maricopa eye care

Patient Registration Form

21300 N. John Wayne Pkwy. #119 Maricopa, AZ 85139 Questions: 520-568-7538 or forms@maricopaeyecare.com

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI: _____

D.O.B: _____ SS# _____

Address

Street: _____

City: _____

State: _____ Zip: _____

Occupation: _____

Contact Info/Preferences/Consent:
Maricopa Eye Care (MEC) needs to communicate with patients regarding their care, appointments, & orders. By providing the below contact info, I consent to communications via cell phone, text, voicemail and/or email.
(We require at least one phone number.)

Home #(non-cell): _____

Cell Phone: _____

Can cell phone receive texts? YES ☐ NO ☐

Daytime Phone: _____

Email: _____

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

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

INSURANCE INFORMATION

If you plan to use insurance, we* require your insurance card(s) *to be in your file. It may be easiest to send pictures of your cards to us at 520-568-7538. We require Medical Insurance info AND Vision Insurance info.

MEDICAL INSURANCE ☐ NONE

PRIMARY MEDICAL

Insurance Co: _____

Insured I.D. Number: _____

Group Number: _____

Policy Holder:

☐ Self Other: _____
Name / DOB

SECONDARY

Insurance Co: _____

Insured I.D. Number: _____

Group Number: _____

Policy Holder:

☐ Self Other: _____
Name / DOB

VISION INSURANCE ☐ NONE

PRIMARY VISION

Insurance Co: _____

Insured I.D. Number: _____

Group Number: _____

Policy Holder:

☐ Self Other: _____
Name / DOB

SECONDARY

Insurance Co: _____

Insured I.D. Number: _____

Group Number: _____

Policy Holder:

☐ Self Other: _____
Name / DOB

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.

Signature: _____ **Date:** _____

APPOINTMENT INFO

What is the primary reason for your appointment?

Please use the table to the right to tell us which days and times you are generally available. The more open your availability, the sooner we can likely schedule you.

Mark your preferred days and times

	8:00-10:00	10:30-2:30	3:00-4:30
Mon			
Tue			
Wed			
Thu			
Fri			

YOUR EYE PROBLEMS

Please describe any problems you are having with your eyes or your vision

Describe your eye symptom or problem (blurry vision, pain, dry eye, etc.)	How long have you been experiencing the problem?	Sudden? Gradual? Recurrent?	Which eye?	How often?	How severe?
1		Sudden [ ] Gradual [ ] Recurrent [ ]	Right [ ] Left [ ] Both [ ]	Constant [ ] Occasional [ ] Rarely [ ]	Mild [ ] Moderate [ ] Severe [ ]
2		Sudden [ ] Gradual [ ] Recurrent [ ]	Right [ ] Left [ ] Both [ ]	Constant [ ] Occasional [ ] Rarely [ ]	Mild [ ] Moderate [ ] Severe [ ]

YOUR GLASSES & VISION

Without correction, do you have blurry vision? Yes [ ] No [ ]

IF YES:
where is your vision blurry?
Distance [ ] Near [ ] Both [ ]

Have you been prescribed eyeglasses Yes [ ] No [ ]

If yes, what type of glasses do you currently use?

Single Vision [ ] Progressives [ ] Drugstore Readers [ ]
Bifocals [ ] Office Lenses [ ] Driving Glasses [ ]
Trifocals [ ] Don't know [ ] Rx Sunglasses [ ]

Do you have double vision? Yes [ ] No [ ]

Ever been prescribed glasses with prism? Yes [ ] No [ ]

! IMPORTANT: Bring your current glasses to your appointment, even if they are broken. !

CONTACT LENS INFO

Do you want the doctor to generate a prescription for contact lenses? Yes [ ] No [ ]

Additional forms and fees will be required

If Yes:

Do you currently use contact lenses? Yes [ ] No [ ]

Name/Brand: _____

Base curve/Power: _____

Pro Tip: It's often easier to just take a picture of the numbers on your contact lens boxes and send it to us at 520-568-7538

When describing eye problems, please tell us which eye(s) and when

	Yes	No	
Do you have floaters in your vision?	◯	◯	If yes, describe: _____
Do you have light flashes in your vision?	◯	◯	If yes, describe: _____
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 (other than wearing glasses)?	◯	◯	If yes, describe: _____
Do you currently use any type of eye medicine or/drop?	◯	◯	If yes, describe: _____

