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

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 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 **$50.00 CANCELLATION FEE** for failure to cancel within 24 hours prior to your appointment. Except for visual evaluations/perceptual appointments, there is a **$100.00 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 ASSIGMNENT OF BENEFIT

I HEREBY AUTHORIZE DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER 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 DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER, 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:** _____

Dr. Andrea Thau · Dr. Fran Reinstein · Dr. Marilyn Vricella

77 Park Avenue New York, NY 10016

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
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

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

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and/or 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 companies.
- There is a **$50.00 CANCELLATION FEE** for failure to cancel within **24 hours** prior to your appointment. Except for visual evaluations and/or 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 AUTHORIZATOIN TO BE USED IN PLACE OF THE ORIGINAL.

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: _____