Last Name_____ First Name_____ Date_____

Address_____

City/State/Zip_____

Home Phone_____ Work Phone_____ Occupation_____

Social Security_____ Email Address_____

Sports _____ Hobbies _____

Birth Date __/__/____ Date of Last Eye Exam _____ Last Physical Exam _____

If worn, do you see well with your present glasses? _____Age of glasses _____

If worn, do you see well with your present contacts? _____Age of contacts_____

Do you work at a computer terminal? Hrs per day_____

Check any of the following that apply to you:

( ) Blurred Vision
( ) Squinting
( ) Headaches
( ) Double Vision
( ) Eye Fatigue
( ) Itching or burning eyes
( ) Spots in your vision
( ) Eyes tear frequently
( ) Sensitivity to light
( ) Frequent Red Eye
( ) Excessive blinking
( ) Seeing flashes of light

Check any of the following that affect you or your family members:

Family	Self
( )	( ) Heart Problems
( )	( ) High Blood Pressure
( )	( ) Diabetes
( )	( ) Thyroid Problems
( )	( ) Allergies
( )	( ) Asthma
( )	( ) Sinus Trouble
( )	( ) Glaucoma (high eye pressure)
( )	( ) Cataracts
( )	( ) Previous Eye Disease / Infection/ Injury / Surgery (circle one)
( )	( ) Blindness
( )	( ) Macular Degeneration

List any allergies _____

List any Medications taken _____

Dr. Nermin Gendy
Union Family Eyecare
521 Newman Springs Road, Suite 11
Lincroft, New Jersey 07738

Privacy Notice Summary

THIS SUMMARY NOTICE OUTLINES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED. PLEASE REVIEW IT CAREFULLY.

WE ARE LEGALLY OBLIGATED TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION, PROVIDE THIS NOTICE OF PRIVACY PRACTICES, AND ABIDE BY THE TERMS OF THIS NOTICE; WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES. THIS NOTICE IS EFFECTIVE APRIL 14th, 2003.

YOU CAN REVIEW THIS FULL VERSION OF THIS NOTICE BY ASKING THE RECEPTIONIST FOR A COPY OF IT.

- PROTECTED HEALTH INFORMATION ("PHI") IS INFORMATION RELATING TO YOUR HEALTH STATUS OR TREATMENT AS WELL AS INFORMATION RELATING TO YOUR HEALTH INSURANCE, BILLING OR PAYMENT FOR YOUR HEALTH CARE.
- WE WILL ONLY USE OR DISCLOSE YOUR PHI FOR PURPOSE OF OUR TREATING YOU, VERIFYING YOUR INSURANCE, BILLING YOUR INSURANCE COMPANY, PROCESSING PAYMENTS FROM THAT INSURANCE COMPANY OR IN OUR PERFORMANCE OF OTHER NECESSARY BUSINESS FUNCTIONS. WE WILL ONLY USE OR DISCLOSE THE MINIMUM INFORMATION NECESSARY IN ORDER TO ACCOMPLISH THE INTENDED PURPOSE. WE WILL NOT USE NOT DISCLOSE YOUR PHI FOR ANY OTHER REASON WITHOUT YOUR SPECIFIC AUTHORIZATION TO DO SO.
- YOU HAVE THE RIGHT TO INSPECT AND RECEIVE A COPY OF YOUR PHI FOR AS LONG AS WE MAINTAIN IT.
- YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW WE USE OR DISCLOSE YOUR PHI.
- YOU HAVE THE RIGHT TO REQUEST THAT WE AMEND YOUR PHI IF YOU BELIEVE THAT IT IS INACCURATE
- YOU HAVE THE RIGHT TO REQUEST THAT WE COMMUNICATE WITH YOU BY NON-ROUTINE MEANS OR AT AN ALTERNATIVE LOCATION
- IF WE EVER ASK YOU TO AUTHORIZE US TO USE YOUR PHI FOR ANY OTHER REASON OTHER THAN TREATMENT, INSURANCE VERIFICATION, BILLING PAYMENT, OR OTHER NECESSARY BUSINESS FUNCTIONS AND YOU GIVE THAT AUTHORIZATION, YOU HAVE THE RIGHT TO REVOKE THAT AUTHORIZATION AT A LATER DATE AS WELL AS TO RECEIVE AN ACCOUNTING OF ANY DISCLOSURES OR USES WE HAVE MADE PURSUANT TO YOUR AUTHORIZATION

I HAVE READ THIS PRIVACY NOTICE

Patient's signature **Date**

Lifestyle Questionnaire- Guidelines continued

Patient Names: _____
Date of Visit: _____
Occupation: _____

This questionnaire is designed to assist your eye care professional in helping you select the perfect lenses, frames, and/or contacts to suit your visual reflects and lifestyle. Please take a few moments to answer the following questions.

