

Northern Arizona Eye Associates

PATIENT INFORMATION

Patient's Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell _____
Social Security #: _____
 Single Married Male Female Other
Birth Date: _____

EMAIL

I acknowledge that I will be receiving email notifications for appointment reminders and newsletters.
Please check box if you do not wish to receive email notifications

SPOUSE OR LEGAL GUARDIAN

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell _____
Social Security #: _____
Relation to Patient _____
Birth Date: _____

EMAIL

EMERGENCY CONTACT OR CARETAKER (if other than spouse or legal guardian)

Name _____ EMAIL: _____
Address _____ Relation to Patient _____
Phone _____ Cell _____

Name of Primary Care Physician: _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

****Please complete if insurance cards NOT available****

Primary Insurance

Insurance Company _____
Insured's Name _____
Relationship to Patient _____
ID Number/Social Security # _____
Group Number _____
Insured's Birth Date _____

Secondary Insurance

Insurance Company _____
Insured's Name _____
Relationship to Patient: _____
ID Number # _____
Group Number _____
Insured's Birth Date _____

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I authorize treatment of the above to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing and insurance claims, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician and also authorize the physician to release any information required in the processing of the insurance claim. Once payment is received from the insurance company, I will receive only one statement for the balance. It is expected that payment will be made within 10 days of receipt of first statement. If payment is not received, it will be considered past due and may be sent to collections. A 40% fee will be assessed to any balance sent to a collection agency.

Please note that you will be responsible for a \$30.00 appointment fee if you miss an appointment or cancel without 24 hours notice. Please do your best to notify us in advance if you are unable to attend your appointment, and we will gladly find time to reschedule.

PATIENTS WITH MEDICARE OR MEDICARE REPLACEMENT

I request that payment under the medical insurance program be made on my behalf to Robert Mahanti, M.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services. I further permit a copy of this authorization to be used in place of the original. Refractions are a non-covered service of Medicare and are the patient's responsibility. I certify that I have given proper insurance information. If a referral is necessary with my insurance plan, it is my responsibility to obtain the necessary referral.

ALL PATIENTS MUST SIGN HERE

Patient's Signature: _____ Date: _____

(Please check this box if you are the spouse or legal guardian signing for the patient)

NAEA Surgery Center LLC

HEALTH QUESTIONNAIRE

Please complete this form as accurately as you can. For major health events please include approximate dates. You may forgo duplicating any information on this form if you have provided us with a current list of allergies, medications, health conditions and / or surgeries. Eye health will be specifically addressed on the next page.

Patient's Name: _____ Date you are completing this form: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

List any medications you are allergic to & reaction: _____

Are you sensitive to topical iodine? Yes No OR Any type of tape? Yes No

Have you or a blood relative ever had a problem with anesthesia? Yes No _____

Have you or a blood relative ever had a problem with bleeding and / or clotting? Yes No _____

Describe that bleeding/clotting/anesthesia problem: _____

Last PCP Visit: _____ Facility or PCP Name: _____

Please check all that you have / had:

- | | | |
|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> O2 Usage/Liters _____ | <input type="checkbox"/> Blood Clots / DVT |
| <input type="checkbox"/> Able to climb a flight of stairs | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Depression / Anxiety |
| <input type="checkbox"/> AFIB/Pacemaker | <input type="checkbox"/> Seizure | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Head injury / Loss of consciousness | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Open heart surgery | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Cardiac Stents | <input type="checkbox"/> Dialysis/# of Days _____ | <input type="checkbox"/> AIDS / HIV positive |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Wheelchair User | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Cardiac arrest | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug addiction |
| <input type="checkbox"/> Diabetes/A1C _____ | <input type="checkbox"/> Emphysema / COPD | |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Chronic bronchitis | |
| <input type="checkbox"/> Cancer: Type / Surgery? Chemo or Radiation?: _____ | | |

List previous surgeries and /or recent hospitalizations. Include any you can remember, and approximate date (Example: "8 years old Tonsillectomy" or "1998 gall bladder", etc) Use the back side of this form if necessary.

Please list ALL medications you take on a regular basis, including eye drops. Include dose and frequency. Use the back of this form if necessary. If you have a current list, you may have us copy that instead:

Medication	Dosage	Number of Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TO BE COMPLETED ON DAY OF SURGERY WHEN APPLICABLE: Date of Last Menstrual Cycle? _____

Are you currently pregnant? Yes No Unsure Post-Menopausal Hysterectomy

** Please note that our facility does not have the capability to perform pregnancy testing. If you are unsure if you are pregnant but wish to proceed with your surgery, you will need to sign a separate consent form.

I attest that the above health history is correct to the best of my recollection.