MEDICAL HISTORY

Medical Doctor's Name: _____ **Phone:** _____

Please list any your current medical conditions, medications, and when diagnosed.
If you have a medications list or medical conditions list, feel free to send a picture to 520-568-7538

CONDITION	MEDICATION(S)	WHEN DIAGNOSED

Have you ever had an allergy or adverse reaction to medication? Yes [ ] No [ ]

If yes, which medication(s) and what reaction(s)? _____

MAJOR INJURIES, SURGERIES OR HOSPITALIZATIONS	WHEN

Are you pregnant or nursing? Yes [ ] No [ ] If yes, provide your due/delivery date:_____

SOCIAL HISTORY

Do you smoke or use tobacco?	Yes [ ]	No [ ]	If yes, how much/how often?
Do you drink alcohol?	Yes [ ]	No [ ]	If yes, how much/how often?
Do you use recreational drugs?	Yes [ ]	No [ ]	If yes, what/how often?

FAMILY HISTORY

CONDITION	YES	NO	Which family member?
Multiple Sclerosis	[ ]	[ ]	
Diabetes	[ ]	[ ]	
Heart Disease	[ ]	[ ]	
Hypertension	[ ]	[ ]	
Rheumatoid Arthritis	[ ]	[ ]	
Cancer	[ ]	[ ]	

Type of Cancer:_____

EYE DISEASE	YES	NO	Which family member?
Lazy or Turned Eye(s)	[ ]	[ ]	
Glaucoma	[ ]	[ ]	
Macular Degeneration	[ ]	[ ]	
Retinal Detachment	[ ]	[ ]	
Retinal Disease	[ ]	[ ]	

Other Eye Disease(s) Which family member(s)?

_____ _____

_____ _____

REVIEW OF SYSTEMS

Have you ever experienced problems/symptoms with any of these body systems? If yes, please indicate which ones.

Allergies
NONE ☐ YES ☐
If yes, please mark which:

Seasonal/Hay Fever	☐
Hives/Skin Rashes	☐
Foods	☐
Pets/Dander	☐

Cardiovascular
NONE ☐ YES ☐
If yes, please mark which:

Arteriosclerosis	☐
Cardiovascular Disease	☐
High Cholesterol	☐
Hypertension	☐
Stroke	☐
Chest Pain/Angina	☐
Palpitations	☐

Immunological/ Infectious
NONE ☐ YES ☐
If yes, please mark which:

Cytomegalovirus	☐
Herpes Zoster	☐
Histoplasmosis	☐
HIV/AIDS	☐
Sarcoidosis	☐
Toxoplasmosis	☐
Tuberculosis	☐

Gastrointestinal
NONE ☐ YES ☐
If yes, please mark which:

Colon Cancer	☐
Hepatitis	☐
Inflammatory Bowel	☐
Abdominal Pain	☐
Chronic Diarrhea	☐

Constitutional
NONE ☐ YES ☐
If yes, please mark which:

Fever	☐
Geneal Fatigue	☐
Weight Gain	☐
Weight Loss	☐

Hematologic/Lymphatic
NONE ☐ YES ☐
If yes, please mark which:

Breast Cancer	☐
Coagulation/Clotting Disorder	☐
Hodgkins Disease/ Lymphoma	☐
Leukemia	☐
Sickle Cell Disease	☐
Abnormal Bleeding	☐
Abnormal Bruising	☐

Integumentary/Skin
NONE ☐ YES ☐
If yes, please mark which:

Acne Rosacea	☐
Albinism	☐
Dermatitis/ Contact Dermatitis	☐
Eczema	☐
Psoriasis	☐
Vitiligo (Whitening of the skin)	☐
Excessive Dry Skin	☐

Respiratory
NONE ☐ YES ☐
If yes, please mark which:

Asthma	☐
COPD	☐
Emphysema	☐
Persistent Cough	☐
Shortness of Breath	☐

Head/Ear-Nose-Throat
NONE ☐ YES ☐
If yes, please mark which:

Sinusitis/Sinus Infection	☐
Excessively Dry Mouth	☐
Hearing Loss/ Impairment	☐

Genitourinary
NONE ☐ YES ☐
If yes, please mark which:

Prostate Cancer	☐
Uterine/Cervical Cancer	☐

Psychiatric
NONE ☐ YES ☐
If yes, please mark which:

Anxiety Disorder	☐
Bipolar Disorder	☐
Depression	☐
Schizophrenia	☐
Agitated/Anxious Mood	☐
Depressed Mood	☐
Abnormal Mood Swings	☐

