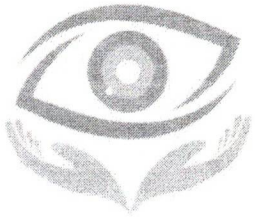


Navesink Eye

Denise Balacich, OD

225 State Hwy 35 N, Red Bank, NJ 07701

732-889-3299

NEW PATIENT INTAKE FORM

Personal Information

Full name: _____ **Date:** ___/___/_____

Date of birth: ___/___/_____ **Age:** _____ **M/F:**_____ **SSN:** _____

Address: _____

_____

Phone: Home: _____ Mobile: _____ **Email:** _____

Marital status: Single_____Married_____Widowed_____Divorced_____

Referred by: _____

Family Doctor: _____ **Phone:**_____

Emergency Contact

Name: _____ **Relationship:** _____ **Phone:** _____

IF MINOR****

Name of father: _____ Employer:_____

Address: _____ Phone:_____

Name of mother: _____ Employer:_____

Address: _____ Phone:_____

PATIENT HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____ Date _____

CONDITIONS Check (✓) conditions you have or have had in the past.

☐ Blurred Vision	☐ Eye Pain or Soreness	☐ Loss of Side Vision
☐ Burning	☐ Eye Surgery	☐ Mucous Discharge
☐ Cataracts	☐ Foreign Body Sensation	☐ Prominent Eye
☐ Cross Eyes	☐ Floaters	☐ Redness
☐ Diabetes	☐ Glare/Light Sensitivity	☐ Retinal Disease
☐ Double Vision	☐ Glaucoma	☐ Seeing Flashes
☐ Drooping Eyelid	☐ Headaches	☐ Seeing Halos
☐ Dryness	☐ Hypertension	☐ Tired Eyes
☐ Eye Infection	☐ Lazy Eye	Other _____
☐ Eye Injury	☐ Loss of Vision	

Check (✓) if your blood relatives had any of the following		Relationship to you
	Blindness	
	Cataracts	
	Diabetes	
	Glaucoma	
	Other	

VISION CORRECTIONS

Do you wear eye glasses? ☐ Yes ☐ No

Please (circle)

Reading Distance Both

How old is your current prescription? _____

Do you wear contact lenses? Type _____

ALLERGIES you have to medications

Seasonal Allergies? Hay Fever?

MEDICATIONS List medications you are currently taking

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

Number of packs per day _____

Do you drink? ☐ Yes ☐ No

Number of drinks per day _____

MAJOR ILLNESSES and INJURIES: Please list _____

SURGERIES: Please list _____

Have you or any member of your family experienced any problems with ANESTHESIA? ☐ Yes ☐ No

~~Please Complete Other Side~~

Navesink Eye

Denise Balacich, OD

225 State Hwy 35 N, Red Bank, NJ 07701

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice). We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA; Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death. SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:
Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value

that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information, we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  - was not created by us, unless the person that created the information is no longer available to make the amendment,
  - is not part of the health information kept by or for us, o is not part of the information you would be permitted to inspect or copy, or o is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically). **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

- ***Contact Person:*** Our contact person for all questions, requests or for further information related to the privacy of your health information is: ***Navesink Eye : 732-889-3299*** ***Complaints:*** If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or E mail shown above. If you prefer, you can discuss your complaint in person or by phone. ***Changes to This Notice:*** We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: **ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Dr. Denise Balacich's Notice of Privacy Practices.

Date _____

Patient name_____

Signature _____

Navesink Eye

Denise Balacich, OD

225 State Hwy 35 N, Red Bank, NJ 07701

732.889.329

Financial Agreement

To help achieve our goal of providing the best medical care possible, we ask for your understanding and cooperation regarding the following payment/insurance policies:

Payments We ask that payments, including any applicable deductible or copayment, be made at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, money orders, debit cards, and most credit cards.

Patients with HMO or POS Insurance If you are a member of an HMO or POS plan, you need to have a valid referral from your primary medical doctor for each office visit and surgical procedure. Prior to your visit, please call in advance to ensure that all necessary forms and authorizations are in place. Without a valid referral, financial responsibility will lie upon the patient, and full payment will be due at the time of service.

Refraction Charge This allows the doctor to determine and provide you with an eyeglass prescription or to update your current eyeglasses. We ask that payments be made at the time the new prescription for eyeglasses is dispensed.

