maricopa eye care

21300 N. John Wayne Pkwy #119
Maricopa, AZ 85139
Phone: 520-568-7538 Fax: 866-447-5551

Please fill out as completely as possible. If you have any questions or concerns, feel free to discuss them with any staff member or the Doctor. All information provided is kept strictly confidential – Thank You.

Bring completed forms to your appointment, fax to 866-447-5551 or email to forms@maricopaeyecare.com.

Patient Information

Last Name: _____ First Name: _____ Initial: _____

Male: ☐ Female: ☐ Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Daytime/Cell Phone: _____

Email: _____ Occupation: _____

If you are filling out the form for a child/dependant:

Parent/Guarantor Name: _____ Your Relationship to the Patient: _____

Insurance Information

If you plan to use insurance for services, we will ***require your insurance card(s)*** to be copied and recorded into your file.

Primary Medical Insurance Name: _____

Insured I.D. Number: _____ Policy Group Number: _____

Name of Person
Insurance is Under: _____ Insurance Holder's SSN _____-_____-_____

Insurance Holder's Date of Birth: _____/_____/_____ Relationship to Patient: _____

Secondary Medical Insurance Name: _____

Insured I.D. Number: _____ Policy Group Number: _____

Name of Person
Insurance is Under: _____ Insurance Holder's SSN _____-_____-_____

Insurance Holder's Date of Birth: _____/_____/_____ Relationship to Patient: _____

Vision Insurance Name: _____ Member ID Number: _____

Name of Person
Insurance is Under: _____ Insurance Holder's SSN _____-_____-_____

Insurance Holder's Date of Birth: _____/_____/_____ Relationship to Patient: _____

Assignment of Benefits

I hereby assign all medical and surgical insurance benefits to Maricopa Eye Care (MEC). I hereby authorize and direct my insurance carrier(s), including Medicare and private insurance, to issue payment directly to Dr. Roger Vesper c/o Maricopa Eye Care. This is to include medical services rendered to myself and/or my dependents. I assume responsibility for any deductible, co-pay, or other balance not covered by my insurance carrier. Should any insurance payment be made directly to me for monies due my account, I agree to immediately remit these funds to MEC.

_____ _____
Signature Date

Patient Name _____ Date _____

Financial Responsibility

I have requested medical services from Dr. Roger Vesper on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment.

I further understand that fees are due and payable on the date that services are rendered and prior to materials being ordered. I agree to pay all such charges in full.

When applicable Maricopa Eye Care (MEC) will, in good faith, attempt to verify, pre-authorize and bill insurance on behalf of patients. I understand that MEC does not claim to know all the specific benefits, restrictions or rules governing my insurance plan. As such, MEC cannot guarantee that my insurance will honor/pay claims submitted. We ***strongly urge*** all patients to contact their insurance directly, in advance of their visit, to determine if services rendered at MEC are covered under their plan. This is particularly important if your insurance either requires you to use a specific network of providers, or charges more for using providers outside of a preferred network (HMOs, EPOs, PPOs, POSs and Medicare Advantage Plans).

I understand that it is my responsibility to comprehend and comply with the individual restrictions and rules of my insurance. In the event that my insurance refuses or denies a claim, I agree to pay all charges I have incurred.

If any outstanding balance on my account should become past-due, I am aware that MEC will actively pursue any and all unpaid balances, including the use of a collections agency. I agree to reimburse MEC the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including attorney's fees, MEC incurs in such collection efforts.

Signature _____ Date _____

Voluntary Consent and Authorization for Limited Release of Patient Information

Maricopa Eye care is committed to keeping our patients' private medical information strictly confidential. As such, Maricopa Eye Care cannot disclose any part of your medical record without your express, written permission.

We are asking for your consent to use and release *only that information necessary for your treatment and our medical operations*. Typical uses would be maintaining your medical records, obtaining payment from insurance companies, sending your prescription to a pharmacy or lens laboratory when making glasses, and coordinating with other doctors involved in your care.

We have a comprehensive ***Notice of Privacy Practices*** that describes these uses and disclosures in detail. You are free to refer to this notice any time before you sign this ***Consent Form***.

I have read this consent and understand it. I hereby authorize Dr. Roger Vesper and Maricopa Eye Care to use and disclose my health information for the purposes of treatment, payment, and health care operations.

