ANDREW M. PRINCE, M.D., F.A.C.S.

NEW PATIENT REGISTRATION FORM

WERE YOU REFERRED BY A CURRENT PATIENT?
If so, please enter their name here: _____

Patient Information

Full Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Race (check one): ☐ African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White ☐ Decline to State

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Decline to State

Primary Language: _____

Occupation: _____

Mailing Address:
Street: _____
Apt/Unit #: _____ City: _____
State: _____ Zip Code: _____

Email Address: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Other

Best Contact Phone Number(s):
☐ Home: _____
☐ Work: _____
☐ Cell: _____

Referring Physician Information

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

Primary Care Physician Information

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Insurance Information

Primary Insurance Company: _____

Policy/ID Number: _____

Secondary Insurance Company: _____

Policy/ID Number: _____

Tertiary Insurance Company: _____

Policy/ID Number: _____

Emergency Contact

Name: _____

Relationship to Patient: _____ Phone Number: _____

Pharmacy Information

Pharmacy Name: _____

Phone Number: _____ Fax Number: _____

Consent and Authorization

I, the undersigned, authorize Andrew M. Prince, M.D., F.A.C.S. to provide medical care and treatment. I assign medical benefits directly to Dr. Prince for services rendered. I understand that I am financially responsible for charges not covered by insurance, and that payment is expected at the time of service.

I authorize the release of medical information required for insurance claims and consent to the use of my signature on all insurance submissions. I acknowledge receipt of the Practice's Notice of Privacy Practices and authorize the use and disclosure of my health information for treatment, billing, and healthcare operations.

Signature of Patient or Legal Guardian: _____Date_____

Medical History Questionnaire

Patient Name: _____

Do you have an Optometrist? _____

Do you wear contacts? _____

Do you smoke? Yes, ___ No, ___ Previous smoke, ____ How longs? _____

Do you consume alcohol? Yes, ____ No, ___ Occasionally, ____ How much? _____

Have you been diagnosed with any of the following:

Blindness____ Macular Degeneration ____ Glaucoma ____ Retinal Detachment ____

Primary Eye Concerns

What concerns do you currently have about your eyes?

Eye Surgery History

Have you ever had eye surgery? ☐ Yes ☐ No
If yes, please describe the type of surgery:

Current Eye Medications

Please list any medications you are currently using for your eyes:

All Other Medications

Please list any additional medications you are currently taking:

Medication Allergies

Please list any allergies to medications:

Medical Review of Systems

Please check all that apply and provide details if needed.
If a family member has the condition, please indicate in the "Family" column.

Symptom Category	Yes	No	Details	Family History
Vision Issues (blurry vision, eye pain, redness, tearing, etc.)	☐	☐	_____	☐
General (fever, fatigue, weight changes, etc.)	☐	☐	_____	☐
ENT (hearing loss, congestion, sore throat, cough, etc.)	☐	☐	_____	☐
Cardiovascular (high blood pressure, palpitations, etc.)	☐	☐	_____	☐
Respiratory (shortness of breath, wheezing, cough, etc.)	☐	☐	_____	☐
Urinary or Reproductive Issues (frequent urination, jaundice, etc.)	☐	☐	_____	☐

For Women: Are you currently pregnant? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

Symptom Category	Yes	No	Details	Family History
Musculoskeletal (joint pain, stiffness, cramps, etc.)	☐	☐	_____	☐
Skin Issues (rashes, growths, acne, etc.)	☐	☐	_____	☐
Neurological (headaches, seizures, numbness, etc.)	☐	☐	_____	☐

Symptom Category	Yes	No	Details	Family History
Psychiatric (depression, anxiety, insomnia, etc.)	☐	☐	_____	☐
Endocrine (diabetes, thyroid issues, etc.)	☐	☐	_____	☐
Hematologic (anemia, high cholesterol, blood disorders, etc.)	☐	☐	_____	☐
Allergy/Immune (seasonal allergies, lupus, HIV, etc.)	☐	☐	_____	☐
Gastrointestinal (nausea, constipation, ulcers, etc.)	☐	☐	_____	☐

Authorization to Receive or Release Health Information

In accordance with HIPAA regulations, please review and complete the following:

Patient Name: _____

1. May we leave a message containing detailed medical information on:
    - Home voicemail? ☐ Yes ☐ No
    - Cell voicemail? ☐ Yes ☐ No
2. May we contact you at your place of employment?
   ☐ Yes ☐ No If yes, may we leave a message? ☐ Yes ☐ No
    - Work Phone: _____ Ext: _____
3. Do you authorize anyone else to receive or discuss your medical or billing information?
   ☐ Yes ☐ No If yes, please provide:

Authorized Person:

Name: _____

Relationship: _____

Phone: _____

Alternate Phone: _____

Medical Power of Attorney? ☐ Yes ☐ No

Patient Consent

I authorize Andrew M. Prince, MD, to obtain or release any necessary health ir
related to my care to or from other providers, labs, imaging centers, or institut
required for treatment. This consent remains valid until revoked in writing.