Developmental/Genetic
NONE ☐ YES ☐
If yes, please mark which:

Premature Birth/ Low Birth Weight	☐
Complicated Birth	☐
Supplemental Oxygen/ Incubator used at Birth	☐
Severe Early Childhood Infection / Fever	☐
Autism	☐
Down Syndrome	☐
Cleft Palate	☐
Attention Disorder/ ADHD	☐
Learning Disability or Dyslexia	☐
Mental Handicap/ Retardation	☐

Endocrine
NONE ☐ YES ☐
If yes, please mark which:

Diabetes Mellitus	☐
Diabetic Suspect	☐
Thyroid Disease	☐
Excessive Thirst	☐
Excessive Urination	☐

Neurological
NONE ☐ YES ☐
If yes, please mark which:

Alzheimer's Disease	☐
Bell's Palsy	☐
Brain Tumor/Cancer	☐
Cerebral Palsy	☐
Epilepsy/Seizure Disorder	☐
Headaches	☐
Migraines	☐
Parkinson's Disease	☐
Multiple Sclerosis	☐
Trigeminal Neuralgia	☐
Blackouts/Fainting	☐
Memory Loss	☐
Motor Loss/Weakness	☐
Numbness/Tingling	☐
Paralysis	☐
Tremors	☐

Musculoskeletal
NONE ☐ YES ☐
If yes, please mark which:

Arthritis	☐
Rheumatoid Arthritis	☐
Fibromyalgia	☐
Muscular Dystrophy	☐
Myasthenia Gravis	☐
Joint Pain/Swelling	☐
Muscle Weakness	☐

OTHER
Any other symptoms?
NONE ☐ YES ☐
If yes, please list:

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Vision Insurance Limitations

IT'S IMPORTANT TO UNDERSTAND THE ROLE AND LIMITATIONS OF ROUTINE VISION INSURANCE

Although Vision Insurance provides very predictable coverage for materials such as eyeglasses and contact lenses, vision insurance does not cover all aspects of your eye exam under all circumstances. We want to be sure you are aware of the limitations of your coverage and that you are prepared, should your visit require billing or payment beyond what your Routine Vision Insurance covers.

Do you have Vision Insurance you'd like to use for your services/materials? _____ *Yes* _____ *No*

If Yes:

Please review and initial each statement about the limitations of this insurance

_____I understand that my Vision Insurance 'Exam Copay' does NOT include a prescription for contact lenses. I understand that if I want a prescription for contact lenses, I will be responsible for a Contact Lens Exam Fee, for which my insurance will either specify a separate copay or provide a discount of 15% off MEC's Contact Lens Exam Fee, which ranges from $75-$150, depending on complexity. We are NOT able to subtract your Contact Lens Exam fee from your Contact Lens Materials Allowance.

_____I understand that Routine Vision Insurance DOES NOT cover the Retinal Screening Photos that Dr. Vesper requires for patients 18 years and older as part of the annual Vision Exam. I understand I may NOT opt out of this test and I will be prepared to pay $39 at check-in to cover this service.

_____I understand that Vision Insurance may only be used if my exam is determined to be a Routine Vision Exam and not a Medical Vision Exam. For my exam to be considered Routine, I understand that I must have completely healthy eyes and vision that corrects to 20/20 with the right lenses, and no systemic illnesses or medications that can impact the eyes. I understand that if my exam finds ocular disease processes or reduced vision, my exam will be reclassified as a medical eye exam and WILL NOT be billable to my Routine Vision Insurance.

_____ In the event that my vision exam is determined to be Medical or Non-Routine in nature, I understand that my exam will NOT be billed to my routine vision coverage, but to my medical insurance, if MEC is in-network. I will be responsible for any copays, deductibles, and coinsurance and for any parts of the exam that are not covered by my medical insurance. If MEC is out-of-network with my medical insurance, or if I have not provided my medical insurance information in advance of my visit, I understand that my out of pocket costs for my visit may range from $179-$315.

For more information on Routine vs. Medical Vision Exams, please see our website: www.maricopaeyecare.com

Please be sure you've provided your medical insurance cards 7 days in advance of your appointment, so we can give you an estimate of costs, should your exam be classified as a Medical Vision Exam

All patients must sign and date:

I have read and understand the limitations of using Routine Vision Insurance and agree to abide by Maricopa Eye Care billing policies with regard to the use of routine vision insurance

Printed Name: _____

Signature: _____

Date: _____

If not the patient, what is the document signer's relationship to the patient?

