WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Cell (_____) _____ Spouse's Work Phone (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home (_____) _____ Cell (_____) _____ Work Phone (_____) _____ Ext _____

EYE HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type _____ Hours/Day _____

Describe any problems you have with your contacts _____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	☐ Yes	☐ No	Floaters or Spots	☐ Yes	☐ No
Blurred Vision – Distance	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Blurred Vision – Near	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No	Itching Eyes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Light Sensitive	☐ Yes	☐ No
Color Vision, Poor	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No	Night Vision, Poor	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Red Eyes	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Seeing Halos	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No	Seeing Flashes	☐ Yes	☐ No
Eye Infection	☐ Yes	☐ No	Temporary Loss of Vision	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No	Twitching Eyelid	☐ Yes	☐ No
Eye Strain	☐ Yes	☐ No	Vision Poor	☐ Yes	☐ No
Fainting Spells, Blackouts	☐ Yes	☐ No	Watering Eyes	☐ Yes	☐ No

– OVER –

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No	Hepatitis (Type_____)	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No	Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No	Are you pregnant? _____	Number of children_____	
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No	Tobacco use _____	Alcohol use_____	

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name_____

Phone (_____) _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____ for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

PrecisionEyecare
at Grayhawk

ACKNOWLEDGEMENT OF RECEIPT

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I received a copy of Precision Eyecare's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Precision Eyecare
at Grayhawk

7970 E Thompson Peak Pkwy, Suite 102

Scottsdale, Arizona 85255

Dear patient,

We would like to inform all patients using insurance that services may not be covered by your plan. There may be fees in addition to your co-pay. These include refraction and dilation which are services considered part of a comprehensive eye examination. For patients wearing contact lenses, some insurances do not cover the contact lens fitting. Please let us know if you have any questions about your specific plan.

Office Policies:

Payment is due in full at time of service.

Insurance must be presented prior to your exam or eyewear purchase.

Only in-store credit will be issued on returns, no refunds. Exchanges only within 14 days on RX purchases.

There is a 24 hour cancellation policy. If you fail to notify us in advance, you will be charged $25.

Dilation

I understand that dilating drops can cause blurry vision for 4 to 8 hours, and I should wear sunglasses and avoid driving and operating machinery until the effects wear off. I will tell the staff at the office if I need assistance walking to the car.

Thank You,

The Staff of Precision Eyecare

Patient Signature _____

PrecisionEyecare
at Grayhawk

7970 East Thompson Peak Parkway – Suite 102
Scottsdale, Arizona 85255

FINANCIAL POLICY

Eyecare is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of these plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

SPECIAL PAYMENT INSTRUCTIONS

Patients Without Insurance
We request that all visits are paid 100% at the time of each visit. We are happy to accept cash, your personal check or credit card.

Group or Individual Insurance
When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays. We may or may not be preferred provider with your insurance company. Please check your provider manual.

"On the Job" Injury (Worker's compensation)
If you are injured on the job, your care should be paid by your employer's Worker's Compensation Insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months or if you suspend or terminate care, any fees for services are due immediately.-

Personal Injury or Automobile Accident
Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for the settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are immediately.

Medicare
We do accept assignment from Medicare. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible, as well as the non-covered services. Our office completes and files the forms at no charge.

Secondary Insurance
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

I have read and understand the payment policy of "Precision Eyecare". I understand that my insurance is an arrangement between myself and my insurance company, **NOT** between "Eyecare" and my insurance company. I request that "Eyecare" prepare the customary forms at no charge so I may obtain insurance benefits. I also understand that, if my insurance does not respond within 60 days or if I suspend or terminate my schedule of care as prescribed by the doctors at "Eyecare", fees will be due and payable immediately.

Patient's signature (or guardian if patient is minor) **Date**

PrecisionEyecare
at Grayhawk

7970 East Thompson Peak Parkway – Suite 102
Scottsdale, Arizona 85255

AUTHORIZATION TO PAY DIRECTLY THE DOCTOR

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, **I understand** that this Eye Care Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that **any amount authorized to be paid directly to this Eye Care Office** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also agree to be responsible for any collection costs, including reasonable attorney fees. I also understand that if I am accepted as a patient by "Precision Eyecare", I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding Eye Care treatment will be explained to me upon my request.

AUTHORIZATION TO RELEASE INFORMATION

I authorize use of my **"Signature on File"** on all of my insurance submissions and direct payment to this office (when applicable), as well as releasing any information you deem appropriate concerning my physical condition **to any insurance company, attorney or adjuster** in order to process any claim for reimbursement of charges incurred by me as the result of professional services rendered by you and I hereby release you of any consequences thereof.

IF NO INSURANCE IS FILED ON MY BEHALF, I AGREE TO PAY SERVICES AS INCURRED.

Patient Signature (or Guardian if patient is minor) Date