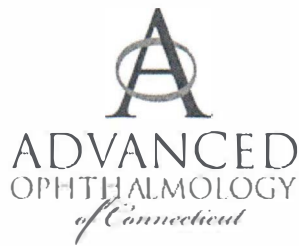


Old Greenwich
1455 East Putnam Ave.
Old Greenwich, CT 06870
www.AOCT.co
(203) 348-7575
(203) 348-2893 Fax



Patient In-Take Form

Social Security # _____ Today's Date: _____

Patients Full Name: _____ Date Of Birth: _____

Are you: Female Male | Are you: Single Married Divorced Widowed

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Employment Status: Retired Employed: _____

Where do you work?

Student: _____

What school? What Grade?

Referring Physician: _____

Doctors Name, Doctors Phone # & Fax #

Primary Care Physician: _____

Doctors Name, Doctors Phone # & Fax #

Do You Smoke: Yes No

Ethnicity: _____ Language: _____ Race: _____

Insurance Information:

Primary Insurance Company _____ Policy/Member ID Number _____ Group Number _____

Secondary Insurance Company _____ Policy/Member ID Number _____ Group Number _____

Billing Information

If billing information is the same as above, check here. ONLY if billing information is different, fill out the form billow.

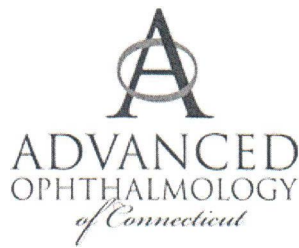
Full Name: _____ Relationship To Patient: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

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Insurance / Managed Care Billing Waiver

Below is an outline of our managed care policies. We hope that clear communication will help alleviate some of the inconsistencies and incongruous policies the managed care companies have placed on their members. Advanced Ophthalmology of Connecticut will make every effort to collect from your insurance plan. With all of the varieties of coverage available, it would be impossible for this office to know each plan or inquire for each patient.

Payment is required at the time of service for the following:

- All co-pay amounts, Deductibles that have not been met & co-insurances.
- Refraction (\$69.00) NOT covered by Medicare or most managed care plans.
- All Contact lenses fitting (\$250.00) & updates (\$95.00 - \$105.00) Evaluation done to determine fit and prescription.

You will be billed for the following:

- Fees for services that were denied due to failure to obtain a referral.
- Any Services denied by your plan that is billable within the guidelines of the managed care system.

I agree to pay for the services rendered by my physician at Advanced Ophthalmology of Connecticut if my insurance company denies coverage. I authorize you to release any information to my insurance company for the purpose of processing claims; this included any medical information.

Signature: _____ Date: _____
Patient or Legal Guardian

Print Name: _____

Medicare Waiver (sign ONLY if Medicare/Medicare HMO is your insurance provider)

I understand that **Medicare** considers a routine exam and refraction as a “Non-Covered” procedure. I understand that I am responsible for payment in full for these procedures at today’s visit. If you have enrolled in a Medicare HMO, it is your responsibility to inform the staff and remit your Co-pay and Deductibles at the time of service. I authorize Advanced Ophthalmology of Connecticut to release any information to Medicare for the purpose of processing claims; this included any medical Information.

Signature: _____ Date: _____
Patient or Legal Guardian

Print Name: _____

HIPAA Acknowledgment (everyone must sign):

I acknowledge that I have been provided with a copy of Advanced Ophthalmology of Connecticut privacy notice

Signature: _____ Date: _____
Patient or Legal Guardian

Print Name: _____