Jennifer P. Wang, M.D. & Associates

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Jennifer P. Wang, M.D. & Associates is committed to providing you with the best possible medical care. If you are covered by medical insurance, we wish to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy. We are contracted with many insurance companies and if you have a question regarding whether or not we are contracted with your plan, please contact your insurance company as they can best answer your questions.

In order to be able to file your insurance claims, we must have a copy of your insurance card. When there is a change in your insurance plan or coverage, please notify us as soon as possible.

Without this information, we will be unable to submit your claim to your insurance for payment.

1. Your insurance coverage is a contract between you and /or your employer, and the insurance company. We are not a party to that contract.

2. As a specialist, some insurance companies require that prior to any visit; you must obtain an authorization or referral from your primary care physician (PCP). If this is not done by the time of your appointment, you will be asked to either reschedule your appointment and contact your PCP, or pay for the services at the time you are seen. Any payments made at the time of service will be promptly refunded upon receipt of payment by the insurance company. Please note that most insurance companies will only cover the cost of the services listed on the authorization or referral. Any services which are not authorized or denied by your insurance company are your responsibility.

3. **Co-payments, if required by your plan, are due at the time of each visit.** Please come prepared to pay the copayment as determined by your insurance plan (most copayments are listed on your insurance card). Most insurance companies require that this amount be paid at the time of service in order to validate the contract.

4. No matter what type of plan you have, HMO, PPO, POS or Indemnity, **it is to your advantage, as well as your responsibility, to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts.** Contact your insurance company to find out what benefits are covered under your plan.

5. We request that as a courtesy to our other patients, that you **please notify us at least 24 hours in advance if you will be unable to keep your appointment**. We reserve the right to charge for any appointment which is not cancelled with proper notice. We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. Therefore, all costs for services provided remain the responsibility of the patient/guarantor from the date the service is rendered. We realize that temporary financial problems may affect timely payment in your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

I HAVE READ THE ABOVE FINANCIAL ARRANGEMENTS AND INSURANCE STATEMENT AND I REALIZE THAT PAYMENT IS MY OBLIGATION FOR COVERED AND NON-COVERED SERVICES REGARDLESS OF INSURANCE OR THIRD PARTY INVOLVEMENT. I AUTHORIZE THE PHYSICIAN TO FURNISH MY INSURANCE COMPANY WITH ANY INFORMATION REQUIRED AND MY INSURANCE BENEFIT PAYMENTS TO GO TO JENNIFER P. WANG, M.D. & ASSOCIATES.

PATIENT SIGNATURE (guarantor, if patient is a minor) **Date**

Jennifer P. Wang, M.D. and Associates

Consent for Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected. The eye drops are necessary to give the doctor the best view of the inside of my eye.

______ Yes, I choose to have my eyes dilated. **I will ask the staff for assistance if my vision is markedly affected.**
______ No, I choose not to have dilation.

Consent for Refraction

In addition to the medical eye evaluation, refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary to write a prescription for glasses. It is NOT a covered service by Medicare or most medical insurance plans. These plans consider refraction a "vision" service not a "medical" service.
Our office fee for refraction is **$67**. We appreciate your payment today.

______ Yes, I choose to have refraction, I may need a prescription for glasses or contacts
______ No, I choose not to have refraction; I do not want a prescription for glasses or contacts.

Consent for HRT (Heidelberg Retinal Tomography) OPTIONAL SERVICE

HRT is a highly advanced laser scanning system that can take a baseline digital image of the optic nerve. This baseline image allows close monitoring of any changes to the optic nerve that may occur in the future, assisting in the detection of Glaucoma. The HRT scans the innermost layers of the retina. There is no discomfort and is safe.

Unless you currently have these diseases it is for screening purposes only and will not be covered by your medical insurance. This test is optional although our doctors would like to recommend this. The fee is **$59** for this screening. We appreciate your payment today.

______ Yes, I choose to have HRT
______ No, I choose not to have HRT

Print Name   Signature (Parent for minor)   Date

Form consent for mvpa.doc

Dr. Jennifer Wang M.D.

