



**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
AND
AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION**

Thank you for selecting Eye Doctors of Arizona for your eye care. We strongly feel that all patients deserve from us the very best medical care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our financial policy.

PLEASE READ AND SIGN THE FOLLOWING

1. I authorize this office to release or receive any information necessary to expedite insurance claims
2. I hereby authorize this office to bill my insurance company directly for their services
3. I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Eye Doctors of Arizona for whom these fees are payable.

It is your responsibility to understand your plans, 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. Without a current referral, we may not be able to provide services, and you may have to reschedule your appointment for another day.

ACCEPTED METHODS OF PAYMENT

We will accept payment of balances due by Cash, Money Orders, VISA, Master Card, Discover, Care Credit, and American Express

AUTHORIZATION TO RELEASE AND / OR RECEIVE INFORMATION

The patient / Responsible Party authorizes (s) the release or receipt of and disclosure of any and all medical information related to the Patient's treatment and care, to or from any entity, which is, or may be liable, for Physicians' charges, or to or from any Professional Review Organization associated therewith. The Patient/Responsible Party authorize(s) the release or receipt and disclosure of all or any part of the Patient's medical records to or from any other health care provider who may be of assistance, in the opinion of the P.C, in providing medical care and treatment for the patient, and /or assisting in any reimbursement or benefits to which patient may be entitled.

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 authorize the release of medical information to the following family/guardian: _____

DILATION INFORMED CONSENT: Dilation may be recommended by your eye doctor during any exam in the office. Many serious and sometimes vision-threatening conditions cannot be accurately diagnosed or detected without dilation. Dilation will make you light sensitive and will make your reading vision blurry. Driving is usually safe when dilated, and the patient assumes all risk of operating a motor vehicle, as well as any other visually demanding tasks, while dilated.

ACKNOWLEDGMENT OF VISION EXAM POLICY: My eye care professional provided me with a copy of my eyewear and/or contact lens prescription at the completion of my eye exam and/or contact lens fitting. Glasses and contact lens rechecks are covered for up to 90 days from the original exam date. After the 90-day period, a new eye exam will be required.

Print Patient Name: _____

Signature: _____ **Date:** ____/____/____



EYE DOCTORS OF ARIZONA

Date: _____ New Patient: Y N Other family members: _____

Patient Name: _____ Sex: M F

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (Cell/Work) _____ DOB ___/___/___ SS# _____

Marital Status Single Married Widowed Divorced Separated Partner

Referred by Doctor Other _____ Email: _____

Employer: _____ Work Phone: _____

Occupation: _____ Have you ever been to this office before: Y N

Emergency Contact Name: _____ Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Insured's Name: _____ Insured's Name: _____

Insured's Birth Date: ___/___/___ Insured's Birth Date: ___/___/___

Policy ID: _____ Policy ID: _____

Relationship to patient: _____ Relationship to patient: _____

Eye Health / History: _____ When was your last eye examination? _____

Reason for Eye Exam: _____

Medical Eye History: Glaucoma Macular Degeneration Other: _____

Surgical Eye History: Yes No Explain: _____

General Surgical History: Yes No Explain: _____

Medical History:

Diabetes Hypertension Other: _____

Approximate Height: _____

Approximate Weight: _____

Smoke Tobacco

Consume Alcohol

Recreational Drugs

Medications: (Please list any current Medications you take)

Are you allergic to any medications? Yes No Please list: _____

Are you currently pregnant or nursing? Yes No