Arizona Eye SPECIALISTS

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PATIENT INFORMATION

(Please Print)

PATIENT'S NAME			
LAST	**FIRST**	**MIDDLE INITIAL**	**SEX:** Male Female

ADDRESS	**DATE OF BIRTH**	**AGE**
CITY, STATE, ZIP	**MARITAL STATUS**	
SOCIAL SECURITY #		
HOME PHONE	**CELL PHONE**	
PREFERRED METHOD OF CONTACT ◯ **Home Phone** ◯ **Cell Phone** ◯ **Email** ◯ **Mail**		
EMAIL	**PREFERRED LANGUAGE**	

OCCUPATION
EMPLOYER / **EMPLOYER PHONE**
EMPLOYER ADDRESS

INSURANCE INFORMATION

(Please bring your insurance card to your appointment.)

PRIMARY INSURANCE	
POLICY NUMBER/ID#	**GROUP #**
SUBSCRIBER'S NAME (If other than patient)	
SUBSCRIBER'S SS #	**DATE OF BIRTH**
Patient's relationship to subscriber:	
SECONDARY INSURANCE (if applicable)	
POLICY NUMBER/ID #	**GROUP #**
SUBSCRIBER'S NAME (If other than patient)	
SUBSCRIBER'S SS #	**DATE OF BIRTH**
Patient's relationship to subscriber:	

IN CASE OF EMERGENCY

NAME	
Relationship to patient:	**PHONE #**
PRIMARY CARE DOCTOR	**PHONE #**

The above information is correct and true to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE **DATE**

7245 E. Osborn Road, #4 Scottsdale, Arizona 85251 480-994-5012

Arizona Eye
SPECIALISTS

PATIENT ACKNOWLEDGEMENT

PATIENT NAME_____**ID#**_____

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 Arizona Eye Specialists 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).

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION UPON PATIENT REQUEST

I, _____ give my permission to disclose protected health information from my health record, including financial information, to the following people:

NAME_____

NAME_____

_____ _____

Patient Signature **Date**

AUTHORIZATION TO ASSIGN BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY

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

SIGNATURE_____ **DATE**_____

PRINTED NAME_____

Relationship to patient (if other than patient) _____

While filing insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date services are rendered. *Arizona Eye Specialists* will file claims to insurances provided (primary & secondary) during registration. Your insurance is a contract between you and/or your employer, and the insurance company, we are not party to that contract. In order for us to file a claim on your behalf, you must present a CURRENT copy of your insurance card(s) at each visit and communicate any changes in your personal information.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover, therefore we can't guarantee payment of all claims by your insurance company. Some common examples of non-covered services are refractions. Rejection of your claim does not relieve you of your financial responsibility to *Arizona Eye Specialists.*

At *Arizona Eye Specialists*, we understand financial problems may affect timely payments. We encourage you to communicate any such problems to our Billing Department so that we may assist you in keeping your account in good standing. We may provide you with additional resources such as payment arrangements, hardship applications, or state Medicaid contact information. Should you have any questions, please contact our Billing Dept. at 480-994-5012, Option 7.

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