Patient Signature: _____ **Date:** _____

Assignment of Benefits & Financial Responsibility Agreement

Please read and sign below to acknowledge your understanding of our policies:

1. **Medicare**: Claims will be submitted. You are responsible for deductibles and co-insurance.
2. **Lifetime Signature on File**: I authorize Medicare benefits to be paid directly to Andrew M. Prince, MD.
3. **Medigap**: If applicable, I request secondary benefits be sent directly to the provider.
4. **Information Release**: I authorize the release of medical and billing info for treatment and insurance purposes.
5. **Referrals**: If your plan requires a referral, you are responsible for bringing it. Without it, you may be responsible for the cost of the visit.
6. **Co-Payments**: Must be paid at the time of service.
7. **Self-Pay Patients**: Payment is due at the time of service unless other arrangements are made.
8. **Non-Covered Services**: You are financially responsible for any services not covered by your insurance plan.

WE ACCEPT CHECKS, MASTERCARD, VISA, DISCOVER AND AMEX

I have read, understand, and agree to the terms of this financial policy.

Signature of Patient or Responsible Party: _____

Date: _____

ANDREW M. PRINCE, MD, FACS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I give my consent to Andrew M. Prince MD, to use and disclose my protected health information (PHI) for purposes related to treatment, payment, and health care operations (TPO). A full explanation of how my PHI may be used or disclosed is provided in the practice's Notice of Privacy Practices.

I understand that I have the right to review the Notice of Privacy Practices before signing this consent. I also understand that Andrew M. Prince, MD, FACS may revise the Notice at any time, and that I can obtain a current copy by sending a written request to the Privacy Officer:

Lisa Todd
680 Kinderkamack Road, Suite 103
Oradell, NJ 07649
Phone: (201) 265-9040
Fax: (201) 523-9784

I give permission for Andrew M. Prince, MD to contact me at my home or other designated location and to leave messages on voicemail or in person regarding any items that help the practice carry out TPO. This includes appointment reminders, insurance matters, and issues related to my clinical care, such as lab results.

I also give consent for the practice to send mail to my home or designated location containing information that supports TPO, such as appointment reminder cards and billing statements, provided the envelope is marked Personal and Confidential.

I understand that I have the right to request restrictions on how my PHI is used or disclosed for TPO. While the practice is not required to agree to any requested restrictions, it is bound by any such agreement if accepted.

I understand that I may revoke this consent at any time in writing, except to the extent that the practice has already acted in reliance on my previous consent. I also understand that if I do not sign this form, Andrew M. Prince MD may decline to provide treatment for me.

Signature of Patient or Legal Guardian: _____

Patient's Name: _____ Date: _____

- I understand I may request restrictions on how my PHI is shared; however, the practice is not required to honor these restrictions.
- I may revoke this consent at any time in writing.

Signature of Patient or Legal Guardian:

_____

Patient Name (Printed): _____

Date:_____

ANDREW PRINCE M.D, OPHTHALMOLOGY
MEDICARE ADVANTAGE NOTICE

Dear patient,

It is important to note that Dr. Prince does NOT participate in all Medicare Advantage plans. However, he DOES participate in Medicare.
If you currently have or have plans on enrolling in a Medicare Advantage PPO plan and wish to see Dr. Prince, your plan will pay for your care on OUT OF NETWORK basis. This will result in your co-pay being higher at the time of service and may result in you being responsible for a portion of your services.

We urge you to speak with your insurance plan to confirm our participation In your plan. We are happy to answer any questions should you need further assistance.

We look forward to providing you with quality care.

Lisa Todd
Practice Administrator

Patient Signature _____ Date _____

GLASSES PRESCRIPTION FEE ACKNOWLEDGMENT

PLEASE READ CAREFULLY

For Medicare Patients:

Medicare has mandated that patients be advised that exams for prescription glasses, also known as a refraction, is NOT covered or reimbursable through Medicare.

A refraction is the necessary testing for the doctor to write a prescription for glasses. You will be responsible for paying that portion of your examination should you request a new glasses prescription.

For All Other Private Insurances:

Should you request a refraction for new glasses you will be charged the $85.00 fee, and our front desk can supply you with an itemized receipt to submit to your insurance should they offer reimbursement.

Charge for refraction (new glasses prescription): $85.00

Patient Name: _____

Signature: _____ Date: _____

NO SHOW / LATE CANCELLED APPOINTMENT FEE

Dear valued patient,

Missed or late appointment changes are reflective of a missed business opportunity (e.g. "When you do not show up for a scheduled appointment, you are taking an appointment slot that could have been used for another patient). Your insurer will not cover late cancelations, missed appointments, or late arrivals, because they are not covered services.

• A no-show is when a patient misses an appointment without cancelling.

• A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time.

In either case, we are now imposing a $50.00 missed appointment fee.

To avoid the imposition of this fee please call our office 24 hours in advance with any rescheduling or cancellations requests.

Please sign below as an acknowledgment to these fees.

Patient Signature _____ Date _____