

DR. ANDREA THAU & ASSOCIATES
DOCTORS OF OPTOMETRY
77 PARK AVENUE
NEW YORK, NY 10016
TELEPHONE: (212) 685-2457
FAX: (212) 685-5989

WELCOME TO OUR OFFICE

REFERRED BY: _____

PATIENT NAME: _____ SS#: _____
ADDRESS: _____ APT#: _____
CITY/STATE/ZIP: _____ HOME PHONE#: () _____
CELL PHONE#: () _____ EMAIL: _____
WORK PHONE#: () _____ WORK FAX#: _____
DATE OF BIRTH: _____ MARITAL STATUS: S M SEP D W
EMPLOYER NAME: _____ OCCUPATION: _____
WORK ADDRESS/CITY/STATE/ZIP: _____
EMERGENCY CONTACT: _____ RELATION: _____
HOME PHONE#: () _____ WORK PHONE#: () _____

INSURED'S INFORMATION (IF NOT THE PATIENT)

NAME: _____ RELATION: _____
ADDRESS/CITY/STATE/ZIP: _____
HOME PHONE#: () _____ DATE OF BIRTH: _____ SS#: _____
EMPLOYER: _____ WORK PHONE#: () _____

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 your insurance requires you to have a referral at the time of the visit, it is your responsibility to obtain the referral. If you do not have one at the time of service, you are required to pay for the visit 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 **\$50 CANCELLATION FEE** for failure to cancel within 24 hours prior to your appointment. Except for visual evaluations/perceptual appointments, there is a **\$75.00 CANCELLATION FEE** 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.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRs. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER 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 ELSA SHEERER, 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 AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: _____ DATE: _____

Name: _____ Who can we thank for referring you? _____

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

Current medication(s) (incl. birth control/herbal): _____

Allergies to medications _____

Date of last Physical Exam: _____ Primary Care Physician: _____

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

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

Do you wear contact lenses? Y / N What type? _____ Do you sleep in them? Y / N

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

Floater 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

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

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

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SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF HIPPA 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. THAU AND ASSOCIATES
77 PARK AVENUE, NEW YORK, NY 10016
212-685-2457
DRTHAUANDASSOC@GMAIL.COM

New Patient Appointment Reservation Form/ Missed Appointment Policy

Missed Appointment Office Policy Form

When your appointment is scheduled a time slot if reserved for you. If you must cancel or reschedule your appointment please notify us at least one business day in advance. This makes it possible to accommodate another patient.

There is a fee of \$75.00 if you fail to cancel at least one business day in advance.

Credit Card Appointment Reservation Form

The credit card below will ONLY be charged if your appointment is not cancelled at least one business day in advance.

Credit Card # _____

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Expiration Date _____

Security Code (3 digits or 4 for Amex) _____

Billing Zip Code _____

Patient Name _____

Patient Signature _____ Date _____