



## Patient Intake Forms

Last Name:		First :	
Single <input type="checkbox"/>	Married <input type="checkbox"/>	Widowed <input type="checkbox"/>	Minor child <input type="checkbox"/> Relation to minor child:
Student <input type="checkbox"/>	Retired <input type="checkbox"/>	Unemployed <input type="checkbox"/>	Employed <input type="checkbox"/> Occupation:
Gender: M <input type="checkbox"/> F <input type="checkbox"/>	SS#:	DOB :	
Address :		City :	
State :	Zip:	E-mail :	
Preferred method of communication : Email <input type="checkbox"/> Cell Phone <input type="checkbox"/> Other:			
Home Ph.	Cell Ph.	Work Ph.	
Emergency contact:		Phone:	

**FINANCIAL RESPONSIBILITY:** (pertains to the person who is financially responsible for this visit)

Primary Insurance Carrier \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ Self Spouse Parent Other

DOB of policy holder: \_\_\_\_\_ Contact number: \_\_\_\_\_

Referral source: Physician \_\_\_\_\_ Internet search \_\_\_\_\_  
Friend \_\_\_\_\_ Other \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone No: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Street/ Town \_\_\_\_\_

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**HEALTH INFORMATION:**

Current medications \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Do you smoke: Yes No Frequency: \_\_\_\_\_ Previous smoker: Yes No

Alcohol use: Yes No Frequency: \_\_\_\_\_ Recreational drug use: Yes No

Have you received a flu vaccine this year? Yes No \_\_\_\_\_

**EYE HISTORY:** Do you have or have you had any of the following:

- Dry Eye :
- Eyelid surgery: type \_\_\_\_\_
- Cataract surgery: Right Left date: \_\_\_\_\_
- Eye drops: \_\_\_\_\_
- Family history of eye disease:

**Please indicate if you have or have had any of these medical conditions:**

- Allergies/ hay fever
- Cancer Type: \_\_\_\_\_
- Gastric/ stomach disorders
- Kidney disorders
- High blood pressure
- Heart stent(s)
- Lung disorders
- Seizure disorders
- Sinus infections:
- Major surgery: \_\_\_\_\_
- Eye disease: \_\_\_\_\_
- Asthma
- Diabetes
- Hard of hearing
- Headaches
- Heart attack
- Other heart condition: \_\_\_\_\_
- Seizure disorders
- Neurological disorders
- Skin disorders
- Thyroid disorders
- Currently pregnant or nursing
- Urinary disorders
- Problems with local or general anesthesia

ADDITIONAL DETAILS OR PERTINENT FAMILY HISTORY: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

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**COMMUNICATION RELEASE**

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services offices of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes, as stated below.

**This waiver authorizes Flora Levin, MD to send or receive my medical information as noted (please circle):**

Leave a **VOICEMAIL** recording, including my personal health information on my phone: **YES** **NO**

Use of electronic communication systems (i.e. **FAX, TEXT**) to transmit prescriptions, disorder related informations, lab results: **YES** **NO**

Use of **EMAIL** to transmit treatment or disorder related information which may include a diagnosis, lab or other results, even if the email is not encrypted: **YES** **NO**

**PERSONAL REPRESENTATIVE**

I permit the individual stated below (Personal Representative) to receive personal health information including prescriptions and/or test results: **YES** **NO**

**NAME** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**PHONE NUMBER** \_\_\_\_\_ **EMAIL** \_\_\_\_\_

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

On this date, I was given the opportunity to receive and review Flora Levin MD's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

**CONSENT FOR PHOTOGRAPHS**

I grant permission to the staff of Flora Levin, MD to obtain photographs of me as they deem necessary to show response to treatment and to assist in treatment decisions. I understand that my photographs may be used for teaching/ educational purposes.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

**OFFICE POLICIES**

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Changes in healthcare have shifted many costs to the patient. If we participate with your insurance, you will be responsible to pay any co-pays, co-insurances, or deductibles at the time of service. You may also be responsible for payment of services that are not covered by your plan. If your insurance company denies payment of your medical bill for any reason, you are fully responsible for payment of services rendered and will be billed accordingly. Please be aware that your insurance company does not guarantee accuracy of its confirmation of coverage and benefits.

**initial** \_\_\_\_\_

**Preapproval and Precertification:**

Prior to having a surgical procedure done, we will call your insurance company to find out if prior authorization or precertification is required. If it is required, we will supply the proper documentation to obtain approval. Some insurances do not require preapproval, but this does not guarantee payment of the claim. If your claim is denied for any reason, whether it was preapproved or did not require preapproval, we will do our best to appeal the denial and attempt to get the claim covered. If the claim is ultimately denied, financial responsibility for payment of medical services rendered will be yours.

**Deductibles, Copays, and Coinsurance:**

We will attempt to obtain your eligibility and coverage benefits prior to your procedure and inform you of any deductible or coinsurance you may be responsible for after your procedure. However, the information obtained is not always accurate or up to date. It is your responsibility to be aware of and understand the terms of your policy. You will be billed for any balance deemed "patient responsibility" by your insurance company.

**Laboratory bills**

If you should undergo a biopsy in our office, the lab will bill your insurance carrier separately. You may receive a separate bill from the lab for any uncovered charges.

**Out-Of-Network, Cosmetic, and self-pay patients:**

Charges for you care and treatment are due at the time of service.

**Cancellation and No-Show policy:**

We allow a significant amount of time for each appointment. If you do not show, or cancel a medical appointment with less than 24 hours notice, you may be subject to a \$100 fee. There is a \$250 fee for any surgical or procedural appointments that are missed or not cancelled with at least 7 days notice.

**Payment Methods:**

We accept cash, check, and all major credit cards as forms of payment. A returned check fee of \$50 will be assessed for any returned checks.

**ACKNOWLEDGEMENT OF UNDERSTANDING OF POLICIES:**

I have read, understood, and agree to all the above financial policies and office policies of Flora Levin, MD. I certify that the information provided is correct to the best of my knowledge. I authorize release of my medical information as necessary to process insurance claims.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

**CREDIT CARD ON FILE POLICY:**

It is our policy that a credit card is left on file as most insurance companies have copays, deductibles, and/ or coinsurance. Your insurance company will determine the amount you will be responsible for after the claim is processed. We will automatically charge your card for the amount determined by your insurance. We will notify you of charges exceeding \$50. Charges under \$50 will automatically be charged to this card. Your credit card information will not be physically stored by us, but will be stored electronically by TransFirst in accordance with HIPAA and PCI regulations and standards. By signing below you are confirming that you are the owner of or an authorized user of this account and you are approving these charges.

Please fill out your credit card information on the following page. This page will be shredded once the information is entered and stored securely. No one in this office, or elsewhere, will have access to this information.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

CC TYPE: MC VISA AMEX DISC CC#: \_\_\_\_\_

NAME ON CARD: \_\_\_\_\_ EXP DATE: \_\_\_\_\_ CVV #: \_\_\_\_\_

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