CONFIDENTIAL PATIENT INFORMATION

Patient's Name:_____Birthdate:_____

Parents' names or that of the legal guardian/s:_____
(if patient is a minor)

Address:_____
(Street) (City) (State) (Zip)

Home phone + area code:_____

Cell:_____ Work:_____

Email Adress:_____

Occupation:_____

Type of work:_____

If patient is a student what grade is he/she in?_____

Name of school?_____

How did you hear about us?_____

Were you referred? By Whom?_____

PAYMENT/CO-PAYMENT IS DUE AT TIME OF SERVICE

Please familiarize yourself with our Financial Policy

Vision Insurance:_____ ID#:_____

Primary Medical Insurance:_____ ID#:_____

Name of Policy Holder:_____ DOB:_____

Relationship to patient:_____

Some insurance policies require the patient's or policy holder's social security #.

If this applies please provide:_____

ESTELLE J. ROBERTS, O.D. Comprehensive Diagnostic and Treatment Services for Children and Adults

205 West Main Street • Suite 307 • Somerville, NJ 08876
Office 908 725-1772 • Fax 908 722-4692

EYEWEAR POLICY

Complete satisfaction with your eye care and eyewear is our primary concern. We have adopted this policy to obtain this goal:

1. All scratch resistant coatings are guaranteed for one year. Return your glasses to us within the year and the coating will be replaced at no additional cost to you.
2. All lab anti-reflective coatings are guaranteed for one year. The lenses will be remade at no additional cost to you.
3. All Crizal coatings are guaranteed for two years. The lenses will be remade at no additional cost to you.
4. If you have any difficulty adapting to your new prescription we will change the lenses at no cost within 20 days of the receipt of your glasses. If there is more than one change or more than 20 days have lapsed there will be an additional lab fee per lens.
5. Progressive lens non-adapts: Try your lenses for 30 days; it frequently takes time to adjust to them. If you cannot adapt to your progressive lenses we will replace them with single vision lenses or a lined bifocal at no additional cost. Unfortunately we can not refund the cost of the progressive lenses.
6. Please make sure that you like the frame you select. If lenses must be made for a new frame you will be charged a replacement fee, dependent on prescription.
7. VSP patients must pay for their glasses in full before we send them to the lab.
8. You are requested to pay at least one half of the cost of your glasses prior to our sending them to the lab.
9. If you opt to use your own frame you will be required to pay a $20.00 lab fee in addition to signing our "Used Frame Policy".
10. Orders that have been sent to the lab are exchangeable but non-refundable. Please be confident in your frame choice. Additional fees may apply
11. Glasses which have not been dispensed within six months will be returned for stock. A restocking fee may apply which would be transferred to you.
12. Frame prices attached to frames are SELF PAY prices only. Dependent on your insurance your actual cost may differ.
13. Please try to come yourself to pick up your glasses so they can be adjusted properly to your face.
14. **CONTACT LENSES** not picked up within **30 days** will be returned to the company.

Signature_____

Date_____

Thank you,

Dr. Roberts

Estelle J. Roberts, O.D. Comprehensive Diagnostic and Therapy Services for Children and Adults
205 West Main Street • Somerville, NJ 08876 • 908-725-1772 •

CONFIDENTIAL: OUR FINANCIAL POLICY

Thank you for choosing us as your vision care provider. We are committed to providing you and your family with exceptional service.

All patients must read and sign this form before our professional services begin.

I understand that it is not the responsibility of Dr. Roberts or Park Vision Therapy Center, LLC to know my insurance coverage or whether or not I require a referral. If I do not supply the proper insurance information or referral forms ***prior*** to the exam then I accept that it is my responsibility to pay for all services provided by Dr. Roberts and to submit any insurance requests on my own. I understand and accept that I am solely responsible for the payment of all fees incurred in the event that I do not have routine vision coverage, have not met my deductible, if I have exceeded the maximum allowances dictated in my policy, or did not present this office with a copy of the referral if one is required by my insurance carrier. I understand that all fees not routinely covered by the major vision plans such as deductibles, co-pays, and contact lens fittings are to be paid-in-full today.

In the event that Dr. Roberts submits a claim on my behalf with the information I supplied, and if that claim is denied by my carrier based upon that information, I will accept the responsibility and pay for all services rendered. If the insurance information provided is incorrect, out-of-date, or for the wrong insurance company Dr. Roberts cannot resubmit the claims; I therefore accept that it is my responsibility to check the validity of my insurance at the time of service.

