



## NEW PATIENT REGISTRATION FORM

### Patient Information:

First Name:		Mi:	Last Name:	
Date of Birth:	Age:	Sex: M / F	SSN:	
Home Address:			Apt. #:	
City:		State:	Zip Code:	
Language:	Race: White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>			
Ethnicity: Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/>		Email Address:		
Home #:	Work #:	Cell #:		
Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>		Spouse's Name:	DOB:	
Is patient residing in a Skilled Nursing Facility/Rehabilitation Center?: Yes <input type="checkbox"/> No <input type="checkbox"/>				
If yes, Name:		Telephone #:		
Address:	City:	State:	Zip Code:	

### Emergency Contact Information:

Name:	Relationship:
Home#:	Work #: Cell #:

### Employer Information:

Name:	Occupation:
Address:	City:
State:	Zip Code: Telephone #:

### Provider Information:

Primary Care Physician:	
Address:	City:
State:	Zip Code: Telephone #:

### Insurance Information:

- Please have your insurance card(s) and driver's license available for verification.
- Please understand that your insurance card is not a guarantee of payment of any health care claim. Final determination will be made based on your eligibility and benefits at the time of processing.
- Referrals, if required, need to be supplied **before** services are rendered.

Primary Insurance:		Effective Date:	
Policy ID#:	Group #:		
Policy Holder's Name:	DOB:	Sex: M / F	
Relationship to patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other <input type="checkbox"/>			
Insurance Address:	City:	State:	Zip Code:
Secondary Insurance:		Effective Date:	
Policy ID#:	Group #:		
Policy Holder's Name:	DOB:	Sex: M / F	
Relationship to patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other <input type="checkbox"/>			
Insurance Address:	City:	State:	Zip Code:
Is the reason for your visit related to a work or auto accident? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Employment <input type="checkbox"/> :	Workers Comp Insurance Carrier:		
	Date of Accident:	Claim #:	
Auto <input type="checkbox"/> :	Auto Insurance Carrier:		
	Date of Accident:	Policy #:	

Whom may we thank for referring you? \_\_\_\_\_

## HIPAA CONSENT FORM

### Consent for Purposes of Treatment, Payment, and Healthcare Options

I consent to the use or disclosure of my protected health information by Giliberti Eye & Laser Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Giliberti Eye & Laser Center. I understand that diagnosis or treatment of me by Orazio L. Giliberti, M.D., Dominick I. Golio, MD. and/or Francesca M. Giliberti, MD. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Giliberti Eye & Laser Center is not required to agree to the restrictions that I may request. However, if Giliberti Eye & Laser Center agrees to a restriction that I request, the restriction is binding on Giliberti Eye & Laser Center and Orazio L. Giliberti, M.D., Dominick I. Golio, MD. and/or Francesca M. Giliberti, MD.

I have the right to revoke this consent, in writing, at any time, except to the extent that Orazio L. Giliberti, M.D., Dominick I. Golio, MD. and/or Francesca M. Giliberti, MD or Giliberti Eye & Laser Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer, or healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Giliberti Eye & Laser Center's Notice of Privacy Practices prior to signing this document. The Giliberti Eye & Laser Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the Giliberti Eye & Laser Center. The Notice of Privacy Practices for Giliberti Eye & Laser Center is also provided at 415 Totowa Road, Totowa, New Jersey and on the Giliberti Eye & Laser Center website at [www.laserandeye.com](http://www.laserandeye.com). This Notice of Privacy Practices also describes my rights and the Giliberti Eye & Laser Center duties with respect to my protected health information.

Giliberti Eye & Laser Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Giliberti Eye & Laser Center website, calling the office and requesting a revised copy to be sent in the mail, or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority



**PRIVACY STATEMENT ACKNOWLEDGEMENT FORM**

**Patient Name:** \_\_\_\_\_  
(Print)

**Parent or Guardian Name:** \_\_\_\_\_  
(Please complete if patient is a minor or not competent)

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Guardian)

**We often need to contact patients by phone. If you are not available, do you give permission for the physician or the office staff to leave a message on your answering machine or voicemail?**

Please initial either 'Yes' or 'No' to indicate your response. If 'Yes', please provide the phone number where we can leave a message.

**Yes:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**No:** \_\_\_\_\_

**Please list the name, relationship, and the phone number of each person with whom we are allowed to discuss your medical and financial information. Also, please indicate if we may leave a message on his/her answering machine or voicemail.**

<b>Name:</b>	<b>Relationship:</b>	<b>Phone Number:</b>	<b>Message?:</b>
1. _____			
2. _____			
3. _____			



## **BENEFICIARY NOTICE AND AGREEMENT FORM**

My signature on this form assures: (1) that Giliberti Eye & Laser Center may be paid directly by my health plan and, in some cases I may have to pay for my treatment; (2) that I am responsible for my belongings; (3) that I have received a copy of the Giliberti Eye & Laser Center Notice of Privacy Practices.

