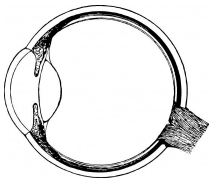

Bradley J. Phillips M.D., LLC
Cataract, Laser Vision Correction, & Neuro-Ophthalmology
1543 Route 27, Suite 23
Somerset, NJ 08873
Tel: (732)-249-6101 Fax: (732)-249-6102
www.supremevisionmd.com

PATIENT REGISTRATION FORM

DATE:_____

PATIENT NAME:_____ SS #:_____

DOB: _____ AGE:_____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

HOME #:_____ CELL#:_____ WORK#:_____

EMAIL: _____

PHARMACY (name, address, phone number): _____

PCP (name, phone number):_____

SEX: ( ) FEMALE ( ) MALE MARITAL STATUS: ( )S ( )M ( )D ( )W

IF MINOR, PARENT/RESPONSIBLE PARTY NAME: _____
PHONE #:_____

EMERGENCY CONTACT:_____ EMERGENCY CONTACT PHONE #:_____

REFERRED BY:_____ FAMILY PHYSICIAN: _____

INSURED EMPLOYMENT INFORMATION
(if patient is minor, parent/guardian's information)

EMPLOYED BY:_____ WORK #_____

RESPONSIBLE PARTY: _____ SS#:_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE:_____ POLICY ID:_____

GROUP # & NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME OF SUBSCRIBER:_____ DOB:_____ SS#:_____

SECONDARY INSURANCE INFORMATION

NAMES OF INSURANCE:_____

POLICY #:_____ GROUP# & NAME:_____

PHYSICIAN'S RELEASE & ASSIGNMENT
I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO BRADLEY PHILLIPS MDLLC. ANY SERVICES FURNISHED ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE COVERAGE IS INDICATED ON ITEM 9 OF THE HCFA-1800 CLAIM FORM OR ELSEWEAR ON OTHER APPROVED ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OF AGENCY SHOWN. IN MEDICARE-ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE COINSURANCE, AND NON- COVERED SERVICES. CO-INSURNCE AND DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER. IT IS UNDERSTOOD THAT THE UNDERSIGNED AND/OR THE PATIENT ARE PRIMARILY RESPONSIBLE FOR THE PAYMENT OF MY BILL.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT'S SIGNATURE:_____ **DATE:**_____

(if minor, parent/guardian signature)

Bradley J. Phillips M.D., LLC
Cataract, Laser Vision Correction, & Neuro-Ophthalm
1543 Route 27, Suite 23
Somerset, NJ 08873
Tel: (732)-249-6101 Fax: (732)-249-6102
www.supremevisionmd.com

REFRACTION SERVICES FORM

Refraction is the process of determining your prescription for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses.

Most medical insurance plans, including Medicare, do not cover refractive services or routine eye examinations.

We are, therefore, expected to charge separately for the refractive portion of the examination since it is not a covered service. Our office fee for the refraction is **50.00**. This fee is collected at the time of service. Should your plan be one of the few that covers your refraction, we will reimburse you accordingly.

Contact lens fitting fees and re-evaluations for existing contact lens wearers are separate charges from the above stated refraction fee that depend upon the complexity of the process. Please ask us before your evaluation if you have concerns. We will be as specific as we can but understand that we cannot always predict the complexity of a contact lens service.

If you have any questions regarding your Medicare coverage, or our insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

_____
PRINTED PATIENT NAME

_____
PATIENT SIGNATURE

_____
DATE

Bradley J. Phillips M.D., LLC
Cataract, Laser Vision Correction, & Neuro-Ophthalmology
1543 Route 27, Suite 23
Somerset, NJ 08873
Tel: (732)-249-6101 Fax: (732)-249-6102
www.supremevisionmd.com

AUTHORIZATION FOR USE OR DISCLOSURE OF MY HEALTH INFORMATION

Patient Name:_____

DOB:_____ SS#:_____

I. My Authorization

You, Bradley J. Phillips, MD may use or disclose the following health information:

- ☐ All health information maintained by you
- ☐ My health information relating to the following treatment or condition:_____
- ☐ My health information for the date(s): _____
- ☐ My insurance information only

You may disclose this health information to:
Name (or title) and organization:_____

Address: _____City: _____ State: _____ Zip:_____

Reason(s) for this authorization (check all that apply):

- ☐ At my request
- ☐ Other (specify)_____
- ☐ Check here only if Bradley J. Phillips, MD will get something of value for providing health information for marketing purposes

This authorization ends:

- ☐ On (date):_____
- ☐ When the following events occurs_____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party

I may revoke by authorization at any time, in writing, sent to Bradley J. Phillips, MD at the address provided below. If I do, it will not affect any actions already taken by Bradley J. Phillips MD based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance. 1543 NJ Route-27 Suite #23, Somerset, NJ 08873

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____ _____ _____
Patient or legally authorized individual signature Date Time

Patient is unable to sign because of:_____
Age of minor or reason for patient's inability to sign

Bradley J. Phillips M.D., LLC
Cataract, Laser Vision Correction, & Neuro-Ophthalmology
1543 Route 27, Suite 23
Somerset, NJ 08873
Tel: (732)-249-6101 Fax: (732)-249-6102
www.supremevisionmd.com

INSURANCE CONSENT FORM

Medicare

Name of beneficiary: _____
Health Insurance Claim Number:_____
I request that payment of authorized health insurance benefits,including medicare and medigap,be made either to me or on my behalf to Dr. Bradley J. Phillips for service furnished to me by this provider I authorize any holder of medical information about me to release to the health care financing administration,and its agents,any information needed to determine these benefits payable for related service.

Signature of Responsible Party:_____ Date:_____

Commercial Insurance

Name of Insurer:_____
I hereby authorize direct payment & surgical/medical benefits to Dr. Bradley J Phillips for services rendered in person or under his supervision, I understand that I am financially responsible for any balance not covered by my insurance, including co-pay, deductibles, refraction and differences between surgeon's charges and the allowables. I hereby authorize Dr.Bradley J Phillips to release any medical or incidental information that may be necessary for the processing of my claim.

Signature of Responsible Party:_____ Date:_____

Advance notice regarding insurance reimbursement and beneficiary agreement

I have been informed that refraction (the measurement & one's eyeglass prescription,and the determination of best visual sharpness) is usually not considered by insurance companies, health maintenance organizations and Medicare to be medically reasonable or necessary. Knowing this, I have instructed the doctor to proceed with the service . If insurance decides to reduce or even deny the fee or services, I agree to pay the doctor fee in full.

Signature of Responsible Party:_____ Date:_____