Oculoplastic Eye Surgeons of Phoenix

PATIENT REGISTRATION

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____

E-mail address_____

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____Relationship_____

PHYSICIAN INFORMATION:

_____	_____	_____	_____	(___)_____
Primary Care Physician	Street Address	City	State	Phone #
_____	_____	_____	_____	(___)_____
Referring Physician	Street Address	City	State	Phone #
_____	_____	_____	_____	(___)_____
Preferred Pharmacy	Street Address	City	State	Phone #

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Oculoplastic Eye Surgeons of Phoenix

PATIENT REGISTRATION

Current Symptoms: _____

How did you find us? _____

Do you have any allergies? _____

Race:
American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Decline to Specify

Ethnicity:
Hispanic or Latino
Not Hispanic or Latino
Decline to Specify

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Oculoplastic Eye Surgeons of Phoenix to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Oculoplastic Eye Surgeons of Phoenix.

_____ _____

Patient's signature **Today's date**

Oculoplastic Surgeons of Phoenix offer its patients the ability to communicate with healthcare providers via electronic mail (e-mail) over the Internet.
If you have an Internet e-mail address and would like to take advantage of this service, please discuss your wishes with your healthcare provider(s) first. Some healthcare providers prefer not to communicate with their patients over the Internet.
If a healthcare provider agrees to exchange e-mail with you, please observe the following:

E-mail Rules:

1. E-mail may be used for requesting information and for asking non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please call 911 or visit the nearest Emergency Department.
2. E-mail messages may not be confidential.

   - Do not use e-mail to send or request very sensitive information. Oculoplastic Surgeons of Phoenix cannot and do not guarantee the confidentiality of any messages being sent over the Internet.
   - Messages can be misdirected or intercepted by unintended parties.
   - Patients who want e-mail sent to work addresses must recognize that employers may have the right to monitor their e-mail.
   - Your healthcare provider may ask a nurse or other provider to assist with email volume or response.
   - We will not respond to communications that are considered obscene or harassing.

3. Your healthcare provider will document e-mail communications in your medical record- either by placing a copy of the message in your record, or by summarizing the message in a written note.

Sending E-mail:

Please be sure to include the following information in the body of every e-mail message that you send to your healthcare provider:

- Your full name
- Your birth date or your medical record number

If you do not provide this information, your healthcare provider may not to be able to respond. In order to protect your confidentiality do not place name, date of birth or medical record number in subject line.

Oculoplastic Eye Surgeons of Phoenix

PATIENT REGISTRATION

If a message is ever returned because of a "bad address," please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address the healthcare provider provided, please call the healthcare provider's office to verify you have the correct address and that the e-mail system is functioning properly.

If your healthcare provider does not answer your e-mail in what you consider to be reasonable period of time, please call his or her office. Your healthcare provider may be out of the office or we could be experiencing a technical problem and unable to respond to e-mail. We cannot guarantee a particular response time.

I agree to not use or forward my health care provider's e-mail for purposes other than communication with me about my health care.

I understand and agree to the terms outlined in this document. After reading the rules and guidelines of communicating via e-mail, I still wish e-mail to be one of my preferred methods of communication with my healthcare providers.

_____

Signature of Patient or Legal Representative

_____

Date

_____

If Signed by Legal Representative, relationship to Patient

_____

Signature of Witness

Oculoplastic Eye Surgeons of Phoenix

PATIENT REGISTRATION

Name:	Ht:	Wt:	Age:	Date:

MEDICAL HISTORY Have you had or do you currently have any of the following?

Cardiovascular:

Heart Surgery	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Abnormal Rhythm	☐ Yes	☐ No
Pacemaker or Defibrillator	☐ Yes	☐ No
Rate set at _____		
High Blood Pressure	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Do you Exercise?	☐ Yes	☐ No
If yes what and how often' _____		
_____		

Lung:

Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Emphysema/ COPD	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
If yes, when? _____		

Systemic:

Kidney Problems	☐ Yes	☐ No
Liver Problem or Cirrhosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Acid Reflux or GERD	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No

Endocrine:

Diabetes	☐ Yes	☐ No
Do you take Insulin	☐ Yes	☐ No
Do you take Pills	☐ Yes	☐ No
Are Diet Controlled	☐ Yes	☐ No
Cortisone / Prednisone use	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
If Yes, What_____		
Arthritis	☐ Yes	☐ No
Autoimmune Disorder	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
If Yes,type_____		

Neurological:

TIA, When_____	☐ Yes	☐ No
Stroke, When_____	☐ Yes	☐ No
Seizures,When_____	☐ Yes	☐ No

LIST all Past Surgeries and the year

_____

_____

Any thing else we should know about? Explain:

_____

_____

_____

ALLERGIES: List all Medications, food or other items that you are allergic to If no allergies write "NONE".

Allergy AND REACTION	Medications

Social History:

Do you smoke	☐ Yes	☐ No
packs/day_____How many yrs_____		
Do you consume alcohol	☐ Yes	☐ No
How much_____How often_____		
Recreational drug use	☐ Yes	☐ No
Name of drug_____		

Other:

Are you sensitive to Iodine/tape/latex	☐ Yes	☐ No
If so did you have: Skin rash or hives	☐ Yes	☐ No
Wheezing or trouble breathing	☐ Yes	☐ No
Runny nose hay fever or itching eyes	☐ Yes	☐ No
Any problems with anesthesia?	☐ Yes	☐ No
What?_____		

Reviewed by Center RN:

Medications: SEE Attatched Medication Reconcilliation Sheet

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

To Release my Information To:

Oculoplastic Eye Surgeons of Phoenix
Name of Person/Organization Receiving Information

4045 E Unions Hills Dr. Ste 115, Phoenix, AZ 85050
Address City / State / Zip

623-522-8687// Fax 623-522-8683
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____Complete Medical Record
_____Medical Records for Specific Dates of Service (please list) from_____ to _____
_____Other (please list) _____

This authorization will remain in effect for one year from the signed date below.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA)*. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____
Description of Personal Representative's Authority (attach necessary documentation)

****

Date Sent: _____ By: _____ Via: _____

Oculoplastic Eye Surgeons of Phoenix

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams**. We do not participate with **ANY** vision plans (VSP/Davis Vision, etc.). **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

A refractive examination is not a covered service by most insurance companies, including Medicare. We do not offer refractive examinations at our practice.

It is the patient's/parent's/guardian's responsibility to:

1. Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
2. Bring all of your current insurance cards to all visits.
3. Provide our office with current information including address, phone numbers and employer.
4. In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. We accept cash, checks, GreenSky, Care Credit, and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a **$50.00** returned check fee.

Any patient who cancels a scheduled, elective surgery without giving more than two (2) business days notice prior to surgery, or does not show up for surgery, will be charged a cancellation fee of **$150.00**. Legitimate emergencies will be taken into consideration.

Oculoplastic Eye Surgeons of Phoenix

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

It is Oculoplastic Eye Surgeons of Phoenix's policy to only accept payment plans as a last resort. We offer financing though our partners GreenSky and Care Credit. Prior to filling out our Economic Hardship Application, you must present a declined application from either GreenSky or Care Credit. If you do not qualify for financing, you can fill out our Economic Hardship Application and provide documents according to our Financial Assistance Policy.

I have read and understand the above financial policy.

_____ _____

Signature of patient/guardian/parent Date

_____ _____

Printed name of patient Date