Dr. Niti Mistry
190 Dayton St, 2nd Floor
Ridgewood, NJ 07450
Ph: (201) 857-7520
Fax: (201) 251-4868

WELCOME LETTER

Account No.:	
Date :	

Dear patient:

We welcome you to our practice and ask that you kindly complete or correct all information on this form.

PATIENT INFORMATION

PATIENT NAME:		SEX:	SOCIAL SECURITY NUMBER:
ADDRESS:		DATE OF BIRTH:	MARITAL STATUS:
CITY, STATE & ZIP:		EMAIL:	
HOME PHONE: ( ) -	WORK PHONE: ( ) -	MOBILE PHONE: ( ) -	
EMPLOYER:		OCCUPATION:	
EMPLOYER'S ADDRESS:		PRIMARY CARE PHYSICIAN:	
EMPLOYER'S CITY, STATE & ZIP:		PRIMARY CARE PHYSICIAN'S PHONE: ( ) -	

Do you or your family have any history of the following conditions (check all that apply)?:

Self	Family	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Macular Degeneration
☐	☐	Heart Problems
☐	☐	Retinal Degeneration
☐	☐	Stroke
☐	☐	Thyroid Condition
☐	☐	Crossed/Lazy Eyes
☐	☐	Asthma/ Allergies
☐	☐	Color Blindness
☐	☐	Arthritis
☐	☐	Tuberculosis
☐	☐	HIV/Hepatitis
☐	☐	Cancer
☐	☐	Neuromuscular
☐	☐	Blindness
		Other: _____ _____

Do you currently have any of the following symptoms (check all that apply)?:

- ☐ Blurry distance vision
- ☐ Poor night vision
- ☐ Eye Strain
- ☐ Blurry Near Vision
- ☐ Trouble Reading
- ☐ Itchy Eyes
- ☐ Discharge
- ☐ Watering
- ☐ Pain in the eye
- ☐ Burning eyes
- ☐ Sandy/dry eyes
- ☐ Red Eyes
- ☐ Glare/reflections
- ☐ Discomfort in sunlight
- ☐ Double vision
- ☐ Floaters or spots in vision
- ☐ Flashes of light
- ☐ Eye injury
- ☐ History of wearing an eye patch
- ☐ History of eye surgery
- ☐ Headaches
- Dental Abscess

Are you interested in any of the following (check all that apply)?:

- ☐ New spectacles
- ☐ A new prescription
- ☐ Light weight glasses
- ☐ Anti-reflective lens
- ☐ Ortho K
- ☐ Colored contact lens
- ☐ Sunglasses
- ☐ Clip-ons
- ☐ Safety glasses
- ☐ Lasik
- ☐ Contact lenses
- ☐ Dry eye therapy
- ☐ Myopia control

How were you referred to us?

- ☐ Family doctor
- ☐ Yellow Pages
- ☐ Insurance company
- ☐ Another patient
- ☐ _____

MEDICATIONS:

ALLERGIES:

SOCIAL HISTORY:

- ☐ Alcohol abuse
- ☐ Drug use
- ☐ Tobacco use
- ☐ Other: _____ _____ _____

Dr. Niti Mistry
190 Dayton St, 2nd Floor
Ridgewood, NJ 07450
Ph: (201) 857-7520
Fax: (201) 251-4868

INSURANCE INFORMATION

Patient Name:	
Account No.:	
Date:	

GUARANTOR		
GUARANTOR NAME:	GENDER:	SOCIAL SECURITY NUMBER:
ADDRESS:	DATE OF BIRTH:	
CITY, STATE, ZIP:	PATIENT'S RELATIONSHIP TO GUARANTOR:	
HOME PHONE: ( ) -	WORK PHONE: ( ) -	

PRIMARY VISION INSURANCE	**SECONDARY VISION INSURANCE**
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	

PRIMARY MEDICAL INSURANCE	**SECONDARY MEDICAL INSURANCE**
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	INSURED PARTY:

MEDICAL INSURANCE POLICY: As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

REFUND/RETURN POLICIES: No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds for optical products, which include frames, lenses, and unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time that the refund is issued. Opened boxes of contact lenses are non-refundable. After the 30 days period, only 50% of the original payment made by the patient (private-pay or with insurance) can be issued back to the patient as store credit with the return of the product. 90 days after a product is dispensed, no refund, no exchange, no return can be made on any goods purchased at this store.

