Dr. Martin G. Ellis, O.D.

3018 St. Rt. 5 Suite C
Cortland, OH 44410
(330) 638-4097

We would like to personally welcome you to our office. It is our privilege to provide you with the best care we are capable of rendering. We offer a broad range of eye services from medical and emergency eye care, ophthalmic surgical co-management, refractive surgery consultations, annual vision care, contact lens examinations and dispensary services in glasses and contact lenses. To help you prepare for your upcoming visit, please read the enclosed information. Please feel free to call in advance with any questions.

- Depending on the type of examination and the number of test or treatment needed, please be prepared to spend about an hour with us. Your appointment is reserved exclusively for you. Therefore, if you are late or are unable to maintain the appointment please give at least 24 hour notice.
- Occasionally you may find that a patient has been called out of turn. These patients are emergency or postoperative patients who require immediate attention. Please try to understand should this happen to you and be assured that we will provide you with the same urgent and courteous attention if needed. We know your time is valuable and we apologize for any extended waiting periods, but please know that our main concern is to provide the best care possible to all our patients.
- It is common that your eyes will be dilated, therefore we recommend that you have a driver if you do not feel comfortable driving yourself.
- Please bring a list of all medications that you use, their dosage and frequency, and the name of your doctor. Also, please bring with you any prescription glasses that you currently are wearing or using. You may wear your contacts to your appointment we will provide a case for you to take them our when the Dr. is ready.

- Please bring your insurance cards with you. There are some insurance companies that we converse with online. Please be advised that we may need your SSN # to access an authorization for services rendered during your visit.
- **To make your visit as efficient as possible, please complete the attached forms and bring them with you for your appointment. Please be prepared to pay all charges due by you on your date of service.**

We hope this letter of introduction will help make your visit with us as pleasant and efficient as possible. If you have any questions, please don't hesitate to give us a call. Again, thank you for allowing us to participate in your eye care.

Sincerely,
Dr. Martin G. Ellis and Staff

DR. MARTIN G. ELLIS

3018 ST. RT. 5, SUITE C, CORTLAND, OHIO 44410

DATE:_____

(PLEASE PRINT)

Mr. Mrs. Ms. Or Miss_____ Sex: M F Date of Birth_____

Address:_____ City:_____ Zip:_____

Phone/Home:_____ Phone/Work:_____

Responsible Party: (if different from above) _____

Social Security No. for Responsible Party:_____

Address of Responsible Party:_____

Vision Insurance Co.:_____ Major Medical Co.:_____

What is your present occupation? _____ Employer: _____

When was your last eye exam? _____

How old are your present glasses and/or contact lenses? _____

Are you interested in getting contact lenses? _____

Are you presently under a physician's care? _____Yes_____No Dr. _____

Are you presently taking any medications? _____Yes_____No, If yes please list them:_____

_____

Do you have any allergies? ____ Yes ____ No, If yes please list them: _____

Please circle any that may apply to you:

High Blood Pressure	Lung Disorder	Anemia	Heart Trouble
Serious head or Eye Injury	Glaucoma	Diabetes	Eye Surgery
Ear Trouble	Eye Diseases	Low Blood Pressure	Sinus Trouble
Thyroid Trouble	Cataract	Cholesterol	Retinal Problems

Do you get any headaches? ____ Yes ____ No, if yes, how often? _____

Have you ever had your pupils dilated? ____ Yes ____ No

If female: Are you taking birth control pills? ____ Yes ____ No

If female: Are you pregnant at this time? ____ Yes ____ No, If yes, how many months? _____

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Signature_____ (Parent, if under 18 years of age) Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple heathcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the notice of Private Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship:_____

Signature:_____

Date:_____

Please list one person that per your request we are to release medical information to:_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ **Initials**: _____ **Reason**: _____

OFFICE FEE POLICY

50% DEPSOSIT REQUIRED BEFORE OPTHALMIC MATERIALS ARE ORDERED. BALANCE DUE UPON COMPLETION OF PROFESSIONAL SERVICES UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO TODAY'S APPOINTMENT.