SCOTTSDALE EYE PHYSICIANS AND SURGEONS P.C.

PLEASE UPDATE YOUR INFORMATION

NAME_____

E-MAIL_____

CELL-PHONE_____

PHARMACY NAME/CROSS STREETS_____

_____

_

HOW DID YOU HEAR ABOUT US? (CIRCLE ONE)

-Referring Physician: _____ -Existing -Insurance

-Friend/Family -Website/Internet: ZOC DOC YELP GOOGLE

SCOTTSDALE
EYE PHYSICIANS & SURGEONS, PC

Personal Information

(Please Print Clearly)

Today's Date _____

Name _____ Social Security Number _____

Date of Birth _____ ○ Male ○ Female

Street Address _____

_____

City, State, Zip _____

Employer Name _____

Occupation (or previous, if retired) _____

Phone Numbers

Cell _____

Home _____

Work _____

Responsible Party _____ ○ Self ○ Other:

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Employer Name _____

Insurance Policy Holder _____

Primary Insurance Company, Plan Name _____

ID # _____ Group # _____

Secondary Insurance Carrier

ID # _____ Group # _____

○ Spouse or ○ Parent Name _____

Other family members seen in our office _____

_____

Relative not at your address _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

How did you hear about our office? ○ Yellow Pages ○ Friend ○ Family Member ○ Website

○ Another patient, who? _____

○ Another doctor, who? _____

○ Hospital, which? _____

○ Letter/Advertisement? _____

Conditions for Treatment and Collection of Payment

I HEREBY AUTHORIZE Scottsdale Eye Physicians & Surgeons, P.C. to examine and treat me or the individual for whom I am responsible. If I am receiving a "vision exam" only, I understand this is not a comprehensive eye examination for eye diseases. During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause blurred vision and glare for several hours. I understand that driving an automobile or operating machinery is not advised until the effects of the drops have worn off.

I understand it is my responsibility to obtain prior authorization for my visit with Scottsdale Eye Physicians & Surgeons, P.C. if required by my insurance plan. I understand I have the primary responsibility for payment of my charges unless the doctor has a contract with my insurance plan that prohibits them from billing me directly for "covered" services. Some services performed by Scottsdale Eye Physicians & Surgeons, P.C., such as after-hours services, some tests, and refractions, may not be "covered" or reimbursed by my insurance company. I understand I will be responsible for payment of any of the following: "non-covered" services, co-payments, unmet deductible amounts, collection fees, if appropriate authorization was not obtained from my insurance company prior to the examination, and if I am no longer covered by the insurance plan I listed.

Unpaid balances over 90 days from the date of service will accrue a charge of 1.5% interest per month on the total balance for amounts greater than $500. Unpaid balances over 90 days for balances under $500 will be charged $15 rebilling fee per month.

I promise not to post on social media or the internet any unauthorized, undisclosed recordings taken in this office, which may include confidential information or matters taken out of context.

Scottsdale Eye Physicians & Surgeons, P.C. is required to submit a completed insurance form to Medicare and some insurance plans. Insurance guidelines permit them to obtain a one-time signature that is valid for this and future visits to their office. I understand that by signing below, the notation "SIGNATURE ON FILE" will appear in lieu of my signature on Medicare and other insurance claim forms submitted for me by this office.
I authorize Scottsdale Eye Physicians & Surgeons, P.C. to release information acquired in the course of my examination and treatment to my insurance carriers and other medical providers.

_____

Printed Patient Name

_____ _____

Patient (or Legal Guardian) Signature Date

HIPAA Privacy Authorization Notice
Scottsdale Eye Physicians & Surgeons, PC

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my personal health information.

A copy of the ***Notice of Privacy Practices*** has been made available for my review. I understand the office will use and disclose my protected health information to provide my medical care, receive payment for services provided to me, and to conduct its business.

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I authorize Scottsdale Eye Physicians & Surgeons, PC (SEPS) to communicate with me by any means of contact I have provided. For example, I may be contacted for appointment reminders, test results, satisfaction surveys, etc.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____
Printed Patient Name

_____ _____
Patient (or Legal Guardian) Signature Date

PRACTICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment of the Patient receipt of ***Notice of Privacy Practices*** but was unable to do so as documented below:

Date: _____ Reason: _____ Initials: _____

Medical History Questionnaire
(Please print clearly. Use the back if you need more space.)