CONSENT FOR TREATMENT: I hereby authorize Ridgewood Eyewear to administer diagnostic and medical procedures as may be necessary for proper health care.

_____ _____

Signature of patient or authorized representative Date

_____

Authorized representative's name

Dr. Niti Mistry
190 Dayton St, 2nd Floor
Ridgewood, NJ 07450
Ph: (201) 857-7520
Fax: (201) 251-4868

HIPAA CONSENT

Patient Name:	
Account No.:	
Date:	

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give Ridgewood Eyewear permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Ridgewood Eyewear has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for Ridgewood Eyewear which describes how Ridgewood Eyewear may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Ridgewood Eyewear may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Ridgewood Eyewear by contacting Ridgewood Eyewear.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Ridgewood Eyewear be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, Ridgewood Eyewear is not required to agree to any restriction that I request. If Ridgewood Eyewear does decide to agree to my request, the use and/or disclosure of my health information by Ridgewood Eyewear must be restricted as I requested. If I wish to request restrictions I can contact Ridgewood Eyewear. Ridgewood Eyewear will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting Ridgewood Eyewear at 160 E. Ridgewood Ave, Ridgewood, NJ 07450-3848. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Ridgewood Eyewear may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____ _____
Signature of patient or authorized representative Date
Name of Patient:

_____
Authorized representative's name

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.

I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for Ridgewood Eyewear but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient is unable to sign
- ☐ Other _____

_____ _____
Signature of employee Date

_____
Employee's name

Dr. Niti Mistry
190 Dayton St, 2nd Floor
Ridgewood, NJ 07450
Ph: (201) 857-7520
Fax: (201) 251-4868

DILATION REFUSAL WAIVER

Patient Name:	
Account No.:	
Date:	

DILATION

We Prefer To Dilate: When indicated, pupillary dilation improves our doctor's ability to examine the internal structures of the eye for signs of disease, which is important for your health and well-being. Normal side-effects usually last 3 to 5 hours, and they include sensitivity to bright light (for which disposable eye shades are provided upon request) and difficulty focusing on near objects. Normally, your distance vision is not affected very much, and it is possible to drive safely after dilation if you currently have fairly up-to-date prescription eyeglasses.

Patients May Refuse: Patients reserve the right to refuse any test or diagnostic procedure recommended. If a patient refuses, however, he or she assumes all of the risk for potentially not detecting, and thereby treating in a timely manner, any serious eye conditions.

Patients May Reschedule: Some patients prefer to reschedule their dilated retinal exam for a different day and time to minimize visual side-effects upon their return to work or school. We will be happy to schedule a second appointment at a later time for this purpose, **privately charging an additional fee of $40.00.** There is absolutely **NO ADDITIONAL CHARGE** if we complete the dilated retinal exam during your initially scheduled comprehensive eye examination.

(To Be Signed ONLY If You Are Refusing Dilation)

I, under my own will and judgment, refuse to have my eyes dilated. As a consequence, I understand that the doctor may not be able to detect cases in which the retina is diseased, physically compromised, or harboring cancerous growths. As such, early detection and diagnosis of certain eye conditions, along with timely and effective treatment, may not be possible. I accept all risk for the possibility of not detecting these eye conditions without pupillary dilation, and I understand that theses conditions may result in permanent blindness, or even death.

_____ _____

Signature of patient or authorized representative Date

_____

Authorized representative's name