

**Complete this section if Patient is a minor or has a Legal Guardian.**

**Patient Information**

Patient Last Name		First Name		Middle Name		Maiden Name	
Address (Street or Box)				City		State	Zip Code
Home Phone Number		Cell Phone Number		Work Phone Number		E-Mail	
Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth		Social Security Number			
Marital Status (Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Race (Check One) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other _____			
Ethnicity (Check One) <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino				<b>Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>If Yes, Name of Facility</b>	
Employer Name				City		Phone Number	
Employer Address				Primary Care Physician Name		Phone Number	
Emergency Contact & Relationship		Phone Number		Referring Physician Name		Phone Number	

**Responsible Party**

<b>Responsible Party</b> Last Name		First Name		Middle Name		E-Mail:	
Address (Street or PO Box)				City		State	Zip Code
Home Phone Number		Cell Phone Number		Work Phone Number			
Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth		Social Security Number			

**Insurance and Subscriber Information**

<b>PRIMARY</b> Insurance Company			Effective Date			<b>SECONDARY</b> Insurance Company			Effective Date		
Claims Mailing Address (Street or PO Box)						Claims Mailing Address (Street or PO Box)					
City		State	Zip Code		City		State	Zip Code			
Policy ID Number		Group ID Number				Policy ID Number		Group ID Number			
Subscriber Name (Policy Holder)		Date of Birth				Subscriber Name (Policy Holder)		Date of Birth			
Subscriber Social Security Number		Relationship to Patient				Subscriber Social Security Number		Relationship to Patient			
Subscriber Employer		Work Phone Number				Subscriber Employer		Work Phone Number			
Subscriber Employer Address (Street or PO Box)						Subscriber Employer Address (Street or PO Box)					
City		State	Zip Code		City		State	Zip Code			

**Pharmacy**

Preferred Pharmacy Name		Pharmacy Address		Pharmacy Phone Number	
Mail-Order Pharmacy Name		Pharmacy Address		Pharmacy Phone Number	

**Vision Insurance (if applicable)**

**Vision Insurance and Subscriber Information**

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

\_\_\_\_\_

**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_

**Date**

**Consent to Treat and Financial Responsibility**

**Consent to Treat** CJEC\_NP\_F101

I hereby authorize employees and agents of Associated Retinal Consultants, LLC ("ARC") dba Coastal Jersey Eye Center, an Affiliate of PRISM Vision Group, including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

\_\_\_\_\_  
**Patient Name (Please PRINT)**

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

***Complete this section ONLY if patient is a minor or requires a Legal Guardian***

I consent for \_\_\_\_\_ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

**Financial Responsibility** CJEC\_NP\_F102

I hereby authorize Associated Retinal Consultants, LLC ("ARC") dba Coastal Jersey Eye Center, an Affiliate of PRISM Vision Group, to apply for benefits on my behalf and for payment of medical benefits directly to ARC for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to ARC. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to ARC. I further understand that should my account balance become delinquent and sent to a third-party collector, I agree to pay an additional 30% of the balance or \$50, whichever is greater. I also understand that a returned check fee of \$35 will be assessed if the check is returned by my bank.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

\_\_\_\_\_  
**Patient Name (Please PRINT)**

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

Preferred Method of Communication C/JEC\_NP\_F104

**Yes**, I want Associated Retinal Consultants, LLC (“ARC”) dba Coastal Jersey Eye Center, an Affiliate of PRISM Vision Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my medical conditions and/or appointment information is indicated below:

Home Phone       Cell Phone       Email       Mailed Letter       Guardian

If the above method of communication is by **phone**, please do one of the following (**please check ONE**):

- Leave a message with detailed information.
- Leave a message with a call-back number only.

If the above method of communication is by **email**, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

**Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.**

Approved HIPAA  
Contacts C/JEC\_NP\_F105

Keeping our patient’s information private is important to us, and by default we will disclose information related to the patient’s Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that Associated Retinal Consultants, LLC (“ARC”) dba Coastal Jersey Eye Center, an Affiliate of PRISM Vision Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient	Contact Phone Number	End Date
<input type="checkbox"/> <b>Billing Account Information</b>	<input type="checkbox"/> <b>Medical Condition Information</b>	<input type="checkbox"/> <b>Emergency Contact</b>	

**Additional Notes:** \_\_\_\_\_

Contact Name	Relationship to Patient	Contact Phone Number	End Date
<input type="checkbox"/> <b>Billing Account Information</b>	<input type="checkbox"/> <b>Medical Condition Information</b>	<input type="checkbox"/> <b>Emergency Contact</b>	

