

# PATIENT/GUARANTOR FORM

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_

CELL PHONE NUMBER: \_\_\_\_\_

WORK PHONE NUMBER: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ RACE: \_\_\_\_\_ LANGUAGE: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

PHARMACY: \_\_\_\_\_

PARENTAL INFORMATION IF PATIENT IS A MINOR AND/OR INSURANCE POLICY OWNER  
INFORMATION IF YOU ARE NOT THE INSURED:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_

CELL PHONE NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

# PATIENT BILLING CORRESPONDENCE

## INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I hereby authorize Houser Newman Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by insurance.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## PLEASE READ AND SIGN IF COVERED BY MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Houser Newman Associates for any service furnished to me by that physician(s) or supplier. 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 or the benefits payable for related services.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

# Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of HOUSER NEWMAN ASSOCIATES, MAHONING VALLEY AMBULATORY SURGERY CENTER, and LEHIGH ANESTHESIA ASSOCIATES **Notice of Privacy Policies**. My information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I will allow the following persons to receive my personal medical information: \_\_\_\_\_

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I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefit apply.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship to patient (e.g., spouse)

Relationship: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

If patient or patient's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to patient and sign below.

Presented on: \_\_\_\_\_ (date/time) By: \_\_\_\_\_ (name/title)



*General Ophthalmology*  
Donald A. Newman, M.D., F.A.C.S.  
Angela G. Houser, M.D.

*Optometry*  
Joseph S. Pancher, O.D.  
Kathleen B. Tanner, O.D.

**What is the difference between Vision Insurance and Medical Insurance?**

**Vision Insurance (Vision Plans)**

It is important that you understand that your Vision Plan (VSP, Davis Vision, NVA, etc.) covers **ROUTINE** well-eye exams only, which includes the refraction to determine your eyeglass prescription. Your plan may also provide discounts or allowances toward eyeglass frames, lenses, or contact lenses.

As part of a routine well-care exam, our doctors examine your eyes for routine eye health and to determine the need for glasses or other refractive correction. If a medical eye condition is known, or discovered during this exam, a separate exam must then be made to address these issues and will be filed under your medical insurance. If your routine well-eye examination reveals a medical condition or disease which requires special testing or follow-up care, the testing and subsequent examinations will be billed to your medical insurance as these are **NOT COVERED** by your Vision Plan.

It is important to know that if you have a specific eye or vision complaint which is related to a new or pre-existing condition, such as cataract, glaucoma, diabetes, dry eyes, etc. or if you are here for a follow up appointment for a pre-existing condition as requested by a doctor, then your visit is **NOT COVERED** by your Vision Plan and will be billed to your medical insurance. Unfortunately, the doctor cannot always be sure whether a complaint such as decreased vision is related to a medical eye condition until after you are thoroughly examined.

**Medical Insurance**

The good news is that your Medical Insurance can be used if you have an eye-related medical problem, such as an eye injury, pink eye, double vision, headaches, cataract, dry eyes, glaucoma, or issues related to diabetes or high blood pressure (among many others). You **DO NOT** need a vision benefits rider on your medical insurance to be covered for a medical eye condition. In these cases, your Medical Insurance will be billed for the eye exam *even though a Vision Plan may also be in effect*. Your Medical insurance co-pays and deductibles prevail and must be paid at the time of your examination. Additionally, if we do file the exam with your medical insurance, you can still use your Vision Plan benefits toward the purchase of glasses or contact lenses, based on your plan and allowances.

At times it can seem like a complicated process, but these are the rules set by the insurance companies. We would be happy to answer any questions that you may have about your coverage.

**Once your exam and materials have been filed with your insurance provider (at the conclusion of your visit) we CANNOT ALTER or CHANGE your examination, materials, diagnosis codes or bill another other insurance.**

I have read the notice of Houser Newman Associates and agree to the terms set forth herein.

