WELCOME TO OUR OFFICE

NEIL S. HALPERN, O.D.

One East Trenton Road
Morrisville, Pennsylvania 19067
Phone (215) 295-4434
Cell (215) 990-3924 (Emergency Only)

Patient Information Today's Date:_____

Mr. Mrs. Miss Ms. Dr. (circle) Last Name:_____ First Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____ Home phone: ( )_____

Work or Cell phone: ( ) _____ Date of Birth:_____/_____/_____

OCCUPATION or SCHOOL_____ HOBBIES/SPORTS_____

If under 18 years of age: Parent Name:_____ phone if different: ( ) _____

MEDICAL INFORMATION: Do you have: [ ] DIABETES [ ] HIGH BLOOD PRESSURE [ ] HIGH CHOLESTEROL [ ] THYROID PROBLEMS [ ] ARTHRITIS [ ] RESPIRATORY (LUNG) PROBLEMS [ ] HEART PROBLEMS [ ] HEARING PROBLEMS [ ] NEURLOGIC PROBLEMS [ ] DIGESTIVE PROBLEMS [ ] SKIN PROBLEMS [ ] ALLERGIES [ ] DENTAL PROBLEMS [ ] DRY EYE DISCOMFORT [ ] PREGNANT

[OTHER]_____

List any medications you are taking:_____

_____

List any medications you are <u>allergic</u> to:_____

_____

INSURANCE INFORMATION: Insurance company_____

ID #_____Group # _____ SS # _____

Policy holder_____ Holder's Date of Birth _____/_____/_____

TO OUR MEDICARE PATIENTS: MEDICARE PAYS FOR MOST OF YOUR EXAMINATION BUT MEDICARE REQUIRES THAT YOU PAY A $25.00 Co-Pay. Unless you have secondary insurance, FEDERAL LAW requires that we collect this sum.

Patient's relation to Policy Holder (circle) SELF SPOUSE CHILD/DEPENDENT

STATEMENT OF FINANCIAL RESPONSIBILITY: I understand that I will be responsible for the full balance of my personal or family account if my insurance does not pay their portion of my/our services provided by Neil S. Halpern, O.D.

Signature of Patient, Parent or Guardian _____

INSURANCE PAYMENT AUTHORIZATION: I authorize the release of any medical or other necessary information needed to process any claim submitted on my behalf, by Neil S. Halpern, O.D. and/or Design for Vision. I authorize payment of medical benefits to Neil S. Halpern, O.D. for services described on the insurance claim submitted for me by Neil S. Halpern, O.D./Design for Vision. I request government benefits if used to be assigned to Neil S. Halpern, O.D. who accepts assignment.

AUTHORIZED SIGNATURE OF PATIENT, PARENT or GUARDIAN _____

PATIENT CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I UNDERSTAND THAT AS PART OF MY HEALTHCARE, Dr. Neil S. Halpern / Design for Vision originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means to communication to other professionals that may be involved in my care
- A means for applying my diagnosis and treatment recommendations to a third party for billing purposes
- A tool for routine healthcare operations such as assessing quality and treatment

A notice of information practices that provides a more detailed description is posted for inspection, and a written copy is available at my request.

I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS AND PRIVELEGES:

The right to review this notice prior to signing this document.

The right to restrict as to how my health information may be used or disclosed to plan treatment, payment or healthcare operations.

If I choose not to make available certain information, Dr. Neil S. Halpern / Design for Vision may refuse to treat me if my request is not compatible with this practice as permitted by Section 164-506 of the Code of Federal Regulations. I understand that I may revoke this consent in writing, except to the extent that it has already been acted upon prior to revocation. _____

_____

I understand that Dr. Neil S. Halpern/Design for Vision reserves the right to change this notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should these changes occur indicate where you would like a new Notice sent:_____

_____

FOR CONTACT LENS PATIENTS:

If requested, I understand and consent to using my prescription to be filled at another entity, I take full responsibility for making sure it is filled properly, and used in accordance with FDA label instructions.

I understand and accept:

Patient, Parent or Guardian_____