Signature _____ Date _____

If signing as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form:

Print Name _____ Relationship to Patient _____ Source of Authority _____

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I received a copy of Maricopa Eye Care's Notice of Privacy Practices.

Signature _____ Date _____

Vision History Please describe below any problems you are having with your eyes/vision.

	Describe your eye symptom or problem.	How long now have you experienced this problem?	Describe the onset of the problem.	Which eye(s) is involved?	How frequently do you experience the symptom?	Describe the severity of the symptom.
1.			Sudden ○ Gradual ○ Recurrent ○	Right ○ Left ○ Both ○	Constantly ○ Occasionally ○ Rarely ○	Mild ○ Moderate ○ Severe ○
2.			Sudden ○ Gradual ○ Recurrent ○	Right ○ Left ○ Both ○	Constantly ○ Occasionally ○ Rarely ○	Mild ○ Moderate ○ Severe ○

	Yes	No	
Do you experience blurry vision?	○	○	If yes, describe: _____
Do you experience double vision?	○	○	If yes, describe: _____
Do you experience floaters in your vision?	○	○	If yes, describe: _____
Do you experience flashes of light in your vision?	○	○	If yes, describe: _____
Do you currently use eye glasses?	○	○	Type of glasses currently using: _____
Do you current use contact lenses?	○	○	Type of contacts currently using: _____
Do you want a prescription for contact lenses today? *	○	○	

* Note: a separate contact lens fitting fee will be applied.

Have you ever had an injury to your eye(s)?	○	○	If yes, describe: _____
Have you ever had eye surgery of any kind?	○	○	If yes, describe: _____
Have you ever been diagnosed with an eye disease?	○	○	If yes, describe: _____
Do you currently take any type of eye medicine/drop?	○	○	If yes, describe: _____

Personal Medical History

Medical Doctor's Name: _____ Phone: _____

	List below any medical conditions you have.	When was it diagnosed?	What medication(s) are you taking for this condition?
1.			
2.			
3.			
4.			

Please list any major injuries, surgeries or hospitalizations:

_____

_____

	Yes	No	
Have you ever had an allergy or adverse reaction to medication(s)?	○	○	If yes, describe: _____
Are you pregnant or nursing?	○	○	If yes, provide your due/delivery date: _____

Social History

	Yes	No	
Do you smoke or use tobacco?	○	○	If yes, how much/how often? _____
Do you drink alcohol?	○	○	If yes, how much/how often? _____
Do you use recreational drugs?	○	○	If yes, describe: _____

Please indicate if you have ever experienced any of the following symptoms/conditions.

Allergies	Yes	No
Seasonal/Hay Fever	○	○
Hives/Skin Rashes	○	○
Foods	○	○
Pets/Dander	○	○

Constitutional	Yes	No
Fever	○	○
General Fatigue	○	○
Weight Gain	○	○
Weight Loss	○	○

Endocrine	Yes	No
Diabetes Mellitus	○	○
Thyroid Disease	○	○
Excessive Thirst	○	○
Excessive Urination	○	○

Neurological	Yes	No
Alzheimer's Disease	○	○
Bell's Palsy	○	○
Brain Tumor/Cancer	○	○
Cerebral Palsy	○	○
Epilepsy/Seizure Disorder	○	○
Headaches	○	○
Migraines	○	○
Parkinson's Disease	○	○
Trigeminal Neuralgia	○	○
Blackouts/Fainting	○	○
Memory Loss	○	○
Motor Loss/Weakness	○	○
Numbness/Tingling	○	○
Multiple Sclerosis	○	○
Tremors	○	○

Cardiovascular	Yes	No
Arteriosclerosis	○	○
Cardiovascular Disease	○	○
High Cholesterol	○	○
Hypertension	○	○
Stroke	○	○
Chest Pain/Angina	○	○
Palpitations	○	○

Hematologic/ Lymphatic	Yes	No
Breast Cancer	○	○
Coagulation/Clotting Disorder	○	○
Hodgkin's Disease/ Lymphoma	○	○
Leukemia	○	○
Sickle Cell Disease	○	○
Abnormal Bleeding	○	○
Abnormal Bruising	○	○