_____

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Financial Policy

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Maricopa Eye Care's primary focus is on providing eye care to our patients. Although we, as a courtesy, accept and bill several types of insurance, our primary relationship is with you, the patient. Your insurance policy is a contract between you, your employer, and your insurance company(s). We will cooperate fully with the regulations and requests of your insurance company that may assist in processing your claim. However, our office will not enter into a dispute with your insurance company over processing your claim. Although we will do our best to provide an estimate of your out-of-pocket costs, it is only an estimate. Determining whether an exam must be billed to routine vision insurance (like VSP) or to your major medical insurance (like Medicare, BCBS, etc.), depends on your medical history, your ocular history and the diagnostic results of your exam.

PLEASE INITIAL EACH ITEM, THEN SIGN AND DATE THE DOCUMENT AT THE BOTTOM OF THE PAGE

_____I understand that estimated out-of-pocket costs for my exam, including but not limited to copays deductibles, coinsurance and payment for services not covered by my insurance, are due at check-in, and are payable via Cash, Visa, MasterCard, American Express, Discover or Care Credit. Checks are NOT accepted for estimated out-of-pocket costs.

_____I understand that out-of-pocket costs for glasses and contact lenses must be paid in full before my order will be placed. These costs may be paid via Cash, Visa, MasterCard, American Express, Discover or Care Credit. Checks are NOT accepted for glasses or contact lenses.

_____ I understand that coordinating benefits with my insurance company(s) is entirely my responsibility. In the event that a claim is denied because of improper coordination of benefits, I understand that I am responsible for the entire balance due. I understand that if I have multiple coverages, the insurance companies ultimately decide which policy must be billed as the primary payer.

_____ I understand that it is my responsibility to provide Maricopa Eye Care with current insurance information in advance of my office visit. I agree to inform MEC of any changes to my insurance coverage. In the event that a claim is denied because of incorrect insurance information, I understand that I am responsible for the entire balance due.

_____ I understand that my insurance company(s) may require additional information from me to process a claim. In the event that a claim is denied because I have not submitted the requested information in a timely manner, I understand that I am responsible for the entire balance due.

_____I understand that upon processing my claim, any balance due is my responsibility and must be paid within 30 days of the statement date. Statements may be paid via Cash, Visa, MasterCard, American Express, Discover or Care Credit. Checks ARE accepted for payment of statement, however, checks returned for insufficient funds will incur a $30 returned check fee. I understand that future payments will need to be made via cash or credit card.

_____ I understand that, in the event I default on payment of my balance, I will be sent to collections and discharged from the practice. I understand that I will pay collection costs and reasonable attorney's fees incurred by Maricopa Eye Care while attempting to collect the balance due. I understand that an additional charge of 35% of the balance due will be added to the balance.

_____ If my vision exam is determined to be medical in nature, rather than routine, and I have not provided my medical insurance information in advance, or if Maricopa Eye Care is NOT in-network with my medical insurance, or is unable to verify my coverage in advance of my visit, I understand that my insurance will NOT be billed and I will owe a discounted fee of $179-$249, due the day of the exam.

I have read and understand the above financial policy and agree to abide by it.

Printed Name: _____

Signature: _____

Date: _____

If not the patient, what is the document signer's relationship to the patient?

_____

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Information Consent & Privacy

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Voluntary Consent and Authorization to Release Patient Information

Maricopa Eye Care (MEC) is committed to keeping all private medical information regarding its patients strictly confidential. Any use and/or disclosure of your private medical information is regulated and restricted by federal and state law. As such, MEC cannot disclose any part of your medical record without your express, written permission.

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

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.

_____ _____ _____

Printed Name Signature Date

If signing as a personal representative of the patient, describe your relationship/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 have received or been offered a copy of Maricopa Eye Care's Notice of Privacy Practices.

_____ _____

Signature Date

Consent to Release Medical Information to a Personal Third Party

Is there someone you authorize to assist in your care?

By providing the following information, I grant permission to this individual to receive information relative to my medical history, appointments, insurance information, etc. They may also act on my behalf in making decisions pertinent to my care with Maricopa Eye Care.

_____ _____ _____

Name Relationship Phone number

I understand that by opting-out of the above consent, I cannot have anyone other than myself:

- Pick up glasses/contacts.
- Schedule/verify appointment times
- Update insurance information
- Request a prescription refill
- Act on my behalf regarding my care

_____ _____

Signature Date