

THE EYE CENTER OPHTHALMIC ASSOCIATES, P.A.

Christopher R. Bruno, M.D.
1051 West Sherman Ave
Building 5 Suite A
Vineland, NJ 08360
 www.EyeCenterVineland.com
 Tel: 856-696-0020
 Fax: 856-205-1721

PLEASE
USE
BLACK
PEN
ONLY



Your appointment at The Eye Center has been scheduled for:

_____ at _____ am/ pm with Dr. Bruno

Prior to your appointment, please complete the attached forms and bring them with you on the day of your appointment. If you would like to minimize your wait time, please bring forms and all listed below prior to your appointment.

You will also need to bring the following:

- + Photo ID
- + Insurance card
- + List of current medications
- + Referral, if your insurance carrier requires one
- + Please be prepared to pay for your visit with cash or credit card. Sorry we **do not accept checks from new patients**. We apologize for any inconvenience.
- + Self-pay patients are required to bring a photo ID for identification purposes and payment is due at the time of the visit.

Please note:

- + You may be in the office for 1 to 2 hours.
- + You may be dilated. (This causes you to be light sensitive and blurry for a few hours. Please bring a driver and sunglasses.)

*If you would like to **minimize your wait time** in the office, please feel free to drop off your completed paper work, bring your photo ID and Insurance cards to the office **1-2 weeks prior** to your appointment. (Please do not mail back as the mail maybe delayed or can get lost)*

Should you need to reschedule or cancel your appointment, please call (856) 696-0020 at least 24 hours in advance of your scheduled appointment.

Thank you,

Christopher R. Bruno, M.D.

Attention: OUR NEW LOCATION
 1051 West Sherman Ave
 Building 5, Suite A
 Vineland, NJ 08360
STRAIGHT BACK TO THE LEFT

Patient Information

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Today's Date _____ Soc. Sec. # _____ Birth Date _____
 Name _____ Home Phone _____
 Address _____ Cell Phone _____
 City _____ State _____ Zip _____ E-mail _____
 Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
 Which form of communication do you approve/prefer our office to contact you?
☐ Mail ☐ Home phone ☐ Cell phone ☐ Text message ☐ Email ☐ Patient portal ☐ All of the above
Choose one- How would you like to be reminded of your appointment?
☐ Do not call ☐ Email ☐ Text Cell Phone ☐ Call Home Phone ☐ Call Cell Phone
 Race: ☐ Asian ☐ African American ☐ American Indian or Alaska Native
☐ Native Hawaiian or another Pacifica Island ☐ White ☐ Declined to Specify/other

Language: ☐ English ☐ Other ☐ Sign Language ☐ Spanish ☐ Declined to Specify

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Declined to Specify/other

Insurance Company _____ Member ID # _____
 2nd Insurance Company: _____ Member ID # _____

Emergency contact _____ Relation _____ Tel. _____

Patient's Family Physician _____ Tel. _____
 Pharmacy: _____ City: _____

☐ Employed ☐ Retired ☐ Full Time Student ☐ Part-Time Student ☐ Unemployed
 Employer _____ Business Phone _____
 Business Address _____ Occupation _____

Who should we thank for referring you? Insurance Handbook ____ Newspaper ____ Internet ____ Other ____
 Patient Name _____ Physician's Name _____

If Patient is Minor

Parent(s) Guardian Name _____ Phone _____ SS# _____
 Address if different then above. _____

Patient Signature

YOU MUST ACKNOWLEDGE ALL BELOW TO BE SEEN IN THE OFFICE

I request that payment of authorized INSURANCE/MEDICARE/MEDIGAP benefits to be made on my behalf to Ophthalmic Associates for any services furnished me by that physician or supplier. I authorized any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits payable for related services.

Patient/Parent/Guardian Signature _____ Date _____

I understand that my insurance will not cover all procedures including 92015 (refraction-process to figure out if you need new glasses). In the event of a denial, I agree to pay for the procedure in its entirety. This statement is made and signed in accordance with section S1962 (a) (1) of the Omnibus Budget Reconciliation Act (COBRA) of 1986.

Patient/Parent/Guardian Signature _____ Date _____

In consideration of the services rendered, I the undersigned hereby agree to pay Ophthalmic Associates in accordance with the regular fees and terms of the office. I also understand that providing insurance information does not relieve me of the responsibility of any claim. If I have an HMO or PPO, I must follow the rules and regulations of my insurance company. I understand that it is my responsibility to resolve any disputes with my insurance company for non-payment after Ophthalmic Associates has submitted the bill.

Patient/Parent/Guardian Signature _____ Date _____

Health Survey

PLEASE USE BLACK PEN

Name: _____ DOB: _____

Medical HistoryAre you **ALLERGIC** to any **medications**? Yes / No If yes, please list: _____**What medications you are you taking?** (Provide list, if applicable) _____

