Oculoplastic Eye Surgeons of Phoenix

Patient Registration

Patient Name._____ Today's Date_____

Home Address_____

City_____State_____ Zip Code_____

Cell Phone_____Home Phone_____

E-mail address_____ Social Security Number_____

Date of Birth_____ Age _____ Gender ___ M ___ F

Preferred Method of Contact: (Check all That Apply) ___Email ___Phone ___Text ___Mail

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

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

How did you hear about us? _____

What is the main reason for your visit today? _____

PHYSICIAN INFORMATION:

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

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name and Date of Birth		**Relationship to Patient**

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**

Oculoplastic Eye Surgeons of Phoenix

Name	Ht:	Wt:	Age:

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

Ocular:

Dry Eye ☐Yes ☐No
Cataracts ☐Yes ☐No
Glaucoma ☐Yes ☐No
Macular Degeneration ☐Yes ☐No
Retinal Detachment ☐Yes ☐No

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
Shortness of Breath ☐Yes ☐No
If yes, when? _____

Social History:

Do you Smoke? ☐Yes ☐No
Pack/Day_____Years?_____
Do you consume alcohol? ☐Yes ☐No
How much?_____How often?_____
Recreational drug use? ☐Yes ☐No
Name of drug?_____

Other:

Sensitive to Iodine/tape/latex? ☐Yes ☐No
IF "Yes", circle above. Do you get skin rash or hives? _____
Wheezing or trouble breathing? ☐Yes ☐No
Any problems with anesthesia? ☐Yes ☐No
What?_____

Systemic:

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

Endocrine:

Diabetes ☐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" what Type? _____

Neurological:

TIA, When? _____ ☐Yes ☐No
Stroke, When? _____ ☐Yes ☐No
Seizures, When _____ ☐Yes ☐No
Sleep Apnea ☐Yes ☐No

Past Eye Surgeries: List all eye surgeries and dates.

_____
_____
_____
_____
_____

Past surgeries: List all other past surgeries and dates.

_____
_____
_____

Medications: List all Medications including over the counter

_____
_____
_____
_____
_____
_____

Allergies: List all allergies. If you have no allergies, write "**None**".

_____
_____
_____

E-mail Rules:

Oculoplastic Surgeons of Phoenix offers 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. If a healthcare provider agrees to exchange e-mail with you, please observe the following:

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.

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.

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.

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.

_____

Signature of Patient or Legal Representative

Statement of Coverage

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 Date

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.

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.

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.

Cancellation Policy

Any patient who cancels a scheduled, elective surgery without giving more than thirty (30) business days notice prior to surgery, will be charged a cancellation fee of **$150.00**. Any patient who cancels a scheduled, elective surgery without giving more than fourteen (14) business days notice prior to surgery, or does not show up for surgery, will be charged a cancellation fee of **$250.00** Legitimate emergencies will be taken into consideration.

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

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No

If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Oculoplastic Eye Surgeons of Phoenix to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Oculoplastic Eye Surgeons of Phoenix Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

WITNESSED BY: _____

Authorization for Use and Disclosure of Protected Health Information

Name of Practice: Oculoplastic Eye Surgeons of Phoenix, P.L.C. (the "**Practice"**)

Authorization:

By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the "**Patient**"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "**Images**"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "**Information**"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

Purpose:

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice on social media. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability:

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

No Effect on Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

Signature of Patient OR
Parent/Legal Guardian (if signing for minor): _____

Date of Signature: _____

Witness _____