Our office fee for refraction is **$50.00**

Missed Appointment / Late Cancellation Policy

To provide the best care for all our patients and respect everyone's time, we require at least 24 hours' notice for appointment cancellations or rescheduling.

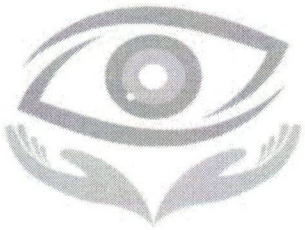
If you do not cancel your appointment at least 24 hours in advance, or if you miss your appointment without notice, a $25.00 fee will be charged to your account. This fee is not covered by insurance and must be paid prior to scheduling your next appointment.

Late Payments It is our policy to render periodic statements for services on a monthly basis. We reserve the right, at our option, to charge interest on outstanding balances beyond 60 days at a rate of 5% per month.

All Vision insurance must be presented at the time of appt check-in. If found after payment is made, there will be no reimbursement. Must be presented at exam.

I hereby authorize Navesink Eye and its Doctors, and/or agents to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Navesink Eye. I further authorize the release of any information necessary to process any claim with my insurance carrier. I understand that I am financial responsible for all charges, including those not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company. I have read and understand the payment policy and agree to abide by its guidelines.

Patient Signature(patient or parent if minor): _____ Date :_____



Navesink Eye
Your health is in our hands

225 State Hwy 35 N Suite 102 A
Red Bank, NJ 07701
732-889-3299
Navesinkeye@gmail.com www.Navesinkeye.com

Most people have vision insurance and medical insurance. While they seem similar, they are very different regarding the services they cover, and patients must understand those differences.

- Vision coverage (VSP, Spectera, Eye Med, Davis Vision, etc.) is mainly designed to determine a prescription for glasses and does not cover complex medical conditions.

- Medical coverage (BCBS, Cigna, UHC, Aetna, etc.) is filed when a medical condition is present such as diabetes, cataracts, dry eyes, floaters, etc. In this case, co-pays and deductibles for your medical insurance will apply.

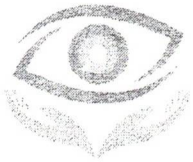
Insurance carriers set these rules, and our office is required to follow them. We do our best to make sure you are aware of any out-of-pocket expenses associated with your visit. Unfortunately, in many incidences, there is no way to know before the examination which type of insurance our office will file for you.

We make every effort to be on every major carrier for your convenience, and we will file those claims for you. If we do not take your insurance, we will provide you with an itemized receipt so that you may file your carrier for reimbursement.

If you have any questions, please let us know.

I understand the paragraph above, and I authorized Navesink Eye to file my insurance by the above guidelines. I am aware that I am responsible for any co-payments or deductibles set in accordance with my insurance provider. I am also responsible for any treatment or testing that my insurance provider does not cover.

Signature: _____ Date:_____



Navesink Eye

Patient Communication Consent – Text Messaging

To enhance our communication and better serve you, we offer text message reminders for appointments, billing, and general office updates.

Please read and sign below to authorize us to contact you via text message.

I consent to receive text messages from Navesink Eye related to:

- Appointment reminders
- Billing notifications, including outstanding balances
- General office updates (e.g., holiday hours, closures)
- Prescription or care coordination notices (no sensitive health information will be included unless through a secure, HIPAA-compliant platform)

I understand:

- Text messages may be sent using an automated system.
- No sensitive medical information (PHI) will be sent via unsecured text.
- Message and data rates may apply depending on my plan.
- I can opt out at any time by notifying the office or replying "STOP" to a text message.

For Adult Patients (18 and over):

Mobile Number: _____

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

For Minor Patients (Under 18):

I am the parent or legal guardian of the patient named below. I authorize Navesink Eye to send text messages to me regarding the minor's care, billing, and appointments as described above.

Minor's Name: _____

Parent/Guardian Name: _____

Mobile Number for Texts: _____

Signature of Parent/Guardian: _____

Date: _____

PRESCRIPTION RELEASE ACKNOWLEDGMENT FORM

I acknowledge that I have received a copy of my prescription(s) from Navesink Eye at the time of my exam. This may include my eyeglass prescription, contact lens prescription, or both, depending on services rendered.

I understand that:

My prescription is valid until the expiration date is printed on it.

I may request another copy at any time.

I have the right to use my prescription at the provider or retailer of my choice.

Patient/Parent/Guardian Signature: _____

Printed Name: _____