After an office visit we send the claim to the insurance company, from the insurance information provided. After the insurance company has processed the claim any remaining balance will be sent as a bill. If the bill has not been paid within 30 days there will be an additional financial charge of 1.5% added to the bill for each month the payment is late. A $30.00 dollar fee will be added to the bill for all returned checks. I understand that if the bill has not been paid after three months it will be sent to a collection agency. Patients are responsible for ALL costs of collection including court costs and attorney fees. The bill owing plus collection fees will be a minimum of $50.00.

A minimum deposit of 50 % will be collected for contact lenses or prescription eyewear that I order today with the balance paid-in-full at pick-up.

MINOR PATIENTS The adult accompanying a minor, or the parents (or guardian of the minor) must accept this financial policy in their stead.

MISSED APPOINTMENTS Please inform us as soon as possible if you realize that you cannot make any appointments scheduled in the future. Failure to attend any scheduled appointment will result in a $40 "no-show" fee, non-recoupable through your insurance provider. It is our policy to charge the full fee if a patient misses two or more scheduled appointments without ample notice.

Please let us know if you have questions or concerns.
I have read and agree to the conditions of this Financial Policy.

X_____ Date_____
Signature of patient or Responsible party

X_____ Date_____
Signature of Co-Responsible Party

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NEW PATIENT FORM

NAME:_____ DATE:_____

Our goal as an optometric practice is to provide each patient with exceptional professional service. In order to achieve this goal we need your assistance. By completing this questionnaire you will provide us with information that will help us to know exactly what your eye health and vision concerns are.

On the lines below please state for us, as completely as possible, your expectations for your visit with us today.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

___

Thank you very much for helping us to better meet your needs and for choosing us as your eye health care provider.

Estelle J. Roberts, O.D.

PLEASE COMPLETE THE CONFIDENTIAL PATIENT INFORMATION ON BACK

NOTICE OF PRIVACY PRACTICES

Estelle J. Roberts, O.D.
205 West Main Street • Somerville, NJ 08876
908-725-1772 • Fax: 908-722-4692

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled, referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audit; internal quality assurance; personnel decisions; participation in managed care plans; defines of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSERS FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such as or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosure to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violation of health care laws;
- Disclosure for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a deceased person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

OTHER USES AND DISCLOSURES

We will not make any other disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we can not make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office address above.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. To ask for a restriction, send a written request to Dr. Roberts at the address, fax or e-mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by not phoning you at work but at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you reimburse us for any extra cost. If you want to ask for confidential communications, send a written request to Dr. Roberts at the address, fax, or e-mail shown at the beginning of the Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You will have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension. If you want to review or get photocopies of your health information, send a written request to Dr. Roberts at the address, fax, or e-mail shown at the beginning of the Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know received the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures without your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Dr. Roberts at the address, fax, or e-mail shown at the beginning of the Notice.
- Get additional paper copies of the Notice of Privacy Practices at your request. It does not matter whether you received one electronically or in paper form already. If you want

additional paper copies, send a written request to the office at the address, fax, or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to amend it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to lodge a complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Dr. Roberts at the address, fax, or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call please call or write to Dr. Roberts at the address, fax, phone number or e-mail shown at the beginning of this Notice.

Please list all persons you would like to have access to your records.

1._____ relationship_____

2._____ relationship_____

3._____ relationship_____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Estelle J. Roberts' Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Estelle J. Roberts, O.D. Comprehensive Diagnostic and Therapy Services for Children and Adults
205 West Main Street • Somerville, NJ 08876 • 908-725-1772

SIGNATURE-ON-FILE FORM

_____ _____

Name of Policy Holder Social Security Number of Policy Holder

I request that payment of authorized health care benefits be made either to my self or on my behalf to Dr. Estelle J. Roberts.

I authorize any hold or medical information about me to release to the Health Care Financing Administration and to its agents any information needed to determine these benefits or the benefits payable to the related services.

I understand that my signature requests that payment be made and authorizes release of all medical information necessary to pay the claim. If Item 9 of the CMS form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

In health care benefits assigned cases, the physician or supplier agrees to accept the charge determination of the carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services (refer to our financial policy). Co-insurance and the deductible amount are bused upon the charge determination of your health care insurance carrier.

_____ _____

Patient, parent, guardian Date