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.

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.

Patient Signature_____ Date_____

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)

_____

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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

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Patient Registration

Patient's Title	□ Mr. □ Mrs. □ Miss	Evening phone	
First Name		Work phone	
Middle Initial		Cell Phone	
Last Name		Social Security #	
Nickname		Employer	Aeva, Inc.
Birth Date & Sex		Occupation	
Street Address		Family/Primary Dr	
City		State	Zip
E-mail address (We won't give this out! Our communications only) :			
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	

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 my employer. I hereby authorize payment directly to Dr. Jennifer Wang's office.

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 AEVA, Inc. Relationship EMPLOYER

I HAVE RECEIVED THE "NOTICE OF PRIVACY". I AGREE TO THE ABOVE AND RECEIVED FINANCIAL STATEMENTS. I also, understand and agree to release a copy of my laser eye exam and results to Aeva, Inc.

Patient's Signature _____ Date _____

Employee #_____