Eye Physicians & Surgeons of Arizona

6677 W. Thunderbird F-101
Glendale, AZ 85306

10603 N. Hayden Rd. H-100
Scottsdale, AZ 85260

Offices of:

George Reiss, MD * Shamil Patel, MD

Kim Patel, OD * Melanie Anspaugh, OD

WE WILL NEED:

***PHOTO ID**

***INSURANCE CARD**

***LIST OF MEDICATIONS (IF ANY)**

*Please make sure to complete all referring and primary doctor information. **Including first and last name**.

*Please be prepared to be in the office for **2-3 hours** for your **full evaluation, dilation, and any testing.**

***Cataract evaluation**: if you wear soft contact lenses remove 48 hours prior to appointment. If you wear hard lenses (gas permeable) remove 2 weeks prior to appointment.

Home of the team-based approach, with Dr. Kim Patel and Dr. Melanie Anspaugh our Residency-Trained Doctors of Optometry that have mentored further with Dr. George Reiss and Dr. Shamil Patel. With this model, we are able to care for more of our patients in need while maintaining the highest level of care that our patients deserve.

We greatly appreciate your patience!

***PLEASE BE SURE ALL FORMS ARE COMPLETE BEFORE GIVING PAPERWORK TO THE RECEPTIONIST**

Phone. 623.878.3939 Fax. 480.393-5144

Eye Physicians & Surgeons of Arizona

Marital status **(circle one)**

Single / Mar / Div / Sep / Wid

REGISTRATION FORM

Patient's last name:_____First:_____Middle:_____

Home #:_____Cell #:_____Birth date:_____

Street Address / P.O. Box:_____Social Security no.:_____

City:_____State:_____Zip:_____E-mail address:_____

Occupation:_____Employer:_____Employer phone no.:_____

PLEASE BE SURE TO COMPLETE THIS SECTION

Primary / Family Dr.:_____Referring Dr.:_____

Phone #:_____Phone #:_____

IN CASE OF EMERGENCY

Name of local friend or relative**:** Relationship to patient: Phone numbers:

_____ _____ _____

HIPAA IMPLEMENTATION PROCEDURES

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time, by informing the Privacy Officer in writing:

*A message may be left with a callback number or appointment reminder on my home, work or cell phone number.

*Postcards may be sent to my home address or an e-mail, will be used for communication from this office and will not be shared with any other entity and give my permission for its use for this purpose.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Eye Physicians & Surgeons of Arizona** or insurance co. to release any information required to process my claims.

Signature:_____Date_____

EYE PHYSICIANS & SURGEONS OF ARIZONA

Medical Insurance

Patient name: _____

Insurance Company: _____

Insurance *ID* number: _____

Insurance billing address (on back of insurance card): _____

_____

Phone number for providers (on back of insurance card): _____

Policy holder name (if different from patient "spouse"): _____

Policy holder date of birth (if different from patient):_____

****PLEASE MAKE SURE YOU PROVIDE YOUR CARD/S, SO THAT WE CAN MAKE A COPY FOR OUR RECORDS****

EYE PHYSICIANS & SURGEONS OF ARIZONA

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

*(PLEASE READ CAREFULLY & COMPLETE **ALL** SECTIONS)*

The information below can only be released to the following persons (Family Members, Personal Representative, etc., NOT INCLUDING DOCTORS):

PRINT NAME/S *RELATIONSHIP*

_____

_____

_____

****Please check here ☐ if you DO NOT authorize anyone to have access or to discuss your account or medical information.****

☐ All medical information, including but not limited to records pertaining to examination, treatments, consultations, billing records, x-rays and reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

☐ Only the following types of information:

_____

_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

Until revoked in writing.

I know that I am entitled to receive a copy of this agreement.

Name:_____

Signature:_____

Signed Date:_____

Current Medications/Allergies

Patient name:_____Date:_____

Current Pharmacy: _____

Pharmacy address/cross streets: _____

Pharmacy phone number: _____

Pharmacy fax number: _____

	MEDICATION NAME AND DOSAGE	FREQUENCY	REASON FOR MEDICATION
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

ALLERGIES

EYE PHYSICIANS & SURGEONS OF ARIZONA

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

☐ **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **Eye Physicians & Surgeons of Arizona** for services furnished me by Dr. Reiss, Dr. S. Patel, Dr. Anspaugh & Dr. K. Patel. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents and information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Dr. Reiss, Dr. S. Patel, Dr. Anspaugh & Dr. K. Patel accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in the item of the HCFA 1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Eye Physicians & Surgeons of Arizona**, is possible or otherwise me.

☐ **OTHER INSURANCE:** As a courtesy, **Eye Physicians & Surgeons of Arizona** will bill all primary insurance coverage if he is a contracted provider. If they are not a contracted provider, I will pay for all services at the same time, they are rendered. I authorize payment of my medical and surgical insurance benefits to **Eye Physicians & Surgeons of Arizona**. **I understand I am financially responsible for any charges whether or not paid by my insurance.** If co-payment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Physicians & Surgeons of Arizona. I authorize Eye Physicians & Surgeons of Arizona to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be in place of the original.

