Phone: (908)955-7715

Siwoff Low Vision Center
385 State Route 24, Suite 2D
Chester, NJ 07930

Fax: (908)955-7718

Patient Information

Last Name		First Name	M.I.
Address		City	Zip Code
Date of Birth	Sex	Social Security #	Marital Status
Home Phone	Cell Phone	Email Address	
Responsible Party's Name (Last)		First Name	Relationship to Patient

Insurance Information

Primary Insurance	
Policy Holder's Name	Date of Birth
Relationship to Patient	
Policy ID #	
Plan or Group #	

Ocular Health History

Eye Doctors Name	Date of Last Visit
Do you wear glasses?(circle all that apply) Yes / no / all the time / occasionally / reading / driving / TV Do you wear contacts? Yes / no / I have in previous years	

Indicate if you have had any of the following:

(Please Circle)	*Floaters or spots*
Blurred Distance Vision	*Glaucoma*
Blurred Near Vision	*Headaches*
Cataracts	*Itching Eyes*
Discharge from eyes	*Light Sensitive*
Dizzy Spells	*Poor night vision*
Double Vision	*Recent Loss of vision*
Drooping Eyelids	*Seeing Halos*
Dry Eyes	*Seeing Flashes*
Difficulty reading	*Temporary loss of vision*
Eye Infection	*Twitching Eyelids*
Eye Injury	*Watery Eyes*

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Health History

General Physician (Name and Phone Number)	Date of Last Exam
Please indicate if you have had any of the following: (Please Circle)	
Alzheimers *Anxiety* *Asthma* *Cancer : Please Specify* _____ *COPD* *Coronary Artery Disease* *Depression* *Diabetes* *Dizziness* *Fever or Chills* *GERD* *Hearing Loss* *Heart Condition: Please specify* _____	*Headaches* *Hepatitis* *High Blood Pressure* *Hyperthyroidism* *Hypothyroidism* *Leukemia* *Lymphoma* *Pacemaker* *Pain: Please Specify* _____ *Parkinson's Disease* *Seizures* *Skin Conditions : Specify* _____ *Other:* _____

Medications	**Allergies**
Please list any medications and vitamins you are currently taking, including eyedrops	*List your allergies to medication or other* substances or materials

Low Vision Information

Please circle which tasks you have difficulty with		
Continuous Text Reading	*Focusing / Concentrating*	*Distance Viewing*

Social History

Please Circle one answer
Do you smoke? Never smoked / Former smoker / Smokes, but not daily / Smokes daily ___ packs a day
Do you drink alcohol? No / Occasionally / Daily
Do you use drugs? No / Occasionally / Daily / Former history of drugs

Financial Policy

All payments are due at the time of the appointment. Payment may be made by cash, check, Mastercard, Visa, American Express, or Discover. We will only bill insurance carriers with whom we participate with. You are responsible to supply our staff with your primary and secondary insurance identification cards at the time of your appointment. If your insurance company requires a referral from your primary doctor, you must also present the referral prior to being seen, as we cannot bill your insurance without it. If you do not obtain the referral when your insurance requires one, you will be required to pay for the bisit in full. If your insurance requires a copay, it must be paid at the time of the appointment. At times your insurance carrier will deny payment for authorized services. If this occurs, you may be asked to help resolve these issues with your carrier directly.

If we do not participate with your insurance, the bill is your responsibility and is due at the time of services.

We do not participate with Medicare; however, we are still recognized and will only charge the accepted fee. In this case, the patient will pay for the appointment upfront. We will then submit your claim to Medicare and any secondary insurances as a courtesy in order for the patient to be reimbursed directly to their home address.

There will be a $35.00 returned check fee for any check that is returned for “insufficient funds”.

Any outstanding balances for which the patient is responsible will be due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. Accounts that go to collection will be subject to an additional 50% charge.

Custom made spectacles and devices are warranted for changes in prescription within a 90 day period. Materials are non-refundable.

I have received and read the above Siwoff Low Vision Center Financial Policy and agree to its contents.

_____ _____

Signature of Patient/Guardian Date

Cancellation and No Show Policy

We will make an effort to reach you on the telephone on the previous business day before your appointment. If you are not available, we will leave a message asking you to call back to confirm your appointment. If we do not hear from you by the morning of your appointment, we will assume you are unavailable and give your appointment to another patient. If you do not hear from our office the business day before your appointment, it is your responsibility to call to confirm your appointment. If you are more than 15 minutes late, we cannot guarantee that you will be seen. There are **no exchanges** or appointments with family or friends.

We reserve the right to charge you a $60.00 fee if you do not cancel or confirm within 24 hours of your appointment and/or you do not show up. This fee is not billable to your insurance. Excessive abuse of missing appointments may result in dismissal from the practice.

By signing below, you agree to the above Cancellation and No Show Policy as stated by Siwoff Low Vision Center.

_____ _____

Signature of Patient/Guardian Date