Dr. Marie R. Levine
33 Lincoln Ave.
Rutherford, NJ 07070
(201) 438-4418

AN IMPORTANT MESSAGE ABOUT INSURANCE COVERAGE

There are two types of insurance that will help pay for your eye care services and products.

1. Vision plans (ie: VSP and EyeMed)
2. Medical insurance (such as Blue Cross/Blue Shield and Medicare)

Vision plans cover one routine exam per year and eyeglasses and/or contact lenses.
Vision plans only cover a basic screening for eye health. Most do not cover diagnosis, management or treatment of eye diseases.

Testing and follow up appointments are not considered routine and are only billed to medical insurance.

Medical insurance may be used if you have any eye health problems or systemic health problems that have eye complications such as allergies, dry eye, diabetes, or loss of vision. Please let the doctor know if you are having any trouble with your eyes.

It is your responsibility to provide us with your current insurance information and cards every time we provide a service or test. Some plans require a signed referral from the patient's primary care physician for examination and/or testing. If your plan requires a referral, it is your responsibility to obtain one and bring it to your appointment.

As a courtesy we will bill your insurance plan for services if we are a participating provider. Depending on your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by your insurance contract. You are responsible to know your insurance coverage. Please call your insurance carrier if you have any questions.

I have read and agree with the above policies.

Signature_____Date_____

The law requires that Marie R Levine OD (Levine Eye Center) make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Levine Eye Center's Notice of Privacy Practice prior to any services offered.

The Notice of Privacy Practice could not be read due to the emergent nature of care and will be acquired when possible_____

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.

YES I authorize the use of standard email, in spite of the known risk involved, to communicate with me.

NO I do not authorize the use of standard email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Signature Relationship to Patient

Date:_____

Name:_____ DOB:_____ Age:_____

Address:_____ City:_____

State:_____ Zip Code:_____SSN:_____

Phone:_____ Cell:_____

Race/Ethnicity:_____ Marital Status: Single Married Divorced Widowed

Vision Insurance Company:_____ Policy Number:_____

Policy Holder Name:_____ DOB:_____

Primary Insurance Company:_____ Policy Number:_____

Policy Holder Name:_____ DOB:_____

SSN:_____ Address:_____

Secondary Insurance Company:_____ Policy Number:_____

Policy Holder Name:_____ DOB:_____

SSN:_____ Address:_____

Please list any prior eye diseases and/or surgeries: _____

_____

Are you having any problems with your eyes?_____

Do you or any of your family any history of the following eye diseases:

Macular Degeneration Yes_____ No_____

Glaucoma Yes_____ No_____

Other:_____

Please list any medical conditions and any surgical history:_____

_____

PLEASE HAVE YOUR MEDICATION LIST READY FOR THE TECHNICIAN

Do you OR anyone in your family have problems with any of the following: Please indicate self or family member.

Fever	Yes / No	Self	Family	**Weight Loss**	Yes / No	Self	Family
Heart	Yes / No	Self	Family	**Ear/Nose/Throat**	Yes / No	Self	Family
Endocrine	Yes / No	Self	Family	**Respiratory**	Yes / No	Self	Family
GI	Yes / No	Self	Family	**Muscular**	Yes / No	Self	Family
Skeletal	Yes / No	Self	Family	**Skin**	Yes / No	Self	Family
HIV	Yes / No	Self	Family	**TB**	Yes / No	Self	Family

Do you smoke? Yes_____ No_____ If so, packs per day:_____Years Smoking:_____

Do you drink? Yes_____ No_____ Socially_____ Drinks per day:_____

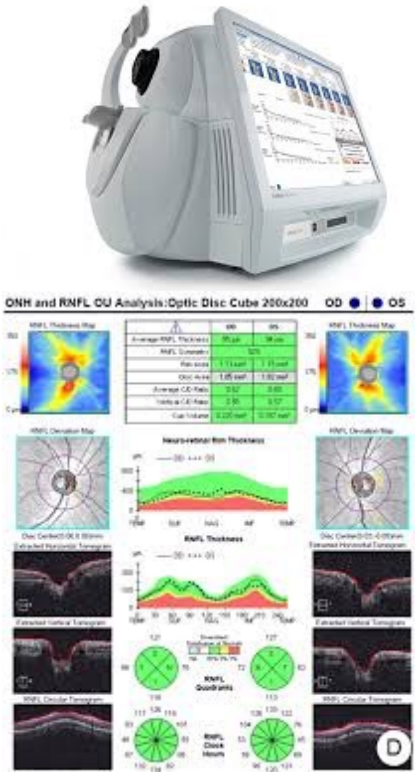
For Insurance: I authorize the release of any medical or pertinent information necessary to process my claim. I authorize payment of medical benefits to Marie R. Levine OD. The Levine Eye Center's notice of privacy practices are available for your review. I understand that I am responsible for any charges not covered by my insurance plan

Signature:_____ Date:_____

(Parent if Patient is a Minor)

OPTICAL COHERENCE TOPOGRAPHY (OCT)

One of the most important parts of the **health** evaluation of your eyes is having them scanned by and Optical Coherence topographer (OCT).



This screening is ***strongly recommended by the doctor*** and assists in the early detection of many disorders of the eye and body.

What is it?
The non-invasive 3D retinal scan is used at premier eye hospitals throughout the country including Wills Eye Hospital in Philadelphia.

What does it check for?
- Glaucoma
- Macular Degeneration
- Signs of stroke
- High blood pressure
- Diabetes
- Tumors
- and many other threatening conditions

The screening is **$39** and ***not covered by insurance***

Please check and sign the appropriate line below

_____**YES** I want the screening _____**NO** I do not want the screening

Signature:_____ Date:_____

_ _

For contact lens wearers

Contact lens evaluations and fittings are not a part of an annual eye exam. They require additional evaluation and decision making related to how the lenses affect your ocular health. A contact lens prescription is different and separate from a glasses prescription.

The cost of the contact lens evaluation or fitting depends on the complexity of the lens and ranges from $60-150. Visits after a 60 day period may incur a $30 office visit fee.

If you trying a new brand of contact lenses, your contact lens prescription can not be released until you return for your scheduled follow up appointment (no additional charge within 60 days). All contact lens service fees are non refundable.

Medical insurance does not cover any contact lens services or supplies. Some vision plans offer a discount or limited coverage that may cover a portion of the fees

Signature:_____ Date:_____
(Parent if Patient is a Minor)