**Additional Notes:** \_\_\_\_\_

**Notice of Privacy Practices and  
Acknowledgement of Receipt**

CJEC\_NP\_F107

Notice of Privacy Practices and Acknowledgement of Receipt

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.*

Associated Retinal Consultants, LLC (“ARC”) dba Coastal Jersey Eye Center, an Affiliate of PRISM Vision Group, is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. “Protected Health Information” is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On \_\_\_\_ / \_\_\_\_ / \_\_\_\_ I, \_\_\_\_\_, received a copy of this office’s Notice of Privacy Practices.  
(Today’s Date) (Patient’s Name)

\_\_\_\_\_  
**Please Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\*\* Coastal Jersey Eye Center’s Notice of Privacy Practices can also be found on our website: [www.coastaljerseyeye.com](http://www.coastaljerseyeye.com)

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

***This Acknowledgement Form will become part of your permanent medical record.***

**Medical Questionnaire / Eye History**  
 CJEC\_NP\_F108

Patient's Name:		Date / /	
What ocular problem brings you in?			
When was your last eye exam?	/ /	Eye Doctor	
What did your doctor tell you?			
YES      NO			
Do you wear glasses for vision?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	If so, last time they were changed?
Do you have Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how is it being treated?
Have you had cataract surgery?	<input type="checkbox"/>	<input type="checkbox"/>	If so, Which Eye?      Date of Surgery      Name of Surgeon
		Left Eye	/ /
		Right Eye	/ /
Have you had other surgery? <i>Please list details below</i>			

**Medical History – Social History**

Have you ever suffered from any of the following?

	YES	NO	Comment
Born Prematurely?			
History of Weight Loss, Fever?			
Headaches, Sinus, Tonsillectomy?			
Heart Condition?			
High Blood Pressure?			
Circulatory Problems?			
Lung Disease?			
Ulcers, Liver, Gall Bladder Disease?			
Do you Smoke?			
Do you Drink?			
Kidney, Bladder, Prostate Disease?			

	YES	NO	Comment
Joint Disease?			
Skin Disease or Breast Cancer?			
Stroke or Neurological Disease?			
History of Psychological Disease?			
Thyroid Disease?			
Diabetes?			
Date of Last Blood Sugar Results:			
Bleeding Disorder, Anemia?			
Aids or Infectious Disease?			
Cancer?			

List ALL Medications that you are presently taking, including any eye drops:

_____	_____	_____
_____	_____	_____
_____	_____	_____

List ALL Allergies Including Medications:

_____
_____
_____

**FAMILY HISTORY**

Is there a family history of	YES	NO	Relative:
Cataracts?			
Glaucoma?			
Retinal Disease?			
Diabetes?			
Hypertension?			
Anemia?			
Other Eye or Systemic Disease?			

**Medical History Questionnaire / Review of Symptoms**  
 CJEK NP F109

<b>Patient's Name:</b>	Date        /        /
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Do you have any problems in the following areas? Please check all applicable

		YES	NO			YES	NO
<b>GENERAL</b>				<b>GI / GU</b>			
Fever				Vomiting			
Fatigue				Bloody Bowel Movement			
Weight Loss / Gain				Heartburn			
Frequent Colds				Loss of Appetite			
<b>EYES</b>				<b>MUSCULOSKELETAL</b>			
Blurred Vision				Muscle Pain			
Double Vision				Joint Pain, Arthritis			
Redness				<b>INTEGUMENTARY</b>			
Sandy or Gritty Feeling				Rash, Bruise Easily			
Blind Spots				Breast Disease			
Floater				<b>NEUROLOGICAL</b>			
Flashes				Fainting, Frequent Headaches			
Lazy Eye				Seizures			
Itching / Burning				<b>PSYCHIATRIC</b>			
Excess Tearing				Depression			
Glare / Light Sensitivity				Anxiety			
Eye Pain				Psychiatric Problems			
Chronic Infection Eye / Lid				<b>ENDOCRINE</b>			
<b>ENT: Ears, Nose &amp; Throat</b>				Excessive Thirst			
Sinus Infection				Excessive Sweating			
Cough				<b>HEMATOLOGIC / LYMPHATIC</b>			
Trouble Walking				Swollen Glands			
Hoarseness				<b>ALLERGIC / IMMUNOLOGIC</b>			
Loss of Hearing				Seasonal Allergies			
Nose Bleeds				Hay Fever			
<b>HEART</b>				<b>OTHER</b>			
Chest Pain				Pregnant			
Irregular Heart Beat				Menopausal			
Pacemaker				Vaginal Bleeding			
Heart Murmur				Breast Lumps			
Swollen Feet / Ankles							
Leg Cramps when Walking							
<b>LUNGS</b>							
Wheezing, Shortness of Breath							
Coughing up Blood / Phlegm							
<b>COMMENTS REGARDING ABOVE ANSWERS: (PLEASE PRINT)</b>							