Today's date _____

Name _____

Your Age _____ **Your race** _____

Who is your usual medical doctor? _____

_____

What is the main reason for your visit? _____

_____

_____

Do you have any of the following symptoms?

□ Blurred distance vision □ Glare, halos around lights
□ Blurred reading vision □ Itching or burning of eyes
□ Double vision □ Eye mattering or tearing
□ Wear contact lenses? □ Dry eye □ Eye pain
□ Flashing lights, floaters □ Red eyes □ None

Do you have allergies to any medications or latex?

□ None □ Latex □ Yes, to: _____

_____

What <u>eye</u> medications do you currently use?

□ None □ Other □ Artificial tears

_____

_____

What <u>non-eye</u> medications do you currently use?

□ None □ Aspirin □ Antihistamines
□ Other (list dose and frequency) _____

_____

_____

_____

Have you had any of these *eye* problems? □ None

□ Cataracts □ Eye injury
□ Glaucoma □ Iritis
□ Macular degeneration □ Lazy eye (amblyopia)
□ Retinal detachment □ Wore a patch as a child
□ Other _____

What *<u>eye</u>* surgeries have you had? □ None

□ Cataract operation: Right eye _____
Left eye _____
□ Laser treatment: Which eye? When? _____

_____

□ Glaucoma surgery: Which eye? When? _____

_____

□ Eye muscle surgery: which eye? When? _____

_____

□ Eyelid or other eye surgery: Which eye? When?

_____

_____

Have any of your blood relatives had the following *eye* diseases?

□ Macular degeneration □ Cataract □ Crossed eyes
□ Retinal detachment □ Glaucoma □ Other _____

_____

Do you currently have any of the following conditions?

□ Headaches □ Allergies
□ Diabetes Type I □ Diabetes Type II
□ High cholesterol □ Cancer □ Stroke
□ Thyroid disease □ AIDS, HIV □ Lung disease
□ High blood pressure □ Dizziness □ Pregnant
□ Parkinson's □ Arthritis □ Dementia
□ Heart disease □ Alzheimer's □ Other

_____

Do you use? □ Tobacco □ Alcohol

What NON-surgery <u>illnesses</u> have caused a hospital stay? _____

_____

What "NON-EYE" <u>surgeries</u> have you had?

_____

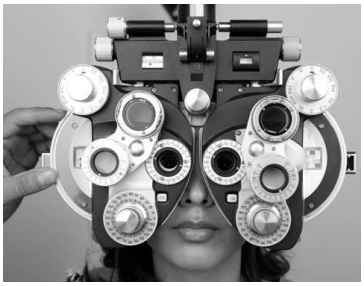
_____

SCOTTSDALE
EYE PHYSICIANS & SURGEONS, PC

Refraction Test Responsibility Agreement

Refraction Test:

- If you are here for a **Comprehensive Eye Exam, you will need a Refraction** to determine how well the eyes can see.
- If you desire a new or updated **glasses or contact lenses prescription, you will need a Refraction test.**
- If your **vision has decreased** (whether observed by you or found during your examination) **you will need a Refraction test**.
- The Refraction test helps the doctor tell if reduced vision is due to incorrect glasses or something medically related.
- Unless you have vision insurance or your medical insurance specifically covers this test, you are responsible for the **$75** charge for the Refraction test.
- Our doctors strongly recommend you get this test.



☐ **YES!** I would like the Refraction test (**$75)**
☐ **No.** I decline the Refraction test

iScription Refraction Test by Zeiss:

- The iScription Refraction test is a separate more precise automated refraction test.
- The iScription Refraction test can also be used to make high-definition digital iScription lenses for your glasses. **iScription lenses provide improved night vision, better definition of color and contrast, and improved visual comfort**. Please ask our optician for more details.
- Our office is one of the few practices in Arizona that offers iScription advanced technology.
- iScription lenses are premium lenses that are more expensive than traditional lenses. The charge for the iScription Refraction test is an additional **$30** over the regular Refraction test charge.
- Payment of the iScription test fee is the responsibility of the patient as the test is not covered by insurance companies.
- iScription lenses are only available in progressive or single vision styles. They are not available in bifocal or trifocal styles.

☐ YES! I would like to add the iScription to my Refraction test (additional $30)
☐ No. I decline the iScription Refraction test.

I hereby affix my signature as an acknowledgement I have read the above and understand my financial responsibility.

Patient or Guardian Signature: _____

Patient Name (Printed): _____

Date: _____