Gregory Cox, M.D.

Eye Physician and Surgeon

Returning Patient Forms

PATIENT NAME:_____ DATE OF BIRTH:_____

Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Cell Phone:_____

Email:_____ Primary Physician:_____

Pharmacy :_____ Pharmacy Number:_____

Primary Insurance

Insurance Name:_____

Subscriber Name:_____ DATE OF BIRTH:_____

ID#_____ Group#_____

**IS A REFERRAL REQUIRED FOR THIS APPOINTMENT? ____ YES____ NO
**IF YES, PATIENT IS RESPONSIBLE FOR OBTAINING/PROVINDING THE REFERRAL

Secondary Insurance: **Tertiary Insurance**

Insurance Name:_____ Insurance Name:_____

Subscriber Name:_____ Subscriber Name:_____

Date of Birth:_____ Date of Birth:_____

ID#_____ ID#_____

Group#_____

Medical Changes Since Last Visit:_____

Medication:_____

_____

Print Name:_____ Date:_____

Signature_____ Date:_____

I understand Dr. Gregory Cox does not participate in the following Medical Insurance Plans:

AETNA BETTER HEALTH	AETNA ASSURE PREMIER PLUS	AMERIGROUP/WELLPOINT	CIGNA MEDICARE
HEALTH FIRST PLANS	HORIZON ADVANTAGE PLANS	HORIZON NJ FAMILY CARE	HORIZON PATIENT CENTERED PLAN
HORIZON TOTAL CARE	KEYSTONE FIRST PLANS	OXFORD GARDEN STATE	MEDICAID & ALL GOVERNMENT ASSISTED PLANS
MERCY HEALTH	UNITED DUAL COMPLETE	UNITED HEALTHCARE COMMUNITY PLANS	WELL CARE
HUMANA GOLD	UNITED OXFORD METRO	HUMANA USAA HONOR PPO	

I understand Dr. Gregory Cox does not participate in the following Vision Plans:

BLUE VISION	DAVIS VISION	EYEMED SELECT

If any of the above are your primary or secondary insurances and you are seen by the doctor, you will be responsible for any outstanding balances.

Referrals and Insurance Coverage:

- I understand that I am expected to know my insurance coverage at the time of service.
- If a **referral** is required with my insurance and I do not have one, I will be responsible for the charges incurred during my office visit.

Vision Plan:

If you have a vision plan (VBA, VSP, EYEMED, etc.), it is imperative that you notify the front desk upon your arrival to alleviate any errors that could occur with the billing. This will help us to process claims efficiently according to your coverage. We will not alter or be responsible for any billing information after the date of service.

Refraction Services:

Some insurance plans, such as Medicare, do not pay for refractive services. This is part of your eye exam that determines your prescription. Medicare mandates a separate billing code (92015) and our fee is $50.00 for which the patient is responsible. Any questions may be directed to our staff.

OPTOS Imaging:

For those patients who are coming for a routine eye exam and are unable or un-wiling to have their pupils dilated with eyedrops we offer the OPTOS widefield retinal imaging for an additional fee of $39.00. Please inform our technician if you are interested in OPTOS

OCT Imaging:

For those patients interested in advance laser imaging (OCT) to screen for glaucoma and retinal/macular disease we can perform this for an additional fee of $39.00. Please inform our technician if you are interested in OCT Imaging.

Signed: _____ Date: _____

Gregory E. Cox, MD LLC **Eye Physician & Surgeon**

HIPAA Rule Acknowledgement

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

- How do you want to be addressed when summoned from the reception area?

  ☐ First Name ☐ Other _____

- Please list any other parties who can have access to your health information:

  Name _____Relationship _____

- I authorize this office to contact me:

  ☐ to confirm my appointments, treatment, & billing information
  ☐ with information about my health
  ☐ about special services, events, fund raising efforts or new health information on behalf of this healthcare facility

  Using (select all that apply):

  ☐ Cell Phone ☐ Home Phone ☐ Email

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.

Print Name_____

Signature_____ Date _____

Office Use Only

As privacy Officer, I attempted to obtain the patient's or representative's signature on this acknowledgement but did not because:

☐ It was emergency treatment ☐ I could not communicate with the patient

☐ The patient refused to sign ☐ The patient was unable to sign because

_____Signature of Privacy Officer