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Signature of Patient and/or Guardian*

\_\_\_\_\_  
*Date*

Main Office  
37 Medical Crossing Road  
Tamaqua, PA 18252  
P: (570) 386-5926  
F: (570) 386-2959

Palmerton Office  
502 Delaware Avenue  
Palmerton, PA 18071  
P: (610) 826-3858  
F: (610) 826-3860

Nesquehoning Office  
40 East Locust Street  
Nesquehoning, PA 18240  
P: (570) 669-7081  
F: (570) 669-7083





# CONFIDENTIAL MEDICAL HISTORY FORM

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following (CHECK BOX FOR YES):

<p><b>HEART &amp; LUNGS</b></p> <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Pneumonia	<p><b>STOMACH &amp; BOWEL</b></p> <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Ulcerative Colitis/Crohn's <input type="checkbox"/> Other	<p><b>HEMATOLOGY &amp; ONCOLOGY</b></p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blood Clots <input type="checkbox"/> Cancer Radiation/Chemo Therapy	<p><b>STDs &amp; INFECTIOUS DISEASE</b></p> <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes/Cold Sores <input type="checkbox"/> Chickenpox/Shingles <input type="checkbox"/> Hepatitis Type: ____ <input type="checkbox"/> HIV <input type="checkbox"/> Infectious Mono <input type="checkbox"/> Tuberculosis	<p><b>SOCIAL HISTORY</b></p> <input type="checkbox"/> Do you drink alcohol? <input type="checkbox"/> Do you smoke? <input type="checkbox"/> Do you take drugs? <input type="checkbox"/> Do you exercise?														
<p><b>ENDOCRINE</b></p> <input type="checkbox"/> Adrenal Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Polycystic Ovary <input type="checkbox"/> Thyroid Disorder	<p><b>NEUROLOGICAL</b></p> <input type="checkbox"/> Concussion <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke/TIA	<p><b>ORTHOPEDICS</b></p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Fractures	<p><b>SURGICAL HISTORY</b></p> <input type="checkbox"/> Appendix removal <input type="checkbox"/> Adenoid removal <input type="checkbox"/> Cataract removal <input type="checkbox"/> Ear tubes <input type="checkbox"/> Gallbladder removal <input type="checkbox"/> Hip replacement <input type="checkbox"/> Knee replacement <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Spleen removal <input type="checkbox"/> Tonsil removal <input type="checkbox"/> Weight loss surgery <input type="checkbox"/> Other Surgery															
<p><b>KIDNEY</b></p> <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Kidney Stones	<p><b>MENTAL HEALTH</b></p> <input type="checkbox"/> ADHD <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Anorexia <input type="checkbox"/> Anxiety <input type="checkbox"/> Bulimia <input type="checkbox"/> Depression <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Other Mental Health Problem:	<p><b>OPHTHALMOLOGY</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Cataracts</td> <td style="width: 50%;"><input type="checkbox"/> Macular Degeneration</td> </tr> <tr> <td><input type="checkbox"/> Cornea</td> <td><input type="checkbox"/> Macular Edema</td> </tr> <tr> <td><input type="checkbox"/> Diabetic Retinopathy</td> <td><input type="checkbox"/> Oculoplastic issue</td> </tr> <tr> <td><input type="checkbox"/> Dry Eye</td> <td><input type="checkbox"/> Other Retinal issue</td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Uses Glasses/contacts</td> </tr> <tr> <td><input type="checkbox"/> Loss of Eye</td> <td><input type="checkbox"/> Other eye issue:</td> </tr> <tr> <td colspan="2"> </td> </tr> </table>			<input type="checkbox"/> Cataracts	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Cornea	<input type="checkbox"/> Macular Edema	<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Oculoplastic issue	<input type="checkbox"/> Dry Eye	<input type="checkbox"/> Other Retinal issue	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Uses Glasses/contacts	<input type="checkbox"/> Loss of Eye	<input type="checkbox"/> Other eye issue:		
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<p><b>SKIN</b></p> <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Hives	<p><b>PREVIOUS HOSPITALIZATIONS:</b></p> <p> </p> <p> </p> <p> </p>																	
<p><input type="checkbox"/> I HAVE NO SIGNIFICANT HEALTH PROBLEMS</p>	<p><b>OTHER HEALTH PROBLEMS/SURGERIES NOT LISTED:</b></p> <p> </p> <p> </p> <p> </p>																	
<p><b>DOES YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING?</b></p>			<p><input type="checkbox"/> I WAS ADOPTED (UNKNOWN HISTORY)</p>															
	MOTHER	FATHER	SIBLINGS	GRANDPARENT														
Alcohol/Drug Abuse																		
Blood Clots/Clotting Disorder																		
Cancer (Breast, colon, melanoma, other (list type under person))																		
Diabetes																		
Eye Disease/Disorders																		
Heart Disease																		
High Blood Pressure																		
High Cholesterol																		
Mental Illness																		
Stroke/TIA																		
Sudden Cardiac Arrest (Under age 50)																		
Other (please explain under person)																		
Deceased (Prior to age 50 please list reason)																		