



CHRISTOPHER ZIEKER, MD
 STEVEN CLARK, RPA-C
 14 MOUNTAIN LEDGE DRIVE
 WILTON, NY 12831
 518-450-1080

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

SSN# _____ Date of Birth _____

Billing Address _____

Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact Name _____ Relation _____
 Phone/s _____

Referring Physician _____

How did you hear about Chris Zieker, MD/Steven Clark, PA? _____

Primary Care Provider _____

RESPONSIBLE PARTY - For patients unable to sign or those under 18 years of age

Last Name _____ First Name _____ Relation _____

SSN# _____ Date of Birth _____

Billing Address _____

Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

By signing below you acknowledge that you have had the opportunity to read through the following four forms and that you consent to the terms of all four. The terms may change with time; we will always post the current information at our office and have copies available for distribution.

- I acknowledge that I have read the *Financial Agreement* and understand that I am responsible for copays, co-insurance, deductibles and non-covered services. I understand that interest will be added to my account for all statements past 60 days and that any balances unpaid at 60 days will be turned over immediately to a collections attorney/agency.
- I acknowledge that I have read the *Refraction Policy* and understand that most insurances do not cover the refraction. I accept full financial responsibility for the \$30 cost of this service. The copay and deductible are separate from, and not included in, the refraction fee. I understand that I am responsible for this fee if I do not decline this service before it is performed.
- I acknowledge that I have read the *Consent to Use or Disclose Protected Health Information for Treatment, Payment and Health Care Operation*. I consent to allow Zieker Eye Ophthalmology PC to use or disclose my protected health information for treatment, payment and health care operations.
- I acknowledge that I have read the *Notice of Health Information Practices Summary*. I consent to allow Zieker Eye Ophthalmology PC to use or disclose my protected health information for treatment, payment and health care operations.

Signature _____ **Date** _____



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Notice of Health Information Practices Summary

Your Medical Record Each time you visit a hospital or physician, a record is made of your visit. This information, commonly known as a medical record, contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. The confidentiality of your medical record is protected under the state-specific and federal law.

Your Health Information Rights Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

Our Responsibilities *Zieker Eye Ophthalmology PC* is required by the Federal Privacy Rule to maintain the privacy of your medical record and to provide you with a notice of our legal duties and privacy practices.

Uses and Disclosures for Treatment, Payment, and Health Care Operations *Zieker Eye Ophthalmology PC* will use your health information in order to treat you. We will provide other providers or hospitals with copies of your medical record to assist them in treating you, should that become necessary. We will also use and disclose health information about you to make appointments for you.

Zieker Eye Ophthalmology PC will use your health information for payment. The information on a bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Zieker Eye Ophthalmology PC will use your health information for regular health operations to assess the quality of your care.

Zieker Eye Ophthalmology PC will disclose your health information to business associates, such as a medical transcription or billing service; so that they can perform the job we have asked them to do.

Uses and Disclosures that We May Make Unless You Object You have the right to object to certain situations in which *Zieker Eye Ophthalmology PC* may disclose information from your medical record.

Disclosures Permitted without Consent *Zieker Eye Ophthalmology PC* is required by state and federal law to disclose health information from your medical record under specific circumstances.

Uses and Disclosures Specifically Authorized by You *Zieker Eye Ophthalmology PC* expects to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you.

To Report a Problem You have the right, under federal law, to report a problem or file a complaint about how your personal health information is being handled. You can do this directly with *Zieker Eye Ophthalmology PC* or to the Secretary of Health and Human Services in Washington, D.C.

Zieker Eye Ophthalmology PC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed *Notice of Privacy Practice* to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our office and have copies available for distribution.



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Consent to Use or Disclose Protected Health Information For Treatment, Payment and Health Care Operations

I consent to allow Zieker Eye Ophthalmology PC to use or disclose my protected health information for treatment, payment and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of the practice.

I consent to allow Zieker Eye Ophthalmology PC to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Zieker Eye Ophthalmology PC to disclose my protected health information to another physician or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Zieker Eye Ophthalmology PC to disclose protected health information to another medical facility for health care operations activities, provided that the practice and the other entity has or had a relationship with the patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.



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FINANCIAL AGREEMENT

Our mission at Zieker Eye Ophthalmology is to preserve and protect the miracle of vision with expertise, kindness and efficiency. We are proud to offer the full spectrum of eye care using the most current, leading edge technology. In order for us to continue offering the best products and services available, the following payment schedule must be followed.

WHEN YOU ARRIVE FOR YOUR APPOINTMENT YOU ARE REQUIRED TO PAY THE FOLLOWING BEFORE SERVICES ARE RENDERED:

- The copay or coinsurance as directed by your insurance provider. This fee is set by your carrier and we are required by them to collect it at the time of service.
 - Inability to pay the required copay/coinsurance at the time of service will result in a \$25 fee in addition to the copay/coinsurance
- Any amount past due for services already rendered (i.e. from prior appointments). This payment is due once your insurance company has informed us of the amount for which you are responsible. This may be due prior to your receipt of a billing statement from us.
- Payment in full for any elective procedure or treatment.
- Payment in full if you are insured by a carrier with which we do not participate.
- Payment in full if you do not have medical insurance.

UPON CHECK OUT YOU *MAY* BE REQUIRED TO PAY A REFRACTION FEE:

- Our office policy is to charge \$30 for this procedure in addition to any office visit copay and/or deductible.
- You will not be charged a refraction fee more than once per year.
- This is due at the time services are rendered. We will bill your insurance and if your insurance pays the fee we will gladly refund you this prepaid \$30 amount once we receive notice from your insurance.
- Most insurances, including Medicare, do not cover this fee.
- Please refer to the Refraction Policy sheet for additional explanation and details about refractions.

PAYMENT

- We accept Visa, Mastercard, Discover, cash and checks. We also accept CareCredit for financing.
- For any returned checks a \$25 fee will be due.
- If you are unable to pay for the fees above on the date of service, prior to services being rendered, we may reschedule your appointment.



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REFRACTION POLICY

- What is a refraction?

Refraction is the testing performed by our ophthalmic technicians used to determine the eye's refractive error, or need for corrective glasses and/or contact lenses. It is an important test that allows us to measure vital signs of the eye.

- Why is it necessary?

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to show to insurance the need for cataract surgery. We must show that your vision cannot be simply improved with a glasses prescription. The refraction is an essential part of an eye exam; however, Medicare and most insurance plans DO NOT cover it.

- What if I do not want the refraction?

You may decline this part of the exam. Please notify the technician **PRIOR** to the beginning of the exam that you want this step skipped. **IMPORTANT:** If you decline, we may not be able to determine the cause for your decrease in vision.

- How much is it?

Our policy is to charge the standard \$30 fee for this procedure. This is in addition to the office visit copay and/or deductible which is set by your insurance carrier. The refraction fee is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. However, if your insurance pays the fee we will gladly refund you this prepaid \$30 amount upon receiving notice from your insurance.

NOTE: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and a new prescription will not be given. The fee covers the technician's time and effort in achieving this process. **This fee will not be charged more than once per year.**