Systemic History		Eye History	
Height:	Weight:	Glaucoma	YES / NO
Diabetes: ☐ Insulin ☐ non-insulin	YES / NO	Cataract	YES / NO
If yes, date diagnosed:		AMD (Age related macular degeneration)	YES / NO
High Blood Pressure	YES / NO	Retinal Disease	YES / NO
Stroke:	YES / NO	Diabetic Eye Disease	YES / NO
If yes, date:		Laser Treatment (retina/glaucoma)	YES / NO
Heart Attack:	YES / NO	Laser Vision Correction	YES / NO
If yes, date:		PRK (Photorefractive Keratectomy)	YES / NO
Heart Disease	YES / NO	RK (Radial Keratotomy)	YES / NO
Asthma	YES / NO	Any Other Eye Surgery	YES / NO
COPD	YES / NO	If yes, Type:	
Emphysema	YES / NO	Any Eye Injury:	YES / NO
Arthritis	YES / NO	If yes, Type:	
If yes, type:		Do you wear Glasses?	YES / NO
Lupus:	YES / NO	If yes, how old are they?	
If yes, date diagnosed:		Do you wear Contact Lenses?	YES / NO
Thyroid Disease:	YES / NO	If yes, Please Bring info with you	
if yes, Hypo/ Hyper		Other: Usually, Male only	
Cancer:	YES / NO	Have you ever taken Prostate Medication? i.e Flomax, Tamsulosin	YES / NO
if yes, type:		If yes, how long?	
High Cholesterol	YES / NO		
Other conditions not listed above:			
Previous Surgery (s):			
Social History			
Smoke	YES / NO	If yes, how much?	
Alcoholic Beverages	YES / NO	If yes, how much?	
Exercise	YES / NO	If yes, how much?	
Drive	YES / NO	If NO, why did you stop?	
Family History			
Arthritis	YES / NO	If yes, relationship	
Asthma	YES / NO	If yes, relationship	
Cancer	YES / NO	If yes, relationship	
Diabetes	YES / NO	If yes, relationship	
Glaucoma	YES / NO	If yes, relationship	
Heart Disease	YES / NO	If yes, relationship	

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Name: _____ DOB: _____

Dr. Christopher R. Bruno
Ophthalmic Associates-The Eye Center
 1051 West Sherman Ave Building 5 Suite A Vineland, New Jersey 08360
 Tel. 856-696-0020 Fax. 856-205-1721

Patient Request for Transmission of Protected Health Information to Alternate Address or by Alternate Means

Patient Name: _____ DOB: _____

I understand that *Ophthalmic Associates* may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. *Ophthalmic Associates* may disclose my PHI to the following persons acting on my behalf:

1. Name: _____

Relationship: _____ Phone Number: _____

2. Name: _____

Relationship: _____ Phone Number: _____

3. Name: _____

Relationship: _____ Phone Number: _____

☐ I **do not** wish to provide anyone on my HIPPA consent to receive my Protected Health Information.

I understand that I can request that *Ophthalmic Associates* send information to me at an alternate address. Please send information to me at the following address and/or by the following means.

Address: _____ unit/apt _____
 City _____ State: _____ Zip: _____

Ophthalmic Associates will agree to this request so long as the information can easily be provided in the manner requested. I understand that if *Ophthalmic Associates* will incur costs by complying with the request, I will be required to provide payment to *Ophthalmic Associates* in advance.

☐ **Acknowledge Receipt of Notice of Privacy Practice**☐ **Decline Notice of Privacy Practice***May we leave **test results** on your answering machine? YES _____ NO _____If no would you like your **results** mailed to you? YES _____ NO _____

What is the best number to reach you at: _____

PLEASE NOTE CONFIRMATION CALLS REGARDING APPOINTMENTS MAY BE LEFT ON A MACHINE_____
Signature of Patient or Patient's Authorized Representative_____
Date_____
Representative's Name and Authority:

Patient Name: _____ DOB: _____

Office Billing & Insurance Policy

Due to changes in the healthcare environment and insurance regulations, our office has updated its billing and insurance policies. These policies are designed to comply with your insurance plan's requirements and help ensure a smooth experience for all patients.

Co-Payments

If your insurance plan requires a co-payment, it must be paid at the time of your visit. Please be prepared to provide your co-payment when you arrive for your scheduled appointment.

Referrals

If your insurance plan requires a referral to see a specialist, **it is your responsibility to obtain and bring the referral with you on the date of service.** Please contact your primary care physician in advance to obtain the necessary referral.

If you do not have the required referral at the time of your appointment, you may be responsible for the full cost of the visit or may need to reschedule your appointment. Our office will be happy to assist you in rescheduling. Please note that referral requirements are determined by your insurance carrier.

Outstanding Balances

If a balance remains on your account due to a deductible, co-insurance, or an unresolved insurance matter, you will be responsible for payment of the outstanding balance before receiving additional services.

We value your relationship with our office and are committed to providing you with a positive experience. If you have questions or concerns regarding your insurance coverage, billing, or financial responsibility, please contact our office. We will be happy to assist you.

Patient Acknowledgment

I acknowledge that I have read and understand the above billing and insurance policy. I accept responsibility for any financial obligations related to services provided by **Ophthalmic Associates, PA**. My signature below indicates my understanding and acceptance of this policy.

Patient Signature: _____ Date: _____

Patient Portal Consent

Our office is beginning to go electronic with most of our records and part of this process requires us to collect an e-mail address from our patients. In order to meet the criteria, patients will have to register into the portal by creating a password and user name.

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information. Using a secure username and password, patients can view limited health information such as: Discharge summaries, Medications, Recent doctor visits, Request prescription refills, and Update contact information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) permit the disclosure of health information about the patient without requiring the patient's express consent.

E-Mail Address: _____ ☐ I do not wish to provide an e-mail address

Patient Signature: _____ Date: _____