1) Which of the following do you encounter on a regular basis? (Check all that apply)

- o Artificial lighting
- o Board work
- o Close up work
- o Computer work
- o Natural lighting
- o Paperwork
- o Potential eye hazards
- o Reading
- o Other

2) Which of the following hobbies or activities do you participate in? (Check all that apply)

- o Auto repair
- o Billing
- o Book keeping
- o Boating/water sports
- o Bowling
- o Competitive sports
- o Computer
- o Drawing
- o Diving
- o Exercise
- o Fishing
- o Golf
- o Home repairs
- o Hunting/shooting
- o Landscaping/gardening
- o Musical instrument

- Painting
- Pilot
- Racquetball
- Reading
- Sewing/arts/crafts
- Snow sports
- Tennis
- Watching TV
- Welding
- Woodwork
- Other

3) Do your eyes seem bothered by glare from any of the following?

- Car headlights
- Computer monitor
- Fluorescent lights
- Haze
- Night driving
- Sunshine
- Traffic lights
- Other

4) If you wear contacts, do you have : (check all that apply)

- Current pair of prescription glasses
- Sunglasses (purchased at a boutique, department/ optical store)
- Other:

5) Do you have any metal or silicon allergies? (yes) (no)

6) What do you like about your current glasses or contacts (color, style, fit etc.)?

7) What don't you like about your current glasses or contacts (weight, thickness, glare etc.)?

Union Family Eyecare
"We Take Your Eyes to Heart"
Dr. Normin Gendy, O.D.
521 Newman Springs Road, Suite 11
Lincroft, NJ, 07738 · Ph (732) 842-6610

Eyewear Order Policy

Dear Patient,

Thank you for allowing us the opportunity to fit you with your next pair of glasses. By combining high-quality lenses with stylish and fashionable frames, we strive to provide you with the best vision possible.

Due to the highly customized nature of eyeglasses orders, please be aware that orders cannot be canceled once they have been placed. A restocking fee may be assessed on stopped orders.

Progressive Lenses: If you are unable to adjust to your progressive lenses, you may have single-vision lenses placed into your frame at no cost. Please be aware that this must be done within 30 days from the original date of purchase.

Your signature is required and acknowledges that you understand and accept these statements.

Patient Signature _____

Print Name _____

Date _____

Reset Print

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE

OMB No. 1240-0044
Expires: 06/30/2021

1. ☐ MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☐ TRICARE (ID#/DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☐ FECA BLK LUNG (ID#) ☐ OTHER (ID#)

1a. INSURED I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last, First, Middle Initial)

3. PATIENT'S BIRTH DATE SEX ☐ M ☐ F

4. INSURED'S NAME (Last, First, Middle Initial)

5. PATIENT'S ADDRESS (Street, City, State, Zip)

6. PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other

7. INSURED'S ADDRESS (Street, City, State, Zip)

TELEPHONE (Include Area Code):

8. RESERVED FOR NUCC USE

TELEPHONE (Include Area Code):

9. OTHER INSURED'S NAME (Last, First, Middle Initial)

10. PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ Yes ☐ No

a. INSURED'S DATE OF BIRTH SEX ☐ M ☐ F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) ☐ Yes ☐ No

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ Yes ☐ No

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. PATIENT'S PLAN OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ Yes ☐ No *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below..

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.

15. OTHER DATE QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: TO:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: TO:

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ Yes ☐ No $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e) ICD Ind. ☐

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From	To	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPSCS	MODIFIER	E. DIAGNOSIS POINTER (A-L)	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER NPI #
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ Yes ☐ No

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH #

a. b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION