PATIENT

Name_____ Nickname:_____ Sex: M F

Address_____ City_____ State____

Zip_____ Date of Birth___/_____/_____ Age_____ Home Phone ( )_____

Primary Email address_____

Emergency contact _____ Phone # ( )_____

Primary Care Doctor_____ Office # ( )_____
FIRST AND LAST NAME

Referring Doctor_____ Office # ( )_____
FIRST AND LAST NAME

Have we treated other members of your family? Y N If yes, please list_____

Parent Name (or Guardian) 1: _____ Relationship to patient _____

Address_____ City _____ State _____ Zip _____

SSN _____ DOB _____ Home or Cell # _____ Work # _____

Employer _____ Employer Address _____ Occupation_____

Parent Name (or Guardian) 2: _____ Relationship to patient _____

Address_____ City _____ State _____ Zip _____

SSN _____ DOB _____ Home or Cell # _____ Work # _____

Employer _____ Employer Address _____ Occupation_____

INSURANCE

Primary Insurance Company Name_____ Subscriber Name_____

Subscriber's SS#_____ Subscriber's Employer_____

Subscriber's Date of Birth_____ Relationship to Patient_____

Secondary Insurance Company Name_____ Subscriber Name_____

Subscriber's SS#_____ Subscriber's Employer_____

Subscriber's Date of Birth_____ Relationship to Patient_____

We have contracts with many health plans to accept an assignment of benefits. We bill the plans that we have an agreement with and we will require you to pay your co-payment at the time of service. If you are in plan in which a referral is required. it is your responsibility to bring a referral with you at the time of service. or have your primary care physician forward the information to us prior to your visit. If you choose not to obtain a referral, you will be financially responsible for all services provided by Dr. Blatt.

Your medical records are protected by HIPAA. Your information is important and confidential. Our policies require that your information be held in strict confidence. If desired. please ask for more information.

Routine vision exams and refractions are not usually covered by insurance with or without a referral. Therefore, payment is due at the time of service. The charge for refraction is $45.00.

I authorize payment of medical benefits to St Louis Eye Care Specialist, LLC for any services provided by Andrew N. Blatt M.D. I understand that I am financially responsible to the provider for charges not covered by my insurance benefit plan. I authorize the release of any medical information necessary to process any insurance claims or as a means of object to the use of my health information but need to do so in writing. **Payment is due upon receipt of statement from our office. Patients who do not show or cancel appointments with less than 24 hours notice will be charged a $50.00 fee.**

Signature of Parent or Guardian _____ Date _____

St. Louis Eye Care Specialists, LLC

Andrew N. Blatt, MD
Pediatric Ophthalmology
Adult Motility Disorders
Board Certified in Comprehensive Ophthalmology

ELECTRONIC PRESCRIBING CONSENT FORM

Patient name(s)_____

St. Louis Eye Care Specialists has my permission to view/use my prescription history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

X_____ Date_____/_____/_____
Signature of Patient or Guardian

I agree that St. Louis Eye Care Specialists will also able to electronically prescribe your prescription medications and eye drops. Please provide us with your pharmacy information.

Pharmacy name:_____

Address: _____

_____

Phone: _____

675 Old Ballas Rd. #220 St. Louis, MO 63141
314-997-3937 (EYES) FAX 314-997-3911 866-869-3937 (EYES)

Financial Policy

St. Louis Eye Care Specialists, LLC
Andrew N. Blatt M.D.
Stephen Cusumano O.D.

St. Louis Eye Care Specialists is dedicated to providing you with the best care and service while keeping charges to you at a reasonable level. We ask for your help by understanding and cooperating with our financial policy.

We accept Visa, MasterCard, Discover, Cash or Check as a form of payment. You are required to pay your portion or co-payment at the time of the service, per your contractual agreement with your insurance carrier. There is a $25.00 returned check fee.

We will submit claims to insurance carriers with which we are contracted. You are financially responsible for all deductible, co-insurance amounts, and non-covered services as designated by your insurance company. It is your responsibility to know what is or is not covered by your insurance company.

If you have a routine vision plan (EyeMed or VSP) your benefits for routine eye exams must be used with Dr. Cusumano. Dr Blatt is a specialist; he can only bill exams through your medical insurance. Routine vision exams and refractions are not usually covered by medical insurance regardless of a referral. The charge for refraction is $45.00.

Please bring your insurance card with you to each visit and keep our office informed of any changes in your insurance coverage, address, telephone or employment.

In the case of divorce, we cannot double bill or split bills between divorced parents. The parent who brings the child for service will be responsible for paying for any charges associated with the visit.

We require a 24 hours notice upon cancellation of any scheduled appointment. Appointments not cancelled in a timely fashion will be charged $50.00. This fee must be paid before a new appointment is scheduled.

If your account becomes past due we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs incurred. You understand that if your account is submitted to an attorney or collection agency, the fact that you received treatment at our office may become a matter of public record.

_____ _____

(Responsible party signature) (Date)

_____

Name of Patient(s)

(5/19/2015)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____