Ocean County Retina P.C.
Dr. Haris I. Amin
Dr. Mohammed E. Hajee

Patient Registration

We require copies of all insurance cards at the time of visit as well as a picture ID, please present these to the front desk.

Patient Name: ______________________________

Date of Birth: _____ / _____/_____ Sex: Male_______ / Female:_______

Home Phone: (___)_____________ Cell Phone: (___)_____________

Mailing Address:______________________________

City:____________________ State:__________ Zip:____________

Patients Social Security Number: ______-_______-_______

Marital Status: Single______/ Married______/ Divorced ________/ Widowed_______

Employer: ______________________________

Employers Phone Number: (___)______________________________

Employers Address: ______________________________

Primary Insurance: ____________________ ID #: ______________

Secondary Insurance: ____________________ ID #: ______________

Third Insurance: ____________________ ID #: ______________

IF your coverage is through a spouse or other family member, you must fill out this section completely:

Subscriber Name: ____________________ Relationship: ______________

Subscriber SSN: _____/_____/_____ DOB:_____/_____/_____

Contact Phone: (___)____________

Employer Name: ______________________________

Insurance Name: ____________________ Policy #: ______________

Referring Physician : ____

Primary Medical Doctor: ____

Preferred Pharmacy: ____________________ Phone #: _____________________

In Case of Emergency - Please list the nearest relative/friend we may contact (not living with you).
Name: ___________________________ Phone #: _________________________

Patient Email Address: ____

Notice OF PRIVACY POLICY- PATIENT ACKNOWLEDGEMENT- HIPPA CONTACT LIST

The following people should be contacted in the event of a medical emergency and are authorized to discuss my medical condition/billing info with the healthcare professionals in this practice.

Name: ___________________________ Relationship: ______________________

Phone # (____)____________________

Name: ___________________________ Relationship: ______________________

Phone # (____)____________________

Name: ___________________________ Relationship: ______________________

Phone #(____)____________________

Patient History Form

Chief Complaint / Reason for visit: ____

____

____

Duration of Complaint: ____

Medical History- Current or Past (Please circle and give us the dates for all that apply)

Anxiety ___/____/____

Arthritis ____/____/____

A-Fib ____/____/____

Cancer Type: ________________, ____/____/____

COPD ____/____/____

Depression ____/____/____

Diabetes ____/____/____

Gerd ____/____/____

Other: ______________________________

Hearing Loss ____/____/____

Heart Disease ____/____/____

High Blood Pressure ____/____/____

Stroke ____/____/____

Seizures ____/____/____

Kidney Disease ____/____/____

Pulmonary Embolism ____/____/____

Hypothyroidism ____/____/____

Hyperthyroidism ____/____/____

Surgical History (Please List and date all prior surgeries)

____

____

____

Ocular History (Please circle all that apply)

Cataract (Right / Left / Both)
Diabetic Eye Disease (Right/Left/Both)
Dry Eye (Right/Left/Both)
Flashes of Light (Right/Left/Both)
Glaucoma (Right/Left/Both)
Macular Degeneration (Right/Left/Both)
Macular Wrinkle/Hole (Right/Left/Both)
None

Narrow Angles (Right / Left / Both)
Ocular hypertension (Right/Left/Both)
Ocular Migraine (Front/ Back/ Center)
Retinal Tear / Detachment (Right/Left/Both)
Strabismus (Right/Left/Both)
Vitreous Detachment (Right/Left/Both)
Vitreous Floaters (Right/Left/Both)
Other: ______________________________

Ocular Surgery (Please circle and date all that apply)

Cataract Surgery (Right/Left/Both) Dates:_______________

Corneal Transplant (Right/Left/Both) Dates:_______________

Glaucoma Surgery (Right/Left/Both) Dates:_______________

Eye Injections (Right/Left/Both) Name of Injection:_______________ Last Received:___________

Retinal Tear / Detachment (Right/Left/Both) Procedure:___________________________________

Date____/____/____

Laser (Right/Left/Both) Type:____________________ Date:______________________

Medications:

____

____

____

Allergies:

____

____

____

Social History (Please circle all that apply)

Smoking Status: Never / Current / Pervious Total Years: ___________ Packs per Day __________

Do you drink alcohol ? Yes / No How many drinks per day ?_______

Driving Status: Daytime /Night / No longer driving

Where do you live? Private Home / Assisted Living / Rehab or Skilled Facility

Occupation: ___________________________ Currently Working / Retired

Family History (Please circle all that apply and state family member history applies to)

Blindness_________________________

Cancer __________________________

Diabetes _________________________

Glaucoma _______________________

Hypertension _________________________

Macular Degeneration _________________

Retinal Detachment ____________________

Stroke ________________________________

Ocean County RETINA, pc

Patient Dilation Consent Form

Dilating drops are used to enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. because driving may be difficult immediately after an examination, its best if you plan not to drive yourself.

