Eye Associates Of Tucson

5240 E Knight Drive
Suite 104
Tucson, AZ 85712-2122
USA
(520) 795-4202

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		DEDUCTIBLE $
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize the release of any information including the diagnosis and records of my visit rendered during the period of such care to third payers and/or other health practitioners.I authorize and request my insurance company and/or Medicare to pay directly to the doctor or doctor's group insurance or Medicare benefits otherwise payable to me.

SIGNATURE OF PATIENT/GUARDIAN

DATE

Eye Associates of Tucson

Patient Name:_____

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. By signing this form, you acknowledge that you had the opportunity to review the Eye Associates of Tucson Notice of Privacy Practices describing the use and disclosure of protected health information about you for treatment, payment, health care operations, and other uses and disclosures as stated in our Notice. We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Protected health information includes, but is not limited to, information related to psychologic disorders, sickle cell anemia, HIV / AIDS, communicable disease, and alcohol and drug abuse diagnosis and treatment, if such information exists.
- Eye Associates of Tucson has a Notice of Privacy Practices and that the patient has the opportunity to review the Notice.
- Eye Associates of Tucson reserves the right to change the Notice of Privacy Practices at any time.
- The patient may revoke this Consent in writing at any time and all future disclosure will then cease.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION UPON REQUEST

I,_____ , give my permission to disclose protected health information from my health records, including financial information, to the following person(s)

Name(s): _____

Signature: _____ Date:_____

AUTHORIZATIONTO ASSIGN BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize and request that the payment of Medicare and/or insurance benefits be made directly to Eye Associates of Tucson for any and all services provided to me by Eye Associates of Tucson. If my health insurance will not allow direct payment to Eye Associates of Tucson or if Eye Associates of Tucson chooses not to accept assignment of medical benefits, I agree to immediately forward to Eye Associates of Tucson any and all health insurance payments I receive. I acknowledge that I am responsible for all charges for services provided by Eye Associates of Tucson, including any non-covered services or amounts not paid by insurance. This also applies if coverage is provided by Medicare, a Health Maintenance Organization, a Worker's Compensation policy, or any other third-party payers.

Printed Name: _____

Signature: _____ Date: _____

Relationship to patient (if other than patient):_____

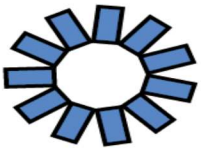
GENERAL CONSENT TO TREATMENT

By signing below, I authorize the health care providers at Eye Associates of Tucson, to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not choosing to undergo the recommended treatment.

Printed Name: _____

Signature: _____ Date: _____

Relationship to patient (if other than patient):_____



Eye Associates of Tucson

RESPONSIBLE PARTY INITIAL THE FOLLOWING, AS RECORD OF FINANCIAL DISCLOSURE:

_____1. I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at **Eye Associates of Tucson** (**EAOT**). Please check with your insurance carrier, prior to your visit, to fully understand anticipated out of pocket costs.

_____2. I understand that EAOT will collect ***Estimated fees***, at or prior to surgery and clinic visits, which include co-payments, deductibles, coinsurance, unpaid balances and non-covered services. Cash, checks, MasterCard, Visa, Discover, and Debit Cards are accepted. Payment is due upon receipt of statement for balances not covered by my health plan. If my insurance pays me directly for services billed by EAOT it is my obligation to forward the payment to EAOT.

_____3.I understand that EAOT accepts both vision and medical plans. Vision plans cover routine eye exams and eyeglasses/contact lenses. All other billable services are usually sent to medical plans.

_____4. I understand that a refraction fee will be collected, following services, if I do not carry vision benefits and/or after surgery during the final post-operative visit if testing is necessary (only for patients receiving post op care at EAOT).

_____5. I request that payment of authorized medical benefits be made on my behalf to all related entities involved or participating in my eye care associated with EAOT. I authorize release of medical information necessary to my claim(s).

_____ 6. I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash).

_____7. I understand the following No Show/Cancellation Policy:

• ***Clinic appointments*** canceled less than a 24-hour advance notice or failure to show up for an appointment will be charged a $25 fee for the occurrences. If I arrive 30+ minutes late for an appointment, I may be rescheduled at the physician's discretion.

_____ 8. I understand that I will receive an Advance Beneficiary Notice of Non-coverage (ABN)/ Informed Consent, also known as a waiver of liability, for any service/treatment not covered by insurance. I agree to pay if my insurance rejects coverage.

_____ 9. I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for paying these fees.

STATEMENT OF FINANCIAL RESPONSIBILITY: I acknowledge that I am responsible for all charges for all services provided, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and understand the above Financial Policy and I agree to abide by its terms.

Printed Name: _____

Signature: _____ Date: _____

Relationship to patient (if other than patient):_____

Eye Associates of Tucson

WHAT IS A REFRACTION?

A refraction is a test that is done to measure your best possible vision. During the test, lenses are placed in front of the eye and the patient is asked, "Which is better- one or two." A refraction is done for many different reasons:

1. It is used to determine the correct prescription for glasses or contact lenses.
    a. There are separate fees for prescribing and fitting contact lenses
2. It is performed as an additional service during a routine exam
3. It is performed as part of the evaluation and monitoring of a medical condition such as diabetes, cataracts, glaucoma, or macular degeneration
4. It is performed during pre-operative care.
5. It is performed post-operative care

The charge for a refraction is $55.00 and is due at the time of service

Once a prescription is expired, glasses and/or contact lens cannot be ordered for any reason. It is recommended that you have this testing done annually. The refraction is guaranteed for 90 days and during those 90 days a recheck of the refraction is completed at no charge.

Office visits to an eye care professional are usually categorized as either "routine" or "medical." The type of eye exam you have is determined by the reason for your visit as well as your diagnosis. This terminology has nothing to do with the steps it takes to perform a comprehensive eye exam, or the type of doctor who performs the exam. A comprehensive "routine" vision exam often contains the same elements as a comprehensive "medical" eye exam.

Federal Guidelines state that the office visit and the refraction are to be reported as two separate charges. However, we are unable to bill a medical plan and vision plan on the same day. Therefore, you may be responsible for the refraction fee depending on your coverage and the reason for your visit today.

*Since 1992, under Section 1862 (a) (1) (A) of the Social Security Act Title XVIII – Health Insurance for the Aged and Disabled, **Medicare** has classified refractions as a **non-covered** benefit for patients. This is a Federal law. Sections 4125 and 5217 of the Medicare Carriers Manual states "Expenses for all refractive procedures, whether performed by an ophthalmologist (or any physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage." Since a refraction is not considered a benefit of the Medicare Part B program, the provider has the right to bill you directly.

☐ Yes, I would like a refraction

☐ No, I would not like a refraction

Name of Patient: _____

Signature: _____ Date: _____