Haddonfield Vision, P.C. | Dr. Judson Moon, OD

Patient Information Form

Name:		Date:
Date of Birth:		SSN:
Street Address:		
City:	State:	Zip Code:
Phone:		Occupation:
Email:		Preferred Contact Method: ❑ Phone ❑ Email
Sex: ❑ Female ❑ Male		Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Are you currently pregnant? ❑ Y ❑ N		
Do you: ❑ Smoke ❑ Drink alcohol ❑ Use recreational substances		
Family doctor:		Phone:
Preferred pharmacy:		Phone:
Year of last eye exam:		Doctor:
Do you currently wear: ❑ Glasses ❑ Contacts ❑ Neither		
Have you had eye surgery or procedures: ❑ Y ❑ N	If yes, what type:	
If yes, what year?	Location/Doctor:	
Do you have personal or family history of: ❑ Glaucoma ❑ Macular Degeneration ❑ Cataract		
Do you take medication? ❑ Y ❑ N	If yes, please list:	
Any known drug allergies? ❑ Y ❑ N	If yes, please list:	

Have you been diagnosed with the following:

❑ Asthma ❑ AIDS ❑ Arthritis ❑ Cardiac issues ❑ COVID-19 ❑ Diabetes (❑ Type 1, ❑ Type 2)

❑ Fibromyalgia ❑ Herpes Simplex ❑ Herpes Zoster ❑ High Blood Pressure ❑ HIV

❑ Lupus ❑ Multiple Sclerosis ❑ Phlebitis ❑ Sarcoidosis ❑ Seasonal Allergies ❑ Shingles

❑ Other _____

Insurance Information (If applicable)

Vision Insurance Plan:	Member ID:
Policy Holder:	Policy Holder DOB:

If you do not sign below, we cannot take your insurance and you will be required to pay in full.

I authorize payment of my benefits to be made to the physician listed above, and will be responsible for any denial of claims if my insurance denies payment. I authorize the release of any medical information in order to process any claims.

Signature: _____ Date: _____

HADDONFIELD VISION

DR. JUDSON MOON, OD

HIPAA Privacy Authorization Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of this practice.

By signing this form, I understand that this practice has the right to request a restriction on the use of the information, but the practice does not have to agree to those restrictions. The practice has the right to revoke this consent in writing at any time. The practice may require this form to be fully executed in order to offer treatment.

My signature confirms that I have read this information and I understand my rights under HIPAA.

Patient name (print): _____ Date: _____

Health Insurance Portability and Accountability Act (HIPAA) - Email Consent

Please be aware that although the information stored in this practice's computers is encrypted, most popular email services do not utilize encrypted email. This means that when you send me an email, or I send you an email, the information is not encrypted. Without encryption, a third party may be able to access the information and read it. Once I receive an email, it can be accessed by outside parties and read.

The federal government has provided guidance on email and HIPAA on the U.S. Department of Health and Human Services website: https://www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that the same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

I understand the risk of unencrypted email and do hereby give permission to Haddonfield Vision to include the specialty services and send me personal health information via unencrypted email. I have read, understand, and will comply with the information contained within this email policy.

Patient signature: _____ Date: _____

Haddonfield Vision 57 Kings Highway E. Haddonfield, NJ 08033 T. (856) 427-0788

Name: _____ Date of Birth: _____

Below are additional services rendered by Haddonfield Vision that are available to you:

Digital Imaging / Retinal photography procedure ($25.00)

This procedure assists in diagnosing: glaucoma, diabetes, macular degeneration, and retinal abnormalities. This helps patients who do not want to get their pupils dilated, however, this is not a substitute for dilation. Typically, this test is not covered by most insurances, therefore you will need to pay this out of pocket at the time of your visit.

- ☐ **Yes**, I would like to have the digital photo taken today.
- ☐ **No**, I would not like to have the digital photo taken today.

Below is information on the services you may be receiving today:

Comprehensive eye exam for glasses: ($135.00)

This is an exam for eyeglasses, glaucoma, cataract testing, and overall ocular health, including drops for pupil dilation. This does not include contact lens evaluation, fitting, or a contact lens prescription.

Contact lens service:

This exam includes a doctor's evaluation, discussion, fitting, and sometimes the sampling of trial contact lenses. This includes previous contact lens wearers, as well as bifocal correction wearers. None of the services below are included in a comprehensive eye exam and are considered an additional service.

First time contact lens wearer (single vision): ($95.00)
- ➢ Includes contact fitting, training, care kit, and one follow-up visit.

Previous contact wearers (single vision): ($50.00)
- ➢ Single vision contact prescription update. Includes one follow-up visit.

First time monovision or bifocal contact service: ($150.00)
- ➢ Includes contact fitting, training, care kit, and one follow-up visit.

Previous contact wearers (monovision or bifocal vision): ($70.00)
- ➢ Monovision or bifocal contact prescription update. Includes one follow-up visit.

New patient that are existing contact lens wearers (single vision): ($55.00)
- ➢ Single vision contact prescription update. Includes one follow-up visit.

New patient that are existing contact lens wearers (monovision or bifocal): ($85.00)
- ➢ Monovision or bifocal contact prescription update. Includes one follow-up visit.

It is your responsibility to provide both your vision and medical insurance cards to Haddonfield Vision as proof of coverage at the time of your visit. After 24 hours, we will not refund, recalculate, reimburse, or redo your insurance benefits based on new information you provide Haddonfield Vision at a later date. You will be responsible for any charges that insurance does not cover.

Patient Signature: _____ Date: _____