Robert G. Alexander, M.D.
Eye Physician & Surgeon

Welcome New Patient

Thank you for choosing Dr. Robert Alexander for your eye examination. To make your first visit as comfortable as possible, we ask that you prepare in advance and bring several items with you to your appointment. If you have any questions, please feel welcome to call us for help.

- ❑ **Bring the completed Patient Registration & Medical History forms with you**. By completing the forms in advance at your home, you have time to look up or verify hard-to-remember dates or facts. Your list of medications is extremely vital to us, so please take time to complete it.
- ❑ **Bring all of your current eyeglasses and/or contact lenses.** Please bring all of your current eyewear, including non-prescription reading glasses. It is helpful, but not necessary, to have a copy of your written prescription. **Attention contact lens wearers:** Please be sure to tell us before you come in that you are a contact lens wearer and what you expect from us so that we may discuss our contact lens policies with you.
- ❑ **Bring your health insurance card(s).** We will make a copy. Call first if you do not have any insurance coverage. If you do not have insurance coverage, payment is expected in full at the time of service, unless you have made other arrangements.
- ❑ **Bring written referral or referral number from your doctor, if your health plan requires it.** Some health insurances require a "referral" from your primary care physician before you see Dr. Alexander. It is your responsibility to understand the terms of your insurance. Please call your primary care office a week in advance of your appointment with us to secure your referral. Some insurances offer an annual eye exam benefit without referral. You are welcome to take advantage of that benefit with us, but please note that if you require any testing for pre-existing or newly discovered conditions, you will have to return with a referral to complete the testing. We recommend that you secure a referral if you are diabetic, have cataracts or glaucoma, or have been told you are a glaucoma suspect. If you are experiencing eye pain, migraines or have noticed an increase in floaters or experienced a sudden loss of vision, you should secure a referral.
- ❑ **Please call if you have questions about your coverage or our insurance affiliations.** We accept: Medicare and most Medicare supplemental plans including Medex, AARP, HPHC, Tufts and United Health. Medicare replacement plans including Tufts Medicare Preferred, HPHC Medicare Enhanced and AARP Medicare Complete from United Health. Most commercial (non-Medicare) products of Blue Cross/Blue Shield, Tufts, Harvard Pilgrim, Fallon Select, Neighborhood Health, Aetna and Aetna/US Healthcare and Cigna and BMC HealthNet Commercial, including plans contracted through the Massachusetts Health Connector. We accept Massachusetts state employee and retiree health plans including Unicare, Harvard Pilgrim, Fallon, Neighborhood Health and Tufts. The copay is Tier 2. We are providers for standard MA Health and are contracted with the Neighborhood Health MCO and the Tufts Network Health MCO. This is a partial list and plans change often. Please check your insurance website or contact us if you are unsure of your coverage. We also accept VISA, Mastercard, Discover and American Express.

We look forward to meeting you. Please plan to arrive 10–15 minutes early so that we may review your paperwork and introduce ourselves. We strive to run our schedule on time and will not keep you waiting long. Warmest greetings and welcome to the practice. The Office Staff—

Roberta, Kathy, Kenneth, Sandy & Terry

3 Woodland Road, Suite 112 ■ Stoneham, MA 02180-1703 ■ Tel: 781-665-3773 ■ Fax: 781-665-6784

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PATIENT REGISTRATION *(please print)*

First Name _____ Initial_____ Last Name _____

Home Address_____ City, State, Zip_____

Billing Address (if different) _____

Home Phone (_____)_____ Work Phone(_____)_____

Cell (_____)_____ Email _____

Primary Language _____ Sex: ❑ Male ❑ Female Date of Birth: _____

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Other _____❑ Prefer not to Answer

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Prefer not to Answer

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ Other How Did You Hear About Us ?_____

Primary Care Physician _____

Employer _____ Employer Phone _____

Guardian Last Name (If applicable) _____ First _____ Initial _____

Emergency Contact _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Co-pay Amount $_____ Policy Effective Dates: From _____ To _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

Authorization to pay Benefits to Provider: I hereby authorize payment directly to the undersigned Provider for my charges.

Authorization to release information: I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Signature (Patient, Guardian, or Parent of Minor) _____ Date: _____

Form: 071513

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PATIENT MEDICAL HISTORY

Please complete this form and bring it with you to your appointment. Add pages if you need space.

