FALCK EYE CENTERS, L.L.C.
DIRECTOR, FRANCIS Y. FALCK, JR., M.D., PH.D., M.S.
SPECIALISTS IN THE DIAGNOSIS AND TREATMENT OF EYE DISORDERS

Dear Patient,

Thank you for choosing Falck Eye Centers, L.L.C.. We would like to welcome you to our practice and make your visit as pleasant as possible. The entire staff is dedicated to providing you with excellent, courteous and compassionate eye care. To ensure you get the most from your visit, we do have some office policies we need to explain.

Each time you come into our office you will need to bring your insurance card with you. Since patients change insurance companies so frequently it is very difficult for us to keep up with these changes. Therefore, each visit you will be asked to present your card at the reception desk. Also, if you are in an HMO or other gatekeeper insurance program, you will need a referral from your medical doctor and it is your responsibility to have one in place for your appointment. If you do not have a current referral, you will be responsible for all charges at the time of the visit.

At the end of your visit you will be expected to pay your co-payment and any fees that your insurance does not cover. If we do not receive your co-payment and fees for noncovered services at the time of your visit, there will be a service charge for billing. If you have extenuating circumstances our office manager will be happy to set up a payment plan to meet your needs.

All new patients will be required to fill out the enclosed patient registration and health history forms prior to their office visit. To expedite our sign in process please do not forget to bring them in with you along with your insurance card and your co-payment. Remember, without your card we will be unable to see you.

We are sure you will be happy with the eye care we provide to you and we would appreciate your kind consideration in helping us out with our office policies. Thank you for understanding this important matter and we look forward to meeting you.

Sincerely,

Falck Eye Centers, L.L.C.

35 WASHINGTON STREET • MYSTIC, CONNECTICUT 06355
TELEPHONE (860) 572-2020 • FAX (860) 572-2000
CROSSROADS PROFESSIONAL BUILDING
196 PARKWAY SO., SUITE 301 • WATERFORD, CONNECTICUT 06385
TELEPHONE (860) 447-3937 • info@falckeyecenterllc.com

PATIENT INFORMATION

NAME:______________________________ EMPLOYER:__________________________

ADDRESS:___________________________ MARITAL STATUS: S M D W

___________________________ IF MARRIED:

___________________________ SPOUSE'S NAME:__________________

SOCIAL SECURITY NUMBER:___________

DATE OF BIRTH:______________________ IN CASE OF AN EMERGENCY:

TELEPHONE: (HOME)_________________ CONTACT:___________________________

(WORK)________________ PHONE #:________________________

REFERRED BY:______________________ RELATIONSHIP TO YOU?___________

PRIMARY PHYSICIAN:__________________

PHONE:__________________

REASON FOR YOUR APPOINTMENT WITH US TODAY?:_____________________________

____

____

****

INSURANCE INFORMATION

PRIMARY INSURANCE:______________________________ ID #:______________________

DEDUCTIBLE:___________________________ COPAY:______________________

SECONDARY INSURANCE:___________________________ ID#:_______________________

**** NAME OF INSURED:____

**** RELATIONSHIP TO PATIENT:____

**** INSURED'S DATE OF BIRTH:____

**** SOCIAL SECURITY NUMBER:____

**** INSURED'S EMPLOYER:__________________________PHONE #:__________________

MYSTIC EYE CENTER, L.L.C

MEDICAL HISTORY QUESTIONAIRE

Name: ______________________________ Birth Date: __________

Name of physician(s) referring you: ______________________________

______________________________ Phone: __________

List of any medications you routinely take: ______________________________

____

Do you presently have any of the following? Circle "YES" or "NO"

Blurred vision	YES	NO	Runny nose	YES	NO
Chest Pain	YES	NO	Sore throat	YES	NO
Diarrhea	YES	NO	Bloody stools	YES	NO
Fatigue	YES	NO	Cough	YES	NO
Headache	YES	NO	Fever	YES	NO
Dizziness	YES	NO	Nausea or vomiting	YES	NO
Pain in joints	YES	NO	Painful urination	YES	NO
Paralysis of extremities	YES	NO	Frequent urination	YES	NO
Shortness of breath	YES	NO	Rash	YES	NO
Upper respiratory infection	YES	NO	Sudden loss of vision	YES	NO

Have you had any of the following medical problems? If yes, give an explanation:

