WELCOME TO OUR OFFICE

DR. ANDREA THAU & ASSOCIATES

DOCTORS OF OPTOMETRY
77 PARK AVENUE, NEW YORK, NY 10016
T: (212) 685-2457 F: (212) 685-5989
DRTHAUANDASSOC@GMAIL.COM

REFERRED BY: _____

PATIENT NAME: _____ SS#: _____

ADDRESS: _____ APT #: _____

CITY/STATE/ZIP: _____ DATE OF BIRTH: _____

CELL PHONE: _____ HOME PHONE: _____

WORK PHONE: _____ EMAIL: _____

PREFERRED CONTACT: CELL WORK HOME EMAIL MARITAL STATUS: S M SEP D W

EMPLOYER NAME: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ RELATION: _____

CELL PHONE: _____ WORK PHONE: _____

INSURED'S INFORMATION (IF NOT THE PATIENT)

NAME: _____ RELATION: _____

DATE OF BIRTH: _____ SS#: _____

HOME ADDRESS/CITY/STATE/ZIP: _____

WORK PHONE: _____ CELL PHONE: _____ EMAIL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ EFFECTIVE DATE: _____

ADDRESS: _____ PHONE: _____

ID#: _____ GROUP #: _____

SECONDARY INSURANCE NAME: _____ EFFECTIVE DATE: _____

ADDRESS: _____ PHONE: _____

ID#: _____ GROUP #: _____

FINANCIAL ARRANGEMENTS AND INSURANCE

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and amount exceeding your annual maximum are due at the time of service.
- If a referral is required, the patient must obtain the referral prior to the visit, if not the visit must be paid in full.
- **Returned checks are subject to a $40.00 fee.**
- Routine eye examinations, refractions, contact lens fittings, contact lens evaluations and vision therapy are **NOT COVERED** by most insurance plans/companies.
- There is a **$100.00 CANCELLATION FEE** for failure to cancel within **24 hours prior to your appointment.** For visual evaluations/perceptual appointments, there is a **$200.00 CANCELLATION FEE** (per evaluation) for failure to cancel these appointments within **48 HOURS prior to your appointment.**
- Visual Skills Evaluations and Visual Perceptual Evaluations are NOT COVERED by any insurance plans/companies.
- Contact lens and frame orders must be paid in full before ordering.

AUTHORIZATION FOR ASSIGMNENT OF BENEFIT

I HEREBY AUTHORIZE DR. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA AND/OR LAUREN STRAWN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SREVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. ANDREA THAU. FRAN REINSTEIN, MARILYN VRICELLA AND/OR LAUREN STRAWN AND CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE BILL IF MY INSURANCE COMPANY DOES NOT COVER ANY SERVICES RENDERED.

PLEASE MAKE SURE YOU HAVE READ THIS DOCUMENT VERY CAREFULLY.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: _____ **DATE:** _____

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and amount exceeding your annual maximum are due at the time of service.
- If a referral is required, the patient must obtain the referral prior to the visit, if not the visit must be paid in full.
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- Visual Skills Evaluations and Visual Perceptual Evaluations are NOT COVERED by any insurance plans/companies.
- Contact lens and frame orders must be paid in full before ordering.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR LAUREN STRAWN AND/OR TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR LAUREN STRAWN, CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE BILL IF MY INSURANCE COMPANY DOES NOT COVER ANY SERVICES RENDERED.

PLEASE BE SURE YOU HAVE READ THIS DOCUMENT VERY CAREFULLY.

I PERMIT A COPY OF THIS AUTHORIZATOIN TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF HIPAA RECEIPT

I acknowledge that I received and/or reviewed a copy of Dr. Andrea P. Thau and Associate's Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized by law under the circumstances described in the Notice of Privacy Practices.

Patient Name: _____

Signature: _____

If you are signing as a personal representative for the patient, describe your relationship to the patient and the source of your authority to sign the form:

Relationship to patient: _____ Print name: _____

Source of Authority: _____

Dr. Andrea Thau Dr. Fran Reinstein Dr. Marilyn Vricella Dr. Lauren Strawn
77 Park Avenue New York NY 10016

Print Name:_____ Who can we thank for referring you_____

Date of Birth: _____ Height: Weight: ____ Last Flu Immunization: _____

What brings you in today?_____

Current medication(s) (incl. birth control/herbal): List drug name, form (tablet, capsule, etc.), dosage (# of mg) and frequency taken: write on separate page if necessary:_____

Allergies to medications: name, reaction, year noticed:_____

Date of last Physical Exam:____ Primary Care Physician name and number: _____

Date of last EYE Exam:____ Name of Dr. and/or Facility: _____

Do you wear glasses? Y / N If so, what kind? Distance/ Near

Contact lenses? Y / N What type?____ Do you sleep in them? Y / N How often do you discard?____

Is your distance vision (corrected) clear? Y / N Is your near vision (corrected) clear? Y / N

Do you have any of the following?

Flashes of light	y / n
Floaters or spots in front of your eyes	y / n
Loss of Vision	y / n
Eye Strain	y / n
Blurry Vision	y / n
Double Vision	y / n
Frequent headaches	y / n
Eye pain	y / n
Any eye injury or surgery	y / n
Lazy eye/ amblyopia	y / n
Burning, itching, redness, discharge	y / n
Eyes turn in or out	y / n

Family History (Does anyone have):

Glaucoma	y / n
Blindness/ other eye problems	y / n
High blood pressure/ heart problems	y / n
Diabetes	y / n
Any other medical condition	y / n

Medical Hx- Do you/have you ever had?

Allergies y / n If yes, please list: ____

Surgery/ hospitalization	y / n
Cardiovascular (heart)	y / n
Breathing problems	y / n
Gastrointestinal problems	y / n
Endocrine (diabetes, thyroid, etc.)	y / n
Urinary problems	y / n
Musculoskeletal problems	y / n
Neurological (high fever, seizures, etc)	y / n
Unexplained weight loss or gain	y / n
Ear/ Nose/ Throat problems	y / n
Blood diseases (i.e. sickle cell)	y / n
Cancer, HIV virus, other	y / n
Smoke	y / n
Drink alcohol	y / n

Additional comments:_____

Patient Signature: _____ **Date: Reviewed by:** _____**, OD**

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Medications and Allergies Form

Medication Name Example: *"Aspirin"*	**Dosage** **(# of mg etc)** Ex: *"81 mg"*	**Form** **(capsule, tablet, drop)** Ex:*"Tablet"*	**Frequency** Ex:*"1x/ day"*	**Indication** **(What is it a treatment for?)** Ex: *"Heart condition"*

Drug/Medication Allergic to Example: *"Penicillin"*	**Allergic Reaction** Ex: *"Hives"*	**Severity** Ex: *"Moderate"*	**Start Date** Ex: *3/1990*