Northern Arizona Eye Associates

PATIENT INFORMATION

Patient's Name_____
Address_____
City_____ State_____ Zip_____
Phone_____ Cell_____
Social Security #:_____
☐ Single ☐ Married ☐ Male ☐ Female ☐ Other
Birth Date:_____
EMAIL_____

SPOUSE OR LEGAL GUARDIAN

Name_____
Address_____
City_____ State_____ Zip_____
Phone_____ Cell_____
Social Security #:_____
Relation to Patient_____
Birth Date:_____
EMAIL_____

I acknowledge that I will be receiving email notifications for appointment reminders and newsletters.
Please check box if you do not wish to receive email notifications ☐

EMERGENCY CONTACT OR CARETAKER (if other than spouse or legal guardian)

Name_____ EMAIL:_____
Address_____ Relation to Patient_____
Phone_____ Cell_____

Name of Primary Care Physician: _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION ****Please complete if insurance cards NOT available****

Primary Insurance

Insurance Company_____
Insured's Name_____
Relationship to Patient_____
ID Number/Social Security #_____
Group Number_____
Insured's Birth Date_____

Secondary Insurance

Insurance Company_____
Insured's Name_____
Relationship to Patient:_____
ID Number #_____
Group Number_____
Insured's Birth Date_____

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I authorize treatment of the above to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing and insurance claims, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician and also authorize the physician to release any information required in the processing of the insurance claim. Once payment is received from the insurance company, I will receive only one statement for the balance. It is expected that payment will be made within 10 days of receipt of first statement. If payment is not received, it will be considered past due and may be sent to collections. A 40% fee will be assessed to any balance sent to a collection agency.

Please note that you will be responsible for a $30.00 appointment fee if you miss an appointment or cancel without 24 hours notice. Please do your best to notify us in advance if you are unable to attend your appointment, and we will gladly find time to reschedule.

PATIENTS WITH MEDICARE OR MEDICARE REPLACEMENT

I request that payment under the medical insurance program be made on my behalf to Robert Mahanti, M.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services. I further permit a copy of this authorization to be used in place of the original. Refractions are a non-covered service of Medicare and are the patient's responsibility. I certify that I have given proper insurance information. If a referral is necessary with my insurance plan, it is my responsibility to obtain the necessary referral.

ALL PATIENTS MUST SIGN HERE

Patient's Signature: _____ Date:_____

(Please check this box if you are the spouse or legal guardian signing for the patient ☐)

NAEA Surgery Center LLC

HEALTH QUESTIONNAIRE

Please complete this form as accurately as you can. For major health events please include approximate dates You may forgo duplicating any information on this form if you have provided us with a current list of allergies, medications, health conditions and / or surgeries. Eye health will be specifically addressed on the next page.

Patient's Name: _____ Date you are completing this form:_____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____

List any medications you are allergic to & reaction: _____

Are you sensitive to topical Iodine? ☐ Yes ☐ No *OR* Any type of tape? ☐ Yes ☐ No

Have you or a blood relative ever had a problem with anesthesia? ☐ Yes ☐ No _____

Have you or a blood relative ever had a problem with bleeding and / or clotting? ☐ Yes ☐ No _____

Describe that bleeding/clotting/anesthesia problem: _____

Last PCP Visit: _____ **Facility or PCP Name: _____**

Please check all that you have / had:

_____ High blood pressure
_____ Able to climb a flight of stairs
_____ AFIB/Pacemaker
_____ Heart attack
_____ Open heart surgery
_____ Chest pain
_____ Cardiac Stents
_____ Stroke
_____ Cardiac arrest
_____ Diabetes/A1C_____
_____ Kidney disease
_____ Cancer: Type / Surgery? Chemo or Radiation?:_____

_____ O2 Usage/Liters_____
_____ Thyroid problems
_____ Seizure
_____ Head injury / Loss of consciousness
_____ Prostate Problems
_____ Sleep apnea
_____ Dialysis/# of Days_____
_____ Wheelchair User
_____ Asthma
_____ Emphysema / COPD
_____ Chronic bronchitis

_____ Blood Clots / DVT
_____ Depression / Anxiety
_____ Hiatal Hernia
_____ Bleeding problems
_____ Hepatitis
_____ Liver disease
_____ AIDS / HIV positive
_____ Alcohol abuse
_____ Drug addiction

List previous surgeries and /or recent hospitalizations. Include any you can remember, and approximate date (Example: “8 years old Tonsillectomy” or “1998 gall bladder”, etc) Use the back side of this form if necessary.

_____

_____

Please list ALL medications you take on a regular basis, including eye drops. Include dose and frequency. Use the back of this form if necessary. If you have a current list, you may have us copy that instead:

Medication	Dosage	Number of Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TO BE COMPLETED ON DAY OF SURGERY WHEN APPLICABLE: Date of Last Menstrual Cycle? _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure ☐ Post-Menopausