SARATOGA OPHTHALMOLOGY

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Two locations
658 Malta Ave, ste 101
Malta NY 12020
P-518-580-0553, F-518-580-0557

2200 Burdett Ave, ste 206
Troy NY 12180
P-518-580-0553, F518-271-6394

Welcome to Saratoga Ophthalmology!

Thank you for choosing us to provide your medical eye care. We are proud to be one of the regions most experienced ophthalmology practices, and we look forward to serving you.
The forms enclosed will assist us in providing you with the best in eye care. Please
complete the forms and bring them with you to your appointment. Also, please know
that we require all patients to bring their insurance cards, photo identification, and
copayment to their first visit, or we will have to reschedule your appointment.

On the day of your first appointment, we strongly recommend that you have a driver,
because both of your eyes will be dilated. Your first appointment will last about 60 to 90 minutes. If you wish to have the doctor discuss your treatment with a relative or friend, please invite that person to join you at your first appointment.

If you have been referred by another doctor, please be sure they have provided you
with, or they have forwarded a letter or your medical record to us.

Our office participates with most insurance carriers. If your insurance requires an in-plan Referral, please contact your primary care doctor to submit a referral to us via fax:
(518)580-0557.

If you have any questions whatsoever, please call our office so we may help you:
(518)580-0553.
Thank you –we look forward to seeing you soon!

SARATOGA
OPHTHALMOLOGY

DEMOGRAPHIC INFORMATION

Name: _____ **DOB:** _____/_____/_____

Street Address: _____

City/State/Zip: _____

Marital Status: _____ **SSN:** _____-_____-_____ **Occupation:** _____

Primary Phone: (_____)_____-_____ **Secondary Phone:** (_____)_____-_____

Email Address: _____@_____

Emergency Contact: _____ **Phone:** (_____)_____-_____

Emergency Contact Relationship: _____

The Doctor Who Referred You Here: _____

Your Primary Care Doctor: _____

Your Pharmacy: _____

Your Pharmacy's Phone Number: (_____)_____-_____

If the patient is a minor, please complete guarantor information below:

Name of Guarantor: _____

DOB of Guarantor: _____/_____/_____ **SSN:** _____-_____-_____

Primary Phone: (_____)_____-_____

MEDICAL HISTORY Questionnaire

NAME_____DOB

Referring Provider:_____Primary Care_____

Provider:_____ Pharmacy:_____

____/____/_____

Pharmacy Phone:(____)_____

Date of Last Eye Exam:_____

Briefly Explain what brings you here Today

Please Check if any of these apply to you:

Do you wear: Glasses____Contacts____Reading ____Distance____.
Both Glasses and Contacts_____

Eye Diagnosis: Cataracts____Retinal Detachment_____Macular Degeneration____Glaucoma_____ DRY EYE____Lazy/Crossed Eye____Keratoconus____Eye Injuries:_____

OTHER:___

Please List any Known Family History of Eye Disease as Listed Above-
PLEASE LIST ANY EYE SURGERIES/LASER/INJECTIONS
SURGERY——————APPROX DATE——————PROVIDER

PLEASE LIST ANY RECENT: CT SCANS/MRI/BLOODWORK DONE

WHEN:_____WHERE:_____

Please Check all that Apply: Have you been diagnosed and or being treated for any of these:

YOURSELF

___Hypertension

___Cardiovascular

___Arthritis

___Lung

__Stroke

___Thyroid____GRAVES_

_____Diabetes Type

1__Type 2___

Insulin___Non Insulin____Diet

_____ ____Cholesterol

____Cancer

____MS

____Myasthenia Gravis

____Other

FAMILY

___Hypertension

___Hypertension

___Arthritis

___Lung

___Stroke

____Thyroid____Graves_____

__ __Diabetes Type 1___Type 2

___ Cholesterol

_____Insulin

___Non Insulin____Diet_____

____Other_____

____Cancer

____MS

____Myasthenia Gravis

Please Check: Have you had a Flu Vaccine:_____Pneumonia Vaccine:_____

Please Check: Do You Smoke? NO_____YES_____FORMER SMOKER_____

SURGERIES: EG: (Tonsils, Appendix)

Surgery_____APPROX DATE_____

PROVIDER_____

_____

_____

_____

_____

ANY KNOWN DRUG
ALLERGIES:

PLEASE LIST ANY MEDICATIONS THAT YOU TAKE INCLUDING EYE DROPS-OR GIVE ATTACHED COPY IF AVALIABLE.

Name: _____ **DOB:** _____/_____/_____

Date: _____

HIPAA POLICY

(Privacy Policy)

Medical Release of Information: I hereby authorize Saratoga Ophthalmology and its representatives to furnish medical information, including photographic or faxed copies of my records to my referring physician(s) and to my insurance company, if requested. As a patient or legal guardian of a patient, I understand that payment for today's service and any future service is ultimately my responsibility. I also authorize a representative of Saratoga Ophthalmology to speak with my insurance carrier on my behalf if required. **I understand that this office bills insurance as a courtesy and that payment of the charges for these services is my responsibility.** A photographic copy of this authorization shall be as valid as the original.

I consent to receive calls, texts, emails, and postcards from Saratoga Ophthalmology for purposes of appointment reminders. I am aware that I can review the Notice of Privacy Practices before signing this consent (available at the front desk). I hereby authorize Saratoga Ophthalmology to disclose the information about myself (or another person for whom I have authority to sign) that is protected under federal law for treatment, payment, and healthcare operations.

I also authorize Saratoga Ophthalmology to communicate with the following individual(s) about my condition or treatment. In accordance with federal laws, I understand that medical information may be withheld from individuals (including family members) unless I list them below.

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

Signature of Patient, Parent, or Legal Guardian: _____

Advance Beneficiary Notice of Non-coverage (ABN)

Patient Name: _____

Patient account Number: _____

Your insurance (_____**) may not offer coverage for the following services even though your health care provider advises these services are medically necessary and justified for your diagnoses.**

NOTE: **If your insurance plan DOES NOT cover the visit or any residual amount you will be responsible to pay the balance.**

Patient signature_____

Cancellation Policy

Please know that if a patient is 15 minutes late we may have to reschedule the appointment. We understand delays happen, however we must try to keep appointments running on time. Failure to show for an appointment or cancel within 24hours of a scheduled appointment will result in a $35.00 fee. Any patient that no shows or fails to give 24-hour notice of a cancellation (up to three times) may be discharged from the practice for non-compliance

Signature of Patient, Parent, or Legal Guardian: _____

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective lenses. However, it is considered a non-covered service by Medicare and most insurance companies; thus, it becomes the responsibility of the patient to pay for the refraction charge. Our fee for the refraction is $35.00 and is collected at the time of visit, in addition to any copayment, deductible, or balance due on the account. I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service should I have a refraction.

Signature of Patient, Parent, or Legal Guardian: _____