Patient History and Information

Name: _____ Age_____ Birthdate_____

Home Address _____ Home Phone_____

_____Cell Phone_____

Do you prefer to be contacted by Home phone, Cell phone; e-mail or U.S. mail? _____

E-Mail Address_____ Social Security#_____

Occupation: _____ Hobbies: _____

Primary Language_____ Race_____ Ethnicity_____

Primary Doctor:(Not Group) _____ Address_____

Would you like us to send a report to your doctor? Y / N (If yes, Please supply complete address above)

Whom may we thank for referring you?_____

Insurance Name and Address: _____

_____

Insurance Subscriber Name & Birthdate_____

Medical:	Self	Family (Relation)
Constitution (Insomnia/Weight Loss)	_____	_____
Cardiovascular (Blood Pressure; Heart Dis.)	_____	_____
Ears, Nose, Mouth, Throat	_____	_____
Respiratory (Asthma, COPD)	_____	_____
Gastrointestinal (Hepatitis, Crohn's)	_____	_____
Genitourinary (Kidney Stones, Dialysis)	_____	_____
Musculoskeletal (Arthritis, MS)	_____	_____
Psychiatric (Dementia, Alzheimer's)	_____	_____
Integumentary (Skin Cancer)	_____	_____
Neurological (Bell's palsy, Epilepsy)	_____	_____
Endocrine (Diabetes, Thyroid)	_____	_____
Hematologic (Anemia, Leukemia)	_____	_____
Allergic/Immunologic (HIV, Lupus)	_____	_____
Other	_____	_____

Eyes:	Self	Family (Relation)
Glaucoma	_____	_____
Cataracts	_____	_____
Macular Degeneration	_____	_____
Eye Injury	_____	_____
Retinal Disease	_____	_____
Other Disease	_____	_____
Blindness	_____	_____
Strabismus (eye turn)	_____	_____
Diabetes	_____	_____
Dry Eye	_____	_____
Refractive	_____	_____
Other	_____	_____

Are you allergic to any medications? Y/ N Names: _____

Cigarette/tobacco use? Current/Former/Never Do you drink alcohol? Y / N

Do you take recreational drugs? Y / N Names: _____

Signature_____ **Date**_____

Parent/Legal Guardian must sign for patients under 18

DR. CRAIG A. CASSEY
DR. GARY OLIVER
DR. MUI LY
DR.CAITLYN CASSEY

MEDICATIONS	DOSAGE	REASON	PRESCRIBED BY

SIGNATURE:_____ DATE: _____

Craig A. Cassey, O.D.
4590 Edgmont Ave
Brookhaven, Pa. 19015

Notice of Contact Lens Policy

All patients wearing contact lenses are required to have an annual evaluation to assess the health of their eyes. We have always provided this evaluation as part of a routine eye exam. Insurance companies consider this a separate service and stipulate that we bill this independent of routine exams. Your specific insurance may or may not provide coverage for this service.

The fee for this service is $40 for regular contact lenses and $60 for Premium lenses ($50/$70 if new fitting is needed for a previous contact lens wearer). We will be happy to submit a claim to any insurance plan that provides for this service otherwise payment is expected at the time of service.

_____ Yes, I understand that as a contact lens wearer I will receive this evaluation and charge.

_____ No, I am not (or do not plan to continue) wearing contact lenses and will not be receiving this evaluation or charge.

_____ _____

Signature Date

CRAIG A. CASSEY, O.D., P.C. & ASSOCIATES
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Craig A. Cassey, O.D., P.C., & Associates appreciate the confidence you have shown in choosing us to provide your eye health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Craig A. Cassey, O.D., P.C., & Associates for providing eye care services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Craig A. Cassey, O.D., P.C., & Associates, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Insurance Information

Insurance Co: _____ Policy No.:_____

Insured's Name: _____ Relationship to Patient: _____

HIPAA Consent for Treatment and Authorization to Release Information

In accordance with federal HIPAA regulations we are required to release information to your primary doctor (for HMO plans) and/or to your insurance company. Our office will only release information to individuals specifically designated by our patients. If you wish to designate any person(s) to access your information please list them below:

Name:_____ Relationship: _____

Name: _____ Relationship: _____

Do we have permission to leave voicemail messages? Yes _____ No_____

Limited health information may be released by fax or email with a verbal release (social security number may be required to verify identity). Your signature below acknowledges that you are allowing Dr. Cassey and his designees to disclose and/or discuss any and all medical and financial information in our possession with any individuals listed above. This authorization will remain in effect until termination with current insurance or, for minors, until they reach age of majority.

Signature: _____ Date: _____
(Minors must have parent/legal guardian)

Emergency Contact: _____ Date: _____

Acknowledgment of Notice of Privacy Practices

Craig. A. Cassey, O.D., P.C.
4590 Edgmont Avenue, Brookhaven PA 19015
610-872-6077

The law requires that Craig. A. Cassey, O.D., P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

___ I have read or had explained to me prior to any services offered Craig. A. Cassey, O.D., P.C.'s Notice of Privacy Practice and agree to continue my care with Craig. A. Cassey, O.D., P.C. under said terms.

___ I was given an opportunity to read Craig. A. Cassey, O.D., P.C.'s Notice of Privacy Practices and declined, but wish to continue my care with Craig. A. Cassey, O.D., P.C. under the terms of Craig. A. Cassey, O.D., P.C.' privacy policies.

___ I have read or had explained to me prior to any services offered Craig. A. Cassey, O.D., P.C.'s Notice of Privacy Practice and do not wish to continue my care with Craig. A. Cassey, O.D., P.C. under said terms.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as:

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____
Patient

_____
Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____
Representative

_____
Relationship to Patient