Patient's Signature #1 _____ Date: _____ #2: _____ Date: _____

Physician Signature #1 _____ Date: _____ #2: _____ Date: _____

NAEA Surgery Center LLC

HEALTH QUESTIONNAIRE

OCULAR HISTORY:

Do you currently wear contact lenses? Yes / No If so, are they Soft / Hard / Gas Perm / Other
Power (if known): _____

Do you suffer from: Dry Eye / Allergy Eye / Blepharitis / Watery Eyes

Which eye drops do you use or have you tried for these problems _____

Do you have any of the following conditions:

- Cataracts Glaucoma (For how long? _____) Macular Degeneration Dry / Wet
 Retinal Disease: _____ Corneal Disease: _____
 Eye Muscle Imbalance Amblyopia or 'Lazy Eye' Prisms in your glasses
 Other _____

Have you had any of the following procedures:

- Cataract Surgery: Right eye / Left eye / Both eyes When _____
 Glaucoma Procedures Describe _____
 Retinal Procedures Describe _____
 Vision Correction Surgery If yes, what type? RK / LASIK / PRK / RLE / ICL
Right eye / Left eye / Both eyes When _____

Have you had any eye Injury or other eye surgery?: _____

SOCIAL HISTORY:

Have you ever smoked tobacco? Yes / No Do you currently smoke? Yes / No
Do you chew tobacco? Yes / No Do you regularly use recreational drugs? Yes / No
Do you drink alcohol? Yes / No If yes, what kind & how frequently? _____

EMPLOYMENT:

Occupation or Employer: _____
How many hours per day are you using a computer / electronic device? _____
How many hours per day do you perform "near" activities (reading, find handywork, etc) _____
Do you have a Commercial Drivers' License? Yes / No Do you drive frequently at night? Yes / No

FAMILY HISTORY: Please note the relation to the patient of the person with the condition:

(f) father (m) mother (s) sister (b) brother (gp) grandparent (o) other family member

_____ Glaucoma	_____ Cataracts	_____ Diabetes
_____ Macular Degeneration	_____ "Lazy Eye"	Type: _____
_____ Retinitis Pigmentosa	_____ Retinal Detachment	_____ Heart Disease
_____ Other eye problems: _____		

Patient/guardian signature

Technician signature

Date

Northern Arizona Eye Associates

Protecting your Confidential Information is Important to Us

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes. i.e., if you are a victim of a crime, suspected abuse or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office. We are required by law to maintain the privacy of your health information and to provide to you this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Rights

This new law is careful to describe that you have the following right related to your health information.

Restrictions

Protecting your confidential health information is important to us. You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family member present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

To Contact You

We may use your information to contact you. For example, we may send newsletters or other information pertaining to patient wellbeing, practice news and product updates. We may also want to call or text you about your appointments.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Patient Acknowledgment

Thank you for taking the time to review how we are carefully using your health information. If you have any questions, we want to hear from you. Please acknowledge your receipt of your policy by signing below.

Patient's Name: _____ Patient's Signature: _____

Today's Date: _____

Northern Arizona Eye Associates

Advance Notice of Refraction Fee's

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing you might have to pay for them yourself. Before you make a decision about your options you should read this entire notice carefully.

Description: Refraction is the measurement of the eye's focusing characteristics and the determinant of an eyeglass prescription. The refraction can also give the eye doctor information about the health of the eye. A refraction may be performed many times for a variety of purposes other than to issue an eyeglass prescription.

The medical portion of your exam will be performed as usual regardless as to whether or not you opt to have the refraction. If there is no medical reason to perform this test, you may decline it.

Our fee for a Refraction is \$40.00

We expect that **Medicare, Medicaid, Blue Cross Blue Shield, and/or all other major insurances** will not pay for the item(s) or services(s) that are described below. Medicare, Medicaid, Blue Cross Blue Shield, and/or all other major insurances do not pay for all of your health care costs. Medicare, Medicaid, Blue Cross Blue Shield, and/or all other major insurances only pay for covered item(s) and service(s) when Medicare, Medicaid, Blue Cross Blue Shield, and/or all other major insurances rules are met. The fact that Medicare, Medicaid, Blue Cross Blue Shield, and/or all other major insurances may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in most cases, your insurance company probably will not pay for the this service.

Do you authorized our staff to perform the refraction test, and understand you may have to pay for this?

PLEASE CHOOSE ONE OPTION CHECK ONE BOX SIGN AND DATE YOUR CHOICE

- Yes. I would like a Refraction.**
I understand that my insurance company may not pay for this service. Payment of \$40.00 will be collected at time of service, and I also understand my claim will be submitted to my insurance company. If for any reason money is not collected at time of service, I understand that you may bill me for this service. I agree to be personally and fully responsible for payment. I understand I can personally appeal my insurance carrier's decision and for any reason if they do not pay.

- No. I have decided not to have a Refraction.**
I will not receive this service. I understand that you will not submit a claim to my insurance carrier. I do understand that the refraction is the only service this refers to, and that all medically necessary testing will still be performed and billed to my insurance carrier as usual.

Patient Signature (or person acting on patient's behalf)

Today's Date

Print Patient Name

Patient Account #