Patient Name _____ Date of Birth _____

1. Do you have now, or have you ever had:

PROBLEM	PATIENT	DATE OF ONSET
Diabetes Mellitus	❑Yes ❑No	_____
Treatment: ❑ Diet control ❑ Oral agents ❑ Insulin		
Name of Physician Treating diabetes_____		
Heart Attack	❑ Yes ❑ No	_____
Chest Pain or Angina	❑ Yes ❑ No	_____
High Blood Pressure	❑ Yes ❑ No	_____
Stroke or "Shock"	❑ Yes ❑ No	_____
Anemia	❑ Yes ❑ No	_____
Hepatitis	❑ Yes ❑ No	_____
Asthma	❑ Yes ❑ No	_____
Emphysema	❑ Yes ❑ No	_____
Bronchitis	❑ Yes ❑ No	_____
Pneumonia	❑ Yes ❑ No	_____
Tuberculosis	❑ Yes ❑ No	_____
Liver Disease	❑ Yes ❑ No	_____
Ulcer	❑ Yes ❑ No	_____
Overactive Bladder	❑ Yes ❑ No	_____
Prostate Treatment	❑ Yes ❑ No	_____
Kidney Disease, Stones	❑ Yes ❑ No	_____
Arthritis	❑ Yes ❑ No	_____
Type: ❑ Osteo ❑ Rheumatoid		
Cancer or Tumor	❑ Yes ❑ No	_____
Type, Location and Treatments: _____		
Thyroid Disease	❑ Yes ❑ No	_____
❑ Underactive .....Treatment _____		
❑ Overactive .....Treatment _____		
Seizures	❑ Yes ❑ No	_____
Varicose Veins, Clots	❑ Yes ❑ No	_____
Transfusions	❑ Yes ❑ No	_____
You have tested positive for AIDS or HIV	❑ Yes ❑ No	_____
Other medical problems	❑ Yes ❑ No	_____

2. Are you allergic to any medications or foods?
❑ Yes ❑ No
Please list_____
_____
_____
_____

3. What eye medications are you using at present?
Name & Dosage _____
_____
_____
_____

4. What other medications do you take regularly (including "social drugs")**?**
Name, Dosage & Frequency
_____
_____
_____
_____

5. When did you last use aspirin in any form?
Name/Product _____
Date _____

Continue

FOR OFFICE USE ONLY
Reviewed and evaluated by:
Dr. _____
Date_____ Time_____

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PATIENT MEDICAL HISTORY

6. When was your last professional eye exam and by whom?
Date_____ Name of Doctor_____
Type of doctor ❑ Ophthalmologist, M.D. ❑ Optometrist, O.D.
Were any existing or future eye problems mentioned by the doctor during this last exam? ❑ Yes ❑ No
If yes, please list: _____
_____

7. Have you had any previous eye surgery, laser surgery or eye injuries? ❑ Yes ❑ No
Types/Dates _____
_____
_____
_____

8. Do you wear Contact Lenses ❑ Yes ❑ No

9. What non-eye operations have you had?
Types/Dates
_____
_____
Date of last General anesthesia _____
Complications? Explain
_____

10. Among you and your blood relatives, is there a history of any of the following?

PROBLEM	PATIENT	BLOOD RELATIVES
Glaucoma	❑ Yes ❑ No	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	❑ Yes ❑ No
Lazy Eye	❑ Yes ❑ No	❑ Yes ❑ No
Retinal Disease	❑ Yes ❑ No	❑ Yes ❑ No
Macular Disease	❑ Yes ❑ No	❑ Yes ❑ No
Night Blindness	❑ Yes ❑ No	❑ Yes ❑ No
Color Blindness	❑ Yes ❑ No	❑ Yes ❑ No
Unexplained Vision Loss	❑ Yes ❑ No	❑ Yes ❑ No
Bleeding Disorder	❑ Yes ❑ No	❑ Yes ❑ No
Diabetes Mellitus		❑ Yes ❑ No
High Blood Pressure		❑ Yes ❑ No
Heart Disease		❑ Yes ❑ No
Tumor or Cancer		❑ Yes ❑ No
Other (Please list)		❑ Yes ❑ No

11. Do you smoke?
❑ Yes ❑ No
How many packs of cigarettes per day? _____

If you smoked in the past, when did you stop and how long had you smoked?
_____
_____

12. Do you drink alcoholic beverages?
❑ Yes ❑ No
How many drinks (beers, wine glasses or ounces of liquor) per day? _____
Per average week? _____
If you drank alcohol in the past, when did you stop and how long were you drinking?
_____
_____

13. In your line of work, hobby, or lifestyle, are your eyes exposed to chemical or air pollutants?
❑ Yes ❑ No
Name and frequency
_____ _____
_____

14. If applicable, are you pregnant? ❑ Yes ❑ No

15. Please identify your family or primary medical doctor (not your eye doctor).
Name _____
Clinic _____
Address_____
City, ST_____
Phone _____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information and that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices (in the New Patient Welcome Packet) containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

3 Woodland Road, Suite 112 ■ Stoneham, MA 02180-1703 ■ 781-665-3773 ■ Fax 781-665-6784

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NOTICE OF PRIVACY PRACTICES (Medical)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

The Health Insurance Portability & Accountability Act of 1966 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating , or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction.If we do agree to a restriction, we must abide by it unless you agree in writing to remove it....***Continued***

NOTICE OF PRIVACY PRACTICES (Medical continued)

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of September 20, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Robert G. Alexander, Eye M.D.
3 Woodland Road, Suite 112
Stoneham, MA 02180
781-665-3773

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775