NON-COVERED SERVICES: I understand that **Eye Physicians & Surgeons of Arizona** contract with health care services plans (i.e., HMO's, PPO's) relates only to items and services which are "covered" by the health care service plans. These procedures may include, but are not limited to refractions. A refraction may be performed to verify whether or not my vision can be improved with a new prescription or whether surgery is indicated. A refraction is considered routine by Medicare and most other health care service plans. Accordingly, **I accept full financial responsibility for all items or services, which are determined by the health care ser- vice plans not to be covered.**

FINANCIAL AGREEMENT: I agree that in return for the services provided to me by **Eye Physicians & Surgeons of Arizona**, I will pay my account, including co-pay, deductible, and non-covered fees at the time service is rendered. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not pay a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance is hereby assigned to **Eye Physicians & Surgeons of Arizona**. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Eye Physicians & Surgeons of Arizona**.

However, I understand that I am primarily responsible for the payment of my bill.

CO-PAYS AND NON-COVERED FEES ARE DUE AT TIME OF SERVICE!

X_____**Date**_____

Signature of Beneficiary or Authorized Party

EYE PHYSICIANS & SURGEONS OF ARIZONA

PLEASE FAX THIS FORM BACK WITH RECORDSTO (480) 393-5144

CONFIDENTIAL Authorization for Disclosure of Protected Health Information.

This form is used to request copies of medical records. Only patients or their legal representative may make a medical record request. **Eye Physicians & Surgeons of Arizona** may verify your identity/ guardianship. ***Please print.***

PATIENT INFORMATION	Patient Name
	Date of Birth Phone
	Address
	City State Zip
INFORMATION REQUESTED	☐ Complete Medical Records ☐ Records from (date)_____to (date)_____
PURPOSE OF REQUEST	☐ Self ☐ Continuation of care ☐ Other (specify)

RELEASE TO:	**RELEASE FROM:**
Name	Name
Phone Fax	Phone Fax
Address	Address
City State Zip	City State Zip

I hereby authorize the release of my complete medical records in your possession. This authorization is valid 6 months from the date of signature. It may take up to 30 days from date of receipt to release your records.

_____ _____

Patient Signature ***Date***

_____

Legal Representative Printed Name and Signature (if applicable)

Relationship to patient _____

For EPSA use only:
Records sent by:_____Date_____
Method of release: ☐ Fax ☐ **Mail** ☐ Self Pick up

CLARUS Scanning Images of your Eye

A baseline retinal and optic nerve exam can be uncomfortable for patients due to the continuous bright light that is needed to obtain a clear image. The CLARUS Imaging device utilizes a more powerful yet rapid source of illumination which captures a wide field high resolution image that your physician can review with you.

The Clarus high-resolution imaging technology allows us to:

- Capture excellent retinal images in seconds.
- Focus with greater accuracy on areas of concern such as Glaucoma, diabetic changes, Macular Degeneration, tumors and other conditions.
- Make comparisons with previous scans to determine disease progression and the overall health of the eye.

As a screening test, the Clarus photo is **not** considered a covered service by most insurances and is therefore an expense paid directly by the patient. There is $30.00 fee for this photo and the patient may request a copy at no additional charge for their records.

Our physicians recommend an annual Clarus scan to provide the most comprehensive exam possible. Please let us know if you have any additional questions regarding this exciting new technology.

Patient Consent

I understand this screening examination is intended to reduce discomfort and improve my doctor's ability to evaluate and monitor the health of my eye for disease and choose to have the exam.

Check accept or decline as appropriate: ☐ Accept ☐ Decline

Print Name: _____

Signature: _____ Date: _____

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of ***Eye Physicians & Surgeons of Arizona*** Notice of Privacy Practices effective Jan. 1, 2021.
(You may obtain a copy in office or on-line at www.eyesarizona.com)

Name (please print): _____

Signature: _____

Date: _____

Co-managing Ophthalmologist/Optometrist confirmation:

In response to the pandemic, we have developed a team-based approach with Dr. Kim Patel and Dr. Melanie Anspaugh; Residency-Trained Doctors of Optometry that have mentored further with Dr. George Reiss and Dr. Shamil Patel. By creating this model, we are able to care for more of our patients in need while

We most value our relationships and have adjusted our clinic to provide our patients with the best clinical and surgical care we can offer you. In the event that we cannot serve your medical eye needs we will help coordinate care for you elsewhere as needed. Your vision is our highest priority.

If you have any questions regarding your care, please discuss it with your doctor at your next appointment.

By signing below, I agree to co-managed care with **Eye Physicians & Surgeons of AZ**.

Signature_____Date_____