PROBLEMS			**EXPLANATION OF PROBLEM**
Blindness	YES	NO	
Cataract	YES	NO	
Glaucoma	YES	NO	
Macular degeneration	YES	NO	
Retinal detachment	YES	NO	
Arthritis	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Heart attack	YES	NO	
Stroke	YES	NO	
Thyroid disease	YES	NO	
High blood pressure	YES	NO	
Kidney stones	YES	NO	
Stomach ulcer	YES	NO	
Asthma	YES	NO	
Emphysema	YES	NO	
AIDS	YES	NO	
HIV Positive	YES	NO	
Other	YES	NO	

List any surgeries you have had in the past: ______________________________

____

Any disease in the family? Circle "YES or "NO", indicate relationship to patient:

DISEASES			RELATIONSHIP TO PATIENT
Blindness	YES	NO	___
Cataract	YES	NO	___
Glaucoma	YES	NO	___
Macular degeneration	YES	NO	___
Retinal detachment	YES	NO	___
Arthritis	YES	NO	___
Cancer	YES	NO	___
Diabetes	YES	NO	___
Heart attack	YES	NO	___
High blood pressure	YES	NO	___
Kidney disease	YES	NO	___
Stroke	YES	NO	___
Thyroid disease	YES	NO	___
Other	YES	NO	___

Do you have allergies to any medications YES:______ NO:_____ IF YES, list medications: ____

___

Do you smoke? YES: _____ NO: _____ If YES, how many packs a day:_______________

Do you drink alcohol? YES: ___ NO: _____ If YES, how many glasses a day:_______________

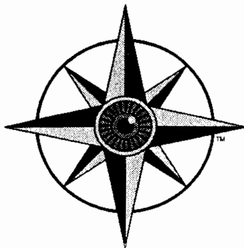
Patient occupation: ____

Education level (please check):
____ High school graduate ___ College graduate ___ Post-graduate degree

Doctor statement:____

___

Physician's signature: ______________________________ **Date:** ______________



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REFERRAL RESPONSIBILITY

I understand that I am seeking the care of this specialty physician. I understand that the terms of my health plan coverage require that I obtain a referral from my primary care physician (PCP). I understand if I fail to do so, I will be responsible for either applicable co-payments and deductibles or the TOTAL cost of the service according to the terms of my health plan coverage.

I acknowledge that I have read and understood that above.

Signed: ____

Witness: ____

DILATION CONSENT

During the course of your examination or treatments at the Falck Eye Centers, L.L.C., you may on occasion have your eyes dilated. This is necessary to perform certain parts of the examination. Dilating your eyes may temporarily blur your vision. You are advised to exercise caution in your activities after having your eyes dilated. It is recommended that you have someone else drive after your eyes have been dilated.

I acknowledge that I have read and understood that above. I agree to have my eyes dilated as needed.

Signed: ____

Witness: ____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Falck Eye Centers, L.L.C. to release all pertinent information including confidential information from my medical records to my health insurance or payor responsible for paying for my care, including Medicare and its agents, and to any entity under contract with them. The purpose of the release is to permit them to review the care and treatment and to determine benefits and payments for services rendered.

AUTHORIZATION TO PAY BENEFITS FROM THIRD PARTY PAYMENT SOURCES: I authorize third party payors, including Medicare and Medicaid, to make payment directly to the Falck Eye Centers, L.L.C. and to any physicians involved in my care for medical expenses and any / all benefits otherwise payable to me. If the services rendered will be paid by my private insurance, I understand that I am financially responsible for charges not covered by this authorization and that I will pay all costs of collection of any delinquent balance including any attorney's fees which may be added to my account. If Medicare will cover the services rendered, I understand that I am responsible for any applicable deductible and coinsurance. If the services rendered are Noncovered services under Medicare, I understand that I may be billed for these services upon receipt of an appropriate notice of Noncoverage.

Your signature indicates full acceptance and acknowledgment of each applicable paragraph.

________________________	__________	________________________
Patient or Authorized Representative	*Date*	*Witness*

If the patient is unable to sign:

________________________	________________________	________________________
Signature	*Relationship to Patient*	*Reason Why Patient Did Not Sign*

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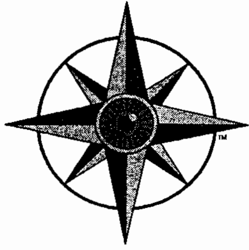

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HIPPA Notice

By virtue of my signature I understand that I have been provided with a copy of the Falck Eye Centers, LLC Notice of Privacy Practices Document. I also understand that I may download a copy at info@falckeyecenterllc.com.

Signed: ____ Date: ____/____/_______

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