



**DEL NEGRO & SENFT**  
**EYE ASSOCIATES**  
**DSeYE.com**

Ralph G. Del Negro, D.O.  
 Carl J. Senft, M.D.  
 Marina Glatman, M.D.

Tina V. Shah, O.D.  
 Patricia E. Carniglia, O.D.

Account# \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M / F  
 Medical (PCP) Dr: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_

**Were you referred by a doctor today for a specific problem? Y or N**  
**If yes, by whom** \_\_\_\_\_

**Race (please check):**  American Indian or Alaska Native  Asian  
 Black or African-American  Middle Eastern  White or Caucasian  
 Native Hawaiian or Pacific Islander  Other  Decline to Answer

**Preferred Language (please check):**  English  Other (please specify) \_\_\_\_\_

**Ethnicity (please check):**  Non-Hispanic or Non-Latino  Hispanic or Latino

**Medical History (circle any that apply):**

Arthritis	Diabetes	Kidney Disease	Other: _____
Asthma	Heart Disease	Stroke	_____
Cancer	Hypertension	Thyroid	_____
Type?	HIV/AID		_____
COPD	High Cholesterol		_____

**Past Surgeries (Please list):** \_\_\_\_\_

**Ocular History (circle all that apply):**

Cataract	Glaucoma	Other: _____
Diabetic Retinopathy	Macular Degeneration	_____
Dry Eyes	Retinal Tear	

**Eye Surgery (Please list):** \_\_\_\_\_

**Family History (circle all that apply):**

Blindness	Glaucoma	Macular Degeneration
Diabetes	Hypertension	Other: _____

**Drugs Allergies:** \_\_\_\_\_

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

Patient Name: \_\_\_\_\_

Account # \_\_\_\_\_

**Social History:**

**Smoking status:** (circle one)

Current every day smoker

Current some day smoker (cigarette)

Never smoker

Light tobacco smoker

Current some day smoker (tobacco)

Former smoker

Heavy tobacco smoker

**Social History Details:** (circle one)

EtOH (Alcohol use) none

EtOH (Alcohol use) 1-2 drinks per day

EtOH (Alcohol use) less than 1 drink per day

EtOH (Alcohol use) 3 or more drinks per day

**Driving Status:** (circle all that apply)    Drives in Daytime    Drives at Night

**Systemic Medications (or please attach list):**

**NAME**

**DOSAGE**

**FREQUENCY**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Eye Medications (or please attach list):**

**NAME**

**DOSAGE**

**FREQUENCY**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name (Printed): \_\_\_\_\_

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



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Name:

First \_\_\_\_\_ MI \_\_\_\_ Last \_\_\_\_\_

Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State and Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Driver's License/State: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Cell \_\_\_\_ Home \_\_\_\_ Business \_\_\_\_

Secondary Phone: \_\_\_\_\_ Cell \_\_\_\_ Home \_\_\_\_ Business \_\_\_\_

Preferred Contact Method for appointment confirmations (Please check one):

Text \_\_\_ Phone call \_\_\_

Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employment Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Relationship/Phone: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referral Source: \_\_\_\_\_

**INSURANCE:**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Insurance Subscriber if other than yourself: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscribers Date of Birth \_\_\_\_\_

CHECK OUT NOTE: Please stop at the check-out counter before leaving our office. Payment is expected at the time of your visit unless other arrangements have been made in advance. We are a Medicare Participating Provider and submit claims on services provided to Medicare recipients. In addition, we will submit claims to any insurance companies to which we participate. You are responsible for any denied claims, co-payments and co-insurance.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION: I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payment from Insurance carriers for services rendered. I understand and agree to the above conditions and certify that, to the best of my knowledge, the information on this form is correct.

Signature

Date



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## **HIPAA**

### **Notice of Privacy Practices**

### **Your Information. Your Rights. Our Responsibilities.**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

THIS NOTICE DESCRIBES:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO EXERCISE YOUR RIGHT TO GET COPIES OF YOUR RECORDS AT LIMITED COST OR, IN SOME CASES, FREE OF CHARGE
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY, OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION, INCLUDING YOUR RIGHT TO INSPECT OR GET COPIES OF YOUR RECORDS UNDER HIPAA

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH OUR PRIVACY OFFICER, 732-774-5566, [info@dseye.com](mailto:info@dseye.com) IF YOU HAVE ANY QUESTIONS.

### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your health record**

- You can ask to see or get an electronic or paper copy of your health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within thirty (30) days of your request. We may charge a reasonable, cost-based fee.
- Ask us about your right to access to inspect and obtain a copy of your health record and other health information, at limited cost or, in some cases, free of charge; and your right to have us send an electronic copy of health records and other health information in an electronic health record to another person or entity.

#### **Ask us to correct your health record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within sixty (60) days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care or we determine that your request is unreasonable.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six (6) years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one (1) accounting a year for free, but will charge a reasonable, cost-based fee if you ask, for another one within twelve (12) months.

### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone health care power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- Unless you are an emancipated minor or there is another law (granting you with legal authority to make your own healthcare decisions), your parent or legal guardian will make decisions regarding your health information.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### **Discuss this notice of privacy practices**

- You have the right to discuss this notice of privacy practices or our privacy practices with the Privacy Officer listed at the top of this notice.

## **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. If you do not tell us that you have a preference, or that you want to limit what we can share, we will exercise our professional judgment in what we share.

### **In these cases, you have both the right and choice to tell us to limit how we may:**

- Share information with your family, close friends, or others involved in your care or payment for your care, including following your death.
- Share information in a disaster relief situation.
- Include your information in a hospital directory. If you are not able to tell us your preference, for example, if you are unconscious or you never told us about your preference, we may go ahead and share your information if we believe it is in your best interest or in our professional judgment. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- Other instances that require written permission

In many cases, written permission will require certain elements to be included in a document you sign that is called a “HIPAA Authorization”. We will let you know when such a document is needed. You can always ask us about this as well.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Treat you

We can use your health information and share it with other professionals who are treating you.

*Example: We may receive health information and from other health care providers for you and we will use your health information to provide health care services to you. We may also disclose your health information to your doctor and other health care providers (including hospitals, nursing facilities, etc.) to coordinate your treatment and provide you with health care services.*

#### Run our health care practice

We can use and share your health information to run our healthcare practice, improve your care, and contact you when necessary.

*Example: We use health information about you to help us in providing healthcare services, writing prescriptions and other services. We may also share your health information with our “business associates” that help us in performing services for us that involves your health information such as our attorneys, accountants, billing company and others.*

#### Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

#### Appointment Reminders and Health-Related Benefits and Services

We may use your health information, as necessary, to contact you to remind you of your appointments, and inform you about alternatives or other health-related benefits and services that may be of interest to you. Let us know if you do not want us to use your health information for these purposes or if you want to limit how we use your information.

## How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

**[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)**

#### Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety
- Other situations as permitted or required by law

#### Do research

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services, if it wants to see that we're complying with federal privacy law or other governmental agencies as required by law.

### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **Incidental Uses and Disclosures**

In the course of providing services to you and other patients, there will be incidental uses and disclosures of your health information. We will try to limit such uses and disclosures, but we cannot ensure that no such incidental uses and disclosures will not occur.

*Example: During your treatment or in the waiting area, other patients may overhear a discussion of your health information.*

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information, other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. You can use the contact information at the beginning of this notice.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

## **Notice Regarding Additional State and Federal Law Protections**

There are certain types of highly confidential information that are specifically addressed in certain federal and state laws and regulations, and which further restrict the use and disclosure of this type of highly confidential information. This highly confidential information, including alcohol and substance abuse treatment information, HIV and sexually transmitted disease-related information, mental health information, psychotherapy information, and pregnancy of minors, as well as some other sensitive information, are considered so sensitive that some federal and applicable state laws provide special protections for them. All uses or disclosures of such highly sensitive information must meet the requirements of such applicable law. Therefore, there may be greater protections under applicable law for such highly sensitive information. Ask us if you have questions or concerns about the ways this type of highly confidential information may be used or disclosed.



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## HIPAA Notice of Privacy Practices Acknowledgement and Consent

By signing below, I acknowledge that I have been provided a copy of **Del Negro & Senft Eye Associates, P.C.**'s HIPAA Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by **Del Negro & Senft Eye Associates, P.C.** and how I may obtain access to and control of this information. I also acknowledge and understand that I may request explanations regarding any questions I may have.

By signing below, I consent to the use and disclosure of my health information as contained in the HIPAA Notice of Privacy Practices of **Del Negro & Senft Eye Associates, P.C.** (as it may be updated from time to time).

Your name: \_\_\_\_\_

Your signature (or of parent or legal guardian): \_\_\_\_\_

If a parent or legal guardian is signing this document, place an "X" before the correct relationship to the patient/customer:

\_\_\_ Parent

\_\_\_ Legal Guardian

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

*Revised on July 7, 2025*