General Health and Medical Questionnaire

Date: ______________________________ Name: ____

Age: _____ DOB: _____/_____/______ Sex: M or F Primary Care Physician:___________________

Occupation: ________________________ (New Patients) Date Of Last Eye Exam: __________

PATIENT HISTORY ** Use back if necessary

List any medications: include all prescriptions and non-prescriptions (ex: aspirin)? ____________________

____

Are you allergic to any medications? Yes or No (If yes, specify)____

List all **major illnesses or injuries** (glaucoma, diabetes, high blood pressure, heart attack, concussion, etc.)

____

List any **surgeries** you have had: (cataract, appendectomy)

____

Have you ever had a **blood transfusion**? **Yes No** Do you wear **glasses? Yes No Contacts? Yes No**

Do you have problems in the following areas?	**No**	**Yes**	**Details**
Females: pregnant, nursing.			
General Constitution: fever, weight loss or gain, tired, etc.			
Ears, Nose, Throat: stuffy nose, ear ache, cough, dry mouth, hard of hearing, etc.			
Cardiovascular: high blood pressure, racing pulse, etc.			
Respiratory: congestion, wheezing short of breath, etc.			
Gastrointestinal: stomach upset, diarrhea, constipation, hernia, ulcers, etc.			
Genital, Kidney, Bladder: painful, frequent urination, impotence, jaundice, etc.			
Muscles, Bones, Joints: pain, stiffness, swelling, cramps, arthritis, etc.			
Skin: acne, warts, growths, rash, etc.			
Neurological: numbness, headache, seizures, paralysis, etc.			
Psychiatric: anxiety, depression, insomnia, etc.			
Endocrine: diabetes, hypothyroid, etc.			
Blood, Lymph: bleeding, high cholesterol, anemia related to transfusion, etc.			
Allergic, Immunologic: sneezing, swelling, redness, itching, hives, lupus, etc.			

FAMILY HISTORY

Has any member of your family had any of these diseases? (circle all that apply) Yes No Unknown

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other inheritable disease:

SOCIAL HISTORY

Does your vision with correction limit any daily living (driving, reading, sports, work, hobbies, etc.)? **Yes No**

Do you drink alcohol? No Yes occasional 1 day 2-3 day 4+ day

Do you smoke? No Yes occasional ½ pack day 1 pack day 1+ pack day

Jennifer P. Wang, M.D. & Associates
Patient Registration

Patient's Title	□ Mr. □ Mrs. □ Miss	Evening phone	
First Name		Work phone	
Middle Initial		Cell Phone	
Last Name		Social Security #	
Nickname		Employer	
Birth Date & Sex		Occupation	
Street Address		Family/Primary Dr	
City		State	Zip

Who may we thank for referring you?

E-mail address (We won't give this out! Our communications only) :

How did you hear about us?
□ Dr. □ Employer □ Friend □ Family □ Insurance □ Mailing □ Paper □ Phone book □ Radio □ Magazine □ Website

Medical Insurance Information

Primary Medical Ins.		**Secondary Medical Ins.**	
ID Number		ID Number	
Group Number		Group Number	
Subscriber name		Subscriber name	
Subscriber birth date		Subscriber birth date	

Vision Insurance Information

Primary Vision Ins.		**Secondary Vision Ins.**	
ID Number		ID Number	
Subscriber name		Subscriber name	
Subscriber birth date		Subscriber birth date	

Minor Patient: I give consent and authorize Dr. Jennifer Wang's office to examine and provide treatment deemed advisable for this minor.

Guardian's Signature ______________________________ Date ________________ Relationship ____________________

Insurance Authorization and Financial Agreement: I hereby authorize Dr. Jennifer Wang's office to release my diagnosis to determine the benefits payable for related services to any insurance carrier I have. I hereby authorize payment directly to Dr. Jennifer Wang's office. I understand that I am responsible for any amount not covered by insurance including deductible, coinsurance, and non-covered services.

I HAVE RECEIVED THE FINANCIAL AGREEMENT OF JENNIFER P. WANG M.D. & ASSOCIATES.

Privacy Notice: I have received the **Notice of Privacy Practices** attached. I hereby authorize the physicians and staff of Dr. Jennifer Wang's office to convey information about my health to the following people:

Name____ Relationship ____________________

I HAVE RECEIVED THE "NOTICE OF PRIVACY". I AGREE TO THE ABOVE AND RECEIVED FINANCIAL STATEMENTS.

Patient's Signature ____ Date _________________________