Adverse reaction, such as acute angle- closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the doctors of Ocean County Retina P.C. and or assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Signature :___________________________________ Date: ____/____/____

Financial Policy

Our policies regarding billing and payment are detailed below. **We reserve the right to reschedule routine appointments when payment is not available at time of service.**

Thank you for choosing Ocean County Retina for your retinal condition. We are committed to excellent patient care. Bellow we have provided an explanation of our Financial Policy Agreement.

Please initial each

_____ 1. Each patient is responsible for his or her own bill. Insurance Co- Payments, Co Insurances and Deductibles are to be paid in full at each visit and prior to any surgery. You are required to place a Credit Card on file and your card will be charged after the insurance pays their portion.

_____2. Ocean County Retina will file claims to your insurance company. You **must** provide all insurance policy information and changes to our office. **If the insurance company had changed and you have failed to inform us you will be responsible for payment of the visit. Your bill is your responsibility.**

____3. " Self Pay" patients are required to pay 100% of services rendered at each visit. A minimum of $500 is expected on the initial visit. Credit Cards must be places on file **NO EXCEPTIONS** For extended treatments, payment plans maybe available and can be made with Jenn B in billing .

____4. As a specialty group, some insurances companies require that a referrals be obtained prior to your visit. It is your responsibility to know if your insurance requires this and to obtain the referral. If this is not done by the day of your appointment, you will be asked to reschedule or to pay for the **FULL** amount of the visit. If a claim is rejected because a referral was not in place, the full cost of the visit will be your responsibility

____5. A $35.00 fee will be charged on all returned checks.

____6. From time to time, you may ask us to complete various forms, there is a $25 service fee to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company. Please allow up to 7- 14 business days to fill them out.

____7. I understand that failure to maintain routine eye visits or excessive cancellations and no shows may result in detrimental eye complications and / or dismissal form the care of Ocean County Retina P.C.

______________________________ ______________________________

Signature of Patient or Responsible Party Date

Credit Card On File Policy

Ocean County Retina P.C. is committed to reducing waste and inefficiency and making our billing process as simple and easy as possible. Starting October 1, 2022, we now are requiring that you provide a credit card on file with our office. We run our payments through our HIPAA-compliant, secure practice management software Mod Med. When you come in, we will scan your card with a card reader. Your payment information is stored on Mod Med's secure servers for future transactions. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system.
Credit Card on File will be used to pay account balances after insurance adjudication. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient responsibility is. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

Notes:

1. During the time you leave a credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment. To avoid a penalty charge to your account.
2. Credits on your account after your insurance claim has been adjusted will be Credited to a future Date of service.
3. Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.
4. To avoid any issues of discrimination or favoritism; all patients will be required to have a credit card on file regardless of insurance or visit type.

FAQs

When I booked my appointment, the receptionist told me I have to keep a credit card on file with the office. I've never heard of that before.
This is not surprising that this is new to you, as it is not yet the norm in this area. Credit Card On File (CCOF) is the new standard in the healthcare industry nationwide, and soon all of the high quality medical practices will adopt it. Insurance reimbursements are declining and the expectation is that health care providers find ways to become more efficient. This year with the Affordable Care Act and the Health Exchanges, we are seeing a massive increase in patient deductibles. These factors are driving many doctors' offices to either squeeze more patients into shorter periods of time or to stop accepting insurance. We have decided to focus on becoming more efficient instead.

How does CCOF work? I'm nervous about giving up my sensitive financial information.

Your card information is securely protected by the credit-card processing component of our HIPAA-compliant practice management system. This system stores the card information for future transactions using the same sort of technology that credit card company's use. We cannot access the entire card number – we only can see the last 4 digits. There is no way to export the card information out of our system. We can only use it to process a payment in our practice management system, which creates an indelible record (one that cannot be deleted).

How the credit card on file system works to drive down administrative costs.

Our staff will now spend less time entering credit card information for each transaction. We also don't have to send out as many statements, which saves trees, money and time. Once your CCOF is in our system, check-in and check-out time is much shorter for you as well.

I always pay my bills on time. Why do I have to do this?.

The entire billing process is wasteful but the few patients that we have to bill multiple times or even send to a collections agency do cost us a lot of time and expense. Reducing unnecessary costs is essential for us to continue to accept insurance and Medicare. This new process dramatically cuts down on the administrative costs associated with billing.
Nothing is changing about how much you pay. When you come into our office and receive a service, you do so with the understanding that you are ultimately responsible for the cost of your care. We bill your insurance company for you, and we have contracts with most insurance companies that help to get you the best possible coverage for your care. CCOF will only cover your responsibility after your insurance pays it's contracted share.

How the CCOF process benefits patients

First and foremost, it is far more convenient for you – you don't have to call the office or buy a stamp or worry about getting around to paying the bill. It takes the hassle out of the process, especially for patients who have HSA cards to pay for their medical care.
If you get your statement and want to use a different card, pay by check, or discuss a payment plan, you may still do so as long as you do so promptly.

What if there is a problem with my bill and I don't notice it until after the payment processes?

We hope that this doesn't happen. And although we love technology in this office, we routinely review the accuracy of claims processed by insurance and will contact you if WE find a problem. But, if you find a problem, call us and we'll investigate it. If we owe you money, we will refund it promptly to the same card.