☐ No Who? _____

Diabetes ☐ Yes ☐ No Who? _____

Macular Degeneration ☐ Yes ☐ No Who? _____

Migraine ☐ Yes ☐ No Who? _____

High Blood Pressure ☐ Yes ☐ No Who? _____

Heart Disease ☐ Yes ☐ No Who? _____

Cancer ☐ Yes ☐ No Who? _____

Sleep Apnea ☐ Yes ☐ No If you have this, do you use a CPAP Machine?

How often? ☐ Nightly ☐ Sometimes ☐ Never

Do you drive? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Laurel Eye Physicians
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# OUR FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **Medical** ophthalmologic care to our patients and **routine eye exams**. We do not participate with **most** vision plans (VSP/Davis Vision, etc.) **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have a valid referral and still wish to be seem, you will be asked to pay for the visit prior to your examination. **A refractive examination (measurement for eye glasses rx) is not a covered service by most insurance companies, including Medicare**. **If you receive a prescription for glasses, you will be charged $55.00 which is payable at the time of the visit. All contact lens visits and purchases must be paid at the time of service.**

It is the patient's/ parent's/ guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.

In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will be charged an additional **$10.00 billing fee.** We accept cash, checks and most major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a $50.00 returned check fee.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

There will be a **$ 50.00** charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. Legitimate emergencies will be taken into consideration.
I have read and understand the above financial policy.

_____ _____
Signature of patient/guardian/parent Date

_____ _____
Printed name of patient Date

# Patient Acknowledgement Regarding Dilation and Contact Lens Exams

## Precautions following Dilation

It may be necessary to dilation your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses or dark sunglass inserts. Patients should wear sunglasses and be cautious walking and going up or down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards.

| _____ | _____ | _____ |
|---|---|---|
| Patient's Signature or Legally Responsible Adult for Minor | Date | Relation to patient |

_____
Patient's name (printed)

## Contact Lens Exam and Fee

If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine their current status. The fee for this service is not covered by insurances and will be collected at the time of service. We will not submit a claim to the insurance company. **If a Contact Lens exam is desired, please speak with our staff regarding the Policy and Pricing.**

I have read and understand the above information. I accept full financial responsibility for the cost of a contact lens evaluation, **if provided**, and understand payment is due at the time of service. I understand that any copayment, coinsurance or deductible I may have are separate from- and not included in- the Contact Lens Exam fee.

| _____ | _____ | _____ |
|---|---|---|
| Patient's Signature or Legally Responsible Adult for Minor | Date | Relation to patient |

_____
Patient's name (printed)

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# PATIENT AUTHORIZATION

I, _____, agree to accept legal responsibility and to promptly pay all charges when billed for the above named patient. This includes copays, deductibles, co-insurance and non-covered services.

- I certify that the information I have reported with regard to my insurance coverage is correct
- I authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent and/or insurance company.
- I permit a copy of this authorization to be used in place of the original.
- I hereby authorize Laurel Eye Physicians to apply for benefits on my behalf for covered services rendered.
- I request that payment from my insurance carrier(s) be made directly to the above provider.
- I authorize the above provider to utilize medical data related to my care for statistical studies.
- I have received a copy of the practices "Notice of Privacy Practices" which provides a detailed description of how my Personal Health Information is used and disclosed.

**PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO BRING YOUR INSURANCE CARD(S) TO EVERY VISIT, A REFERRAL IF NECESSARY AND TO PAY YOUR COPAY AT TIME OF SERVICE IF REQUIRED.**

_____ _____

**DATE** **SIGNATURE**

Thank you for allowing us to participate in your healthcare needs.

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**301-498-6616**

# Authorization to Release Information Form

I, _____ hereby authorize the above office to communicate my health information to the following family member/personal representative:

Name_____ Relationship to patient_____

Address_____

City, State, Zip_____

Phone number_____

Name_____ Relationship to patient_____

Address_____

City, State, Zip_____

Phone number_____

**Patient Name (print)**_____

**Patient Signature**_____

**Date**_____

**Laurel Eye Physicians**

**Contact lens fitting and exam policy**

****PLEASE BE ADVISED THAT WE DO NOT SUBMIT CONTACT LENS FEES TO ANY INSURANCE COMPANY, PAYMENT IS DUE AT THE TIME OF VISIT****

Our initial contact lens fit and contact lens re-fit exams are designed for those patients who wish to be fitted for the first time with contact lenses, or whose contact lenses are being discontinued, or patients who requires a different contact lens type or brand and have had a complete exam with refraction within the past 12 months. The contact lens prescription is valid for 12 months but will not be finalized until you return for any and all recommended follow-up appointments.

As with initial contact lens prescriptions, new contact lens fit and refit visits are covered for a period of thirty (30) days from the date of the initial fit date.

**Follow up care**

Follow-up visits are necessary to establish proper fit, vision and health of the cornea and surrounding eye tissues. Wearing contact lenses can put your eyes at certain risks such as: corneal ulcers, bacterial infections, corneal abrasions, lack of oxygen to the cornea, abnormal corneal blood vessel growth or potential loss of vision. If you fail to give 24 hour notice of an appointment you cannot keep, your follow-up care will no longer be at no charge.

**The fees for new contact lens fit and re-fit exams:**

$215.00 – New contact lens fitting with teaching of proper insertion and removal and contact lens care/trial with 1 (or 1 pair) new trial contact lens. Includes 1 additional visit for final check.

$175.00 – Contact lens re-fit/trial with 1 (or 1 pair) new trial contact lens. Includes 1 additional visit for final check.

$115.00 – Yearly contact lens exam includes an eye exam, prescription for contact lenses and refraction for glasses if needed. We will match 1-800-CONTACTS price per box plus replace defective lenses or exchange unopened boxes if your prescription changes.

**Doctor's fitting fees**

As with all medical procedures, we cannot guarantee 100% success in fitting contact lenses. There are many unknown variables, such as allergies to the contact lens material that may prevent you from being successful in wearing the lenses. Because of this, the doctor's professional fees are not refundable.

**____Patient's initial** – This page explains Laurel Eye Physicians' contact lens policy, possible risks, appointment requirements, and fees involved in wearing contact lenses.

In accepting a contact lens evaluation, I agree to complete all contact lens follow-ups as specified by the doctor. I understand that the doctor or staff will not be held responsible for any ocular problems that may occur.

I understand that a contact lens prescription will not be finalized and/or I may not be able to purchase more contact lenses in the event that I fail to comply with this agreement.

I am aware and I agree that I will be charged a fee for any contact lens follow-up visits which occur more than 30 days after the original exam date.

_____ _____

Signature of patient or responsible party Date

_____ _____

Witness/LEP employee Date