### **1) PAYMENT FOR SERVICES**

I understand that Giliberti Eye & Laser Center may bill my health plan for the care I receive. It is the patient's responsibility to understand their medical insurance and provide us with a current insurance card at the time of each service. If you have a HMO policy that requires a referral from your primary care physician, you are responsible to provide our office with a valid referral at the time of your visit. I agree that payments from my health plan may go directly to Giliberti Eye & Laser Center. All payments of any insurance deductibles, coinsurance, and co-payments are due when services are rendered, and I know that I may need to pay this before I am treated. **If I should receive the payments, I understand that I will be responsible for paying Giliberti Eye & Laser Center.**

If your insurance carrier does not allow for routine eye care, and your visit is for routine eye care, the patient acknowledges to pay a bill in full. Medicare and other insurance companies will pay only for services that they determine to be "reasonable and necessary" under their contracts. If your insurance carrier determines that a particular service(s) is not reasonable and necessary, it will deny payment for that service(s). If your insurance carrier denies payment, the patient is to be personally and fully responsible for this payment. Your insurance (including Medicare) may deny payments for the following non-covered items: **REFRACTION, ANTERIOR SEGMENT PHOTOGRAPHY, SCHIRMER TESTING, HRT, ORBSCAN, PACHYMETRY, AND OTHER NEWLY DEEMED NON-COVERED ITEMS BY YOUR INSURANCE COMPANY.**

I understand and agree that if my plan does not pay the doctor, I will have to do so. Payment for any unpaid balance must be rendered within 10 days of a bill being sent. I further understand that interest (1.5% monthly) will be added to unpaid amounts that are more than **30 days past due**. Delinquent accounts not paid timely will be charged collection, court, and attorney fees.

I understand that Giliberti Eye & Laser Center will hold me responsible in any one of the following situations:

- (1) When I choose to have a service that my health plan covers but I do not obtain the required referral or authorization from my health plan.
- (2) When I choose not to use my health plan and agree to pay for services myself.
- (3) When my out-of-network health plan does not participate with Giliberti Eye & Laser Center for the services I want or need and I agree to pay for my care myself.
- (4) When I receive services that are not covered under my health plan.

If my health plan is subject to ERISA (the Employee Retirement Income Security Act under U.S. law), I agree to have Giliberti Eye & Laser Center act on my behalf to obtain my benefits when Giliberti Eye & Laser Center asks to do so. I understand that I must comply with the policies and procedures set by my employee benefit plan.



**2) MY PERSONAL BELONGINGS**

I understand that I am responsible for my personal belongings and valuables.

**3) THE GILIBERTI EYE & LASER CENTER NOTICE OF PRIVACY PRACTICES**

If I would like, I may request a copy of the Giliberti Eye & Laser Center Notice of Privacy Practices by asking a staff member, or downloading it on web at [www.laserandeye.com](http://www.laserandeye.com).

**DISCLAIMER: FINANCIAL INTEREST OF PHYSICIAN**

Public law of the State of New Jersey and the Regulations of the New Jersey Board of Medical Examiners mandate physicians, podiatrists, and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a healthcare service.

Accordingly, please take notice the practitioner in this office does have a financial interest in the following healthcare entity to which patients may be referred:

Optical Department  
Laser Center

River Drive Laser and Surgery Center

You may of course seek treatment from a healthcare service provider of your own choice. A listing of alternative healthcare service providers can be found in the classified section of your telephone directory under the appropriate headings.

**GILIBERTI EYE & LASER CENTER AGREEMENT**

I agree to the following items as defined in the above Giliberti Eye & Laser Center Beneficiary Notice and Agreement Form, in addition to the Disclaimer.

- Payment for Services
- My Personal Belongings
- The Giliberti Eye & Laser Center Notice of Privacy Practices
- Disclaimer

I hereby authorize Giliberti Eye & Laser Center to furnish information to my insurance carrier(s) concerning my illness and treatment, and assign to the physician all payments for medical services rendered to my dependents or myself.

**My Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

For health care agent/guardian/surrogate/parent (circle one), I, \_\_\_\_\_, am the representative for this patient.

Representative's Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

If you are the health care agent or guardian, please attach proof that you can act on behalf of the patient.

\_\_\_\_\_  
Witness Signature/Agency Representative \_\_\_\_\_  
Date

## Lifestyle Questionnaire

1. Please check the following that apply:
  - I would like to see without glasses.
  - I would like to wake up and see the alarm clock.
  - I would like to read a newspaper or book without glasses.
  - I would like to read labels in a store without glasses.
  
2. Which hand/eye activities do you enjoy? Check those that apply:
  - Crossword puzzles
  - Painting
  - Cooking
  - Gardening
  - Reading books/magazines
  - Computer work
  - Other \_\_\_\_\_
  
3. What recreational activities do you enjoy?
  - Golf
  - Tennis
  - Swimming
  - Other \_\_\_\_\_
  
4. After surgery, would you be interest in seeing well **without glasses** in the following situations?
 

**Distance vision** (driving, golf, tennis, other sports, watching TV)  
 Prefer no **Distance** glasses.       I wouldn't mind wearing **Distance** glasses.

**Mild-range vision** (computer, menus, price tags, cooking, board games, items on a shelf)  
 Prefer no **Mild-range** glasses.       I wouldn't mind wearing **Mild -range** glasses.

**Near vision** (Reading books, newspapers, magazine, detailed handwork)  
 Prefer no **Near** glasses.       I wouldn't mind wearing **Near** glasses.
  
5. Please place an "X" on the following scale to describe your personality as best you can:

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Easy Going

Perfectionist

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date