ARIZONA RETINA AND VITREOUS CONSULTANTS

Patient Information

Patient's Name ________________________ Today's Date ___/___/___

Social Security # _____-_____-_____ Date of Birth ___/___/___ Age: ______

Marital Status (please circle): Single Married Widowed Divorced

Gender (please circle): Male Female

Ethnicity: ___Hispanic/Latino ___American Indian/Alaska Native ____Asian
__African American ___Pacific Islander ___White/Caucasian ____Other

Home Address: ____________________________
____________________________ email:_________________
____

Home Phone # _____-_____-_____ Cell Phone # _____-_____-_____

Occupation:_______________________ Work Phone# _____-_____-_____

Employer Name/Address: ____________________________
____
____

Emergency Contact: ________________/_______ Phone # _____-_____-_____
(relation)

Primary Care Physician:
____
____
Phone # _____-_____-______

Primary Eye Care Provider:
____
____
Phone # ____-_____-_____

Who referred you to our office?____

Social History

Alcohol Use: (circle)? Y N How Much/How Often ____________________

Tobacco : ___Never smoked ___Former Smoker
___Daily Smoker ___Occ'l Smoker

Your Pharmacy Information

Pharmacy Name ______________ Phone Number ______________________
Address ____

Do you have any medication allergies (circle) ? Y N Please list

Allergies____

Primary Insurance Information

Name of Insurance Company___________________ Effective Date ___/___/___

ID # _________________________ Group # ___________________________

Name of Policy Holder ___________________ Relation to patient __________

Policy Holder's Social Security # ____-____-____ Date of Birth ___/___/___

Secondary Insurance Information

Name of Insurance Company___________________ Effective Date ___/___/___

ID # _________________________ Group # ___________________________

Name of Policy Holder ___________________ Relation to patient __________

Policy Holder's Social Security # ____-____-____ Date of Birth ___/___/___

Assignment of Benefits

I hereby assign all money to which I am entitled for medical or surgical expense relative to the service reported herein, but not to exceed my indebtedness to said office. It is understood that any money received over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am responsible for any and all charges not covered by my insurance company.

SIGNED __________________________________ **DATE** _____/_____/_____

ARIZONA RETINA & VITREOUS CONSULTANTS LLC
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practice* containing a more complete description of the uses and disclosures of my health information. I understand that Arizona Retina and Vitreous Consultants LLC has the right to change its *Notice of Privacy Practice* from time to time and that I may contact this organization at any time to obtain a current copy of their *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restricted restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________________

Patient Signature:________________________________

Date: ____/____/____

Patient Representative Name: ____________________ Relationship to patient:______

Patient Representative Signature: __________________________

Date: ____/____/____

You may give us permission to disclose your health information to a friend/ family member

Name:________________________ Relationship:______________________

Phone Number:__________________________

ARIZONA RETINA AND VITREOUS CONSULTANTS LLC
INSURANCE COVERAGE POLICY

To accommodate our patients we have enrolled in numerous insurance plans. With your cooperation and our assistance you should be able to receive all of the insurance benefits to which you are entitled. Each plan has its own restrictions regarding where and how often service may be rendered.

It is your responsibility to understand your plan's guidelines and inform us of any special requirements or changes in your insurance. If a referral is required by your insurance, it is the patient's responsibility to have the referral prior to the appointment and prior to any procedures. With out a current referral, we may not be able to provide services and you may have to reschedule your appointment for another day.

All claims must be sent to your insurance company within a period of time determined by the insurance company. We send claims on a daily basis, making it imperative that you inform us of any new insurance or changes in coverage prior to receiving any services. Any time that you receive a new insurance card, please present it to the reception desk as there may be information that needs to be updated in our system in order to effectively process your medical claims. If we are not informed by you of changes in your insurance coverage in a timely manner, your insurance may deny the claims for failure to file in a timely manner. In this case payment for those services would then become your responsibility.

I understand that I am responsible for any and all charges not covered by my insurance company.

In the case in which collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred and a finance charge of 1% per month applied to any unpaid balance.

CONSENT FOR RELEASE OF INFORMATION

I consent to treatment necessary for the care of the patient mentioned below. I hereby authorize the release of medical information to physicians and to my insurance companies with the following exceptions, if any:

Patient Name:____________________________ Patient Signature:__________________________

Authorized Signer Name:______________________Authorized Signature:____________________

Relationship to patient:____

Today's Date:____