Welcome to St. Lucy's Eye Care Center
Office of Benedict Urmaza, MD

All information MUST be filled in. ALL INFORMATION IS CONFIDENTIAL

Circle one: Dr/Mr/Mrs/Miss/Ms/Rev/Sr Marital Status: S/ M/ D/ W SS#_____
Last Name_____ First Name_____ Middle Initial___
Gender: M____F____ Date of Birth_____ Age_____
Home Address: Street_____ Apt #_____
City_____ State_____ Zip_____
Home Telephone_____ Cell Telephone_____ Other_____
Email address_____

Insurance information

Name of PRIMARY insurance_____ Policy number_____
Name of SECONDARY insurance_____ Policy number_____

If patient is NOT the primary policy holder, please fill out the following section

Insured's Last name_____First Name_____Insured's DOB_____
Relationship to Insured (circle one): Spouse/Child/Other_____
If different from above information: Insured's Telephone Number _____
Insured's Address_____

Medical Care Information

Primary Care Physician Name_____Phone_____
Address_____
Endocrinologist/_____Phone _____
Address_____
Pharmacy name_____Town_____ Phone_____

Receipt of Privacy Practice Notice I understand that St. Lucy's Eye Care Center, PC, its staff, and associates are in compliance with the HIPAA (Health Insurance Portability and Accountability Act) privacy rules and regulations. St. Lucy's Eye Care Center, PC has provided me with a copy of its Privacy Practice Notice that details my patient rights under this notice for me to read and keep. I understand that if I have any questions about the Privacy Practice Notice, I may contact the Privacy Officer Christine Shen at (631)589-2535.
By signing below, I acknowledge that I have received this notice from St. Lucy's Eye Care Center.

Print Name_____ Signature_____ Date_____

Co-Payments

If you are enrolled in a managed care health plan (i.e. HMO, POS, PPO) that our office is contracted with, you are required to pay the co-payment each time you are seen. **This co-pay must be paid at the time of the visit**. If you are not

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Benedict Urmaza for services furnished to me by him. I also authorize any holder of medical information about me to release to the Healthcare Financing Administration and agents, any information needed to determine these benefits and the benefits payable for related services.

Medicare #_____ **Date**_____

Signature_____ **Doctor's Signature**_____
Benedict Urmaza, MD

prepared to pay at the time of your visit, you can opt to be rescheduled. Some insurance require you pay multiple co-pays; those co-pays must be paid at the time of the visits.

Referrals

If you are enrolled in an insurance which requires a referral from your primary care physician, referral must be at our office prior to your scheduled appointment. This office is NOT responsible for obtaining or knowing if a referral is or is not required. If you arrive without a referral, you may reschedule your appointment. If you are seen without a valid referral and your insurance denies payment, you will be responsible for all fees generated from that visit, including but not limited to Office visit, diagnostic testing and screenings.

Annual Deductibles/Co-Insurances

Some plans have annual deductibles or co-insurances due. If there is a balance after the insurance carriers have paid their portions, you will be sent a bill. If you have a high deductible health savings plan, such as United Healthcare Choice Plus-HSA, and you have not met your yearly deductible, we will collect $150 at time of visit. When we receive your insurance explanation of benefits, we will debit or credit your account accordingly.

Billing

It is our policy to send three bills. After the third bill, which will be stamped "FINAL NOTICE," you will receive a pre-collection letter detailing the dates of when you were billed and a ten day collection notice. The pre-collection letter will note that your account will be sent to our collection agency, New York Credit Services Inc. Please pay your bill promptly to avoid such collection issues. If you have any questions about the balance or have financial circumstances that causes you to be unable to pay the balance immediately, please do not hesitate to call our biller at 631-589-2535.

Returned Checks

A returned check will incur a $35 bank charge.

Eyeglass/Contact Lens Prescription Exam

Today's visit may require an examination for an eyeglass or contact lens prescription. These examinations are NOT covered by most medical insurance companies because they are vision services, not medical care services.

The fee for the procedure to prescribe new eyeglasses, called refraction, is $40.00. This fee must be charged each time a patient requests a new prescription for eyeglasses or contact lenses. This fee includes getting a new eyeglass prescription and rechecking of the new eyeglasses after they are made. Post-operative patients are exempt unless it's six months after certain operations (i.e. cataract surgery, glaucoma surgery, pterygium surgery) that affect the vision.

The fee for renewal of a previous contact lenses prescription is $40.00. This renewal fee includes a refraction exam to check for changes in the contact lens prescription strength.

The fee for a new contact lens fitting is $150.00. This fee includes the refraction, the K-reading (which measures the cornea's curve for the new contact lens), possible corneal topography map, instruction on contact lenses placement and care, and follow-up appointments. Not included are the costs of lenses, the shipping charges or their warranties.

Without **this signed form, an eyeglass and/or contact lens prescription will not be made.** Medical care services performed will be billed separately from these vision services to the appropriate responsible party.

********************AFTER YOU HAVE READ THESE POLICIES, PLEASE SIGN BELOW********************

I understand St. Lucy's Eye Care's financial policy as detailed above. I understand the above information and that the fees will be my responsibility. I will pay the designated fee for the service rendered to me at the time of my visit.

Signature_____ Date_____

MEDICARE PATIENTS ONLY

St. Lucy's Eye Care Center PC expects that Medicare will not pay for the eyeglass/contact lens prescription exam and/or contact lens K-reading because these are considered vision services, not medical health care services. We are required to obtain your signature as follows: **Please check to indicate your choice.**

_____YES. I want to receive the prescription exam. _____NO. I have decided not to have the prescription exam.

SIGNATURE_____