ARIZONA EYE CENTER
1500 W. Ray Rd, ~ Chandler, AZ 85224
Phone: 480-963-3881 Fax: 480-899-8610

Complete Medical & Surgical Eye Care for All Ages
Thank you for choosing our office.

PATIENT INFORMATION:

Last Name: _____ First _____ MI _____

Birthdate: _____ Age: _____ Sex: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

Patient Status: ( )-Married ( )-Single ( )-Divorced ( )-Separated ( )-Widowed ( )-Other

Primary Care Physician: _____ Telephone: _____

Referred by: _____ Telephone: _____

SPOUSE/PARENT GUARDIAN INFORMATION:

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ SSN: _____

In Case of Emergency Contact (*Name of person not living with you)*:
Name: _____ Home Phone: _____ Work Phone: _____

AUTHORIZATION:

Do you authorize this office to discuss your medical care or account information with any other person other than yourself? _____ YES _____ NO
If yes, please list name(s) of person(s) and contact phone numbers.
Name: _____ Home Phone: _____
Name: _____ Home Phone: _____

PRIMARY INSURANCE INFORMATION:

Primary Insurance: _____ Effective Date: _____
Subscriber ID: _____ Group No: _____
Policyholder's Name: _____ DOB: _____ SSN: _____
Relation to Insured: _____
Employer's Name: _____ Phone: _____
Employment Related Injury: □ Yes □ No If Workers Comp, date of injury? _____

Secondary Insurance: _____ Effective Date: _____
Subscriber ID: _____ Group No: _____
Policyholder's Name: _____ DOB: _____ SSN: _____

ASSIGNMENT AND RELEASE:

I authorize the release of any medical or other information necessary to process this claim. I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services (ie. **Refractions and Routine eye exams**) and copayments. Also, any unpaid balances may be subject to collection and attorney's fees, if assigned to a collection agency, and is the responsibility of the guarantor.

SIGNED: _____ **DATE:** _____

MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES NO**
If YES, list the medications:_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Have you ever had a blood transfusion?..... **YES NO**
Do you drink alcohol?..... **YES NO** If YES, how much? _____
Do you smoke?..... **YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____

EYE HISTORY

Do you wear glasses? Yes No How Long? _____
Do you wear contact lenses? Yes No How Long? _____

Are you experiencing any of the following ocular symptoms?
(Circle all that apply)

Pain	Aching	Dryness
Itching	Burning	Floaters
Light Flashes	Blurred Vision	Light sensitivity
Glare at Night	Halos	Foreign Body Sensation
Redness	Double Vision	Mucous Discharge
Tearing	Tired Eyes	Sandy/Gritty Feeling
Loss of side vision	Fluctuating Vision	

Please List Current Eye Medications (including Eye Vitamins):

_____ _____ _____
_____ _____ _____
_____ _____ _____

ADDITIONAL INFORMATION

Occupation/Hobbies: _____

Are you interested in learning about Vision Correction Surgery? _____

Pharmacy Name:_____Address:_____Phone:_____

I understand that my glasses prescription (Refraction) is not covered by my insurance and will be collected from me at the time of service. The charge for the refraction is $50.00.

_____ _____
Patient Signature **Date**

I understand that there is a $25.00 fee for any appointments that are cancelled and/or rescheduled within 24 hours or that I fail to attend.

_____ _____
Patient Signature **Date**

Notice of Privacy Practice

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

Uses and Disclosures

- *Treatment*. Your health information may be used by staff members or disclosed to other healthcare professionals for the purposes of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

- *Payment*. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

- *Healthcare Operations.* Your health information may be disclosed as necessary to support the day-to-day activities and management of **Arizona Eye Center.** For example, information on the services you received may be used to support the budgeting and financial reporting, and activities to evaluate and promote quality.

- *Law Enforcement.* Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

- *Public Health Reporting.* Your health information may be disclosed to public health agencies as required by state law. For example, we are required to report certain communicable diseases to the state's public health department.

- *Our Business Associates.* Sometimes, we work with outside individuals and businesses that help us operate our business. We may disclose your health information to them, so that they can perform their contracted tasks. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information. Some examples of a business associate are a transcriptionist, collection agency or attorney.

- ***Other uses and disclosures require your authorization.*** Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

ARIZONA EYE CENTER

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Arizona Eye Center

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. You may ask us for a copy of this at any time.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice of your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

Complaints/Contact Person

If you would like to submit a question, comment, or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Michael J. Depenbusch, M.D., P.C.
Attn: Kelly DaSilva, Privacy Officer
1500 W. Ray Rd., Chandler, AZ 85225
480-963-3881

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge receiving the Notice of Privacy Practices (NPP) from the office of Michael J. Depenbusch, M.D., PC by signing below.

_____ _____
Name of Patient (Please Print) **Signature of Patient**

_____ _____
Signature of Patient Representative & Relationship **Date**
(Required if the patient is a minor or an adult unable to sign this form)

Individuals You Authorize to Receive Your Protected Health Information

The following individuals have my authorization to access my Protected Health Information:

_____	_____	_____
Name	**Relationship**	**Date of Birth**
_____	_____	_____
Name	**Relationship**	**Date of Birth**
_____	_____	_____
Name	**Relationship**	**Date of Birth**

OFFICE USE ONLY

A good faith effort was made to obtain written acknowledgement from the patient/patient's representative for receipt of the Notice of Privacy Practices, without success for the reason indicated below.

☐ Patient refused to sign

☐ Patient Representative refused to sign

☐ Other: _____

Date: _____ Employee Signature: _____

ARIZONA EYE CENTER

SIGNATURE ON FILE FORM

_____ _____
Patient's Name (Print) Medicare Identification Number

1. MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Michael J. Depenbusch, M.D., P.C. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable to related services.

I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 on the CMS 1500 insurance form, my signature authorizes the information to the insurer or agency shown.

Dr. Michael J. Depenbusch accepts the charge determination of the Medicare carrier and the patient is responsible only for the deductible, coinsurance and non-covered services.

_____ _____
Signature Date

2. OTHER INSURANCE

I hereby authorize payment of medical and surgical insurance benefits to Michael J. Depenbusch, M.D., P.C. I understand I am financially responsible for any charges whether or not paid by said insurance. I agree to pay co-payments and/or deductibles as designated by my insurance company to Michael J. Depenbusch, M.D., P.C. I understand any unpaid patient balance will be subject to collection and/or attorney's fees (30%)if assigned to a collection agency, and the responsibility of the guarantor. I authorize Michael J. Depenbusch, M.D., P.C. to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____
Signature Date

3. BILLING POLICIES

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THE BILLING POLICIES FOR MICHAEL J. DEPENBUSCH, M.D.,P.C. I AGREE TO ABIDE BY THE POLICIES OUTLINED AND ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY NON-COVERED SERVICES I ELECT TO RECEIVE (**i.e. REFRACTIONS AND ROUTINE EYE EXAMS**). I ALSO UNDERSTAND THAT I MAY BE CHARGED A $25.00 FEE FOR FAILURE TO CANCEL AN APPOINTMENT WITHOUT A 24-HOUR NOTICE.

_____ _____
Signature Date