Psychiatric	Yes	No
Anxiety Disorder	○	○
Bipolar Disorder	○	○
Depression	○	○
Schizophrenia	○	○
Agitated or Anxious Mood	○	○
Depressed Mood	○	○
Abnormal Mood Swings	○	○

Immunological/ Infectious	Yes	No
Cytomegalovirus	○	○
Herpes Zoster	○	○
Histoplasmosis	○	○
HIV/AIDS	○	○
Sarcoidosis	○	○
Toxoplasmosis	○	○
Tuberculosis	○	○

Integumentary/Skin	Yes	No
Acne Rosacea	○	○
Albinism	○	○
Dermatitis/Contact Dermatitis	○	○
Eczema	○	○
Psoriasis	○	○
Vitiligo (whitening of skin)	○	○
Excessive Dry Skin	○	○

Developmental/ Genetic	Yes	No
Premature Birth/Low Birth Weight	○	○
Complicated Birth	○	○
Supplemental O_2 / Incubator used at Birth	○	○
Severe Early Childhood Infection/Fever	○	○
Autism	○	○
Downs Syndrome	○	○
Cleft Palate	○	○
Attention Disorder/ ADHD	○	○
Dyslexia/Learning Disability	○	○
Mental Handicap/ Retardation	○	○

Musculoskeletal	Yes	No
Arthritis/Rheumatoid Arthritis	○	○
Fibromyalgia	○	○
Muscular Dystrophy	○	○
Myasthenia Gravis	○	○
Joint Pain/Swelling	○	○
Muscle Weakness	○	○

Gastrointestinal	Yes	No
Colon Cancer	○	○
Hepatitis	○	○
Inflammatory Bowel Disease	○	○
Abdominal Pain	○	○
Chronic Diarrhea	○	○

Respiratory	Yes	No
Asthma	○	○
COPD	○	○
Emphysema	○	○
Persistent Cough	○	○
Shortness of Breath	○	○

Genitourinary	Yes	No
Prostate Cancer	○	○
Uterine or Cervical Cancer	○	○

Head/Ear-Nose-Throat	Yes	No
Sinusitis/Sinus Infection	○	○
Excessively Dry Mouth	○	○
Hearing Loss/ Impairment	○	○

Family History Please indicate below if a member of your family has any of the following.

	Yes	No	Which family member(s)?
Diabetes	○	○	_____
Heart Disease	○	○	_____
Hypertension	○	○	_____
Rheumatoid Arthritis	○	○	_____
Multiple Sclerosis	○	○	_____
Cancer	○	○	_____

Type(s) of cancer: _____

	Yes	No	Which family member(s)?
Lazy or Turned Eye(s)	○	○	_____
Glaucoma	○	○	_____
Macular Degeneration	○	○	_____
Retinal Detachment	○	○	_____
Retinal Disease	○	○	_____

Other: _____

_____

Notice of Privacy Practices

Effective date of notice: **June 1, 2014**

Dr. Roger Vesper
c/o Maricopa Eye Care
21300 N. John Wayne Parkway, Suite 119
Maricopa, AZ 85139
Ph: 520-568-7538
Fax: 866-447-5551

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information, which identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office, or disclose it outside of our office, with your written permission, and only for **healthcare operations, treatment,** or **payment** purposes. In all other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

We use and disclose your health information for **healthcare operations** in a number of ways. Health care operations mean those administrative and managerial functions that we use in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, and for outside storage of our records.

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

Appointment Reminders

We may call, or send written notice, to remind you of scheduled appointments or to schedule an appointment. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the Foreign Service.
- Disclosures relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures:

We will not make any other uses or disclosures of your health information unless you sign a **separate** written **authorization form**. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information:

The law gives you many rights regarding your health information.

- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to **Dr. Roger Vesper** at the address or fax shown at the beginning of this notice.
- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. To request confidential communications, send a written request to **Dr. Roger Vesper** at the address or fax shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to **Dr. Roger Vesper.**
- You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with you health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend you health information, send a written request, including your reasons for the amendment, to **Dr. Roger Vesper.**
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to **Dr. Roger Vesper.**

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we chose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to notify us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to **Dr. Roger Vesper** at the address or FAX shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit **Dr. Roger Vesper** at the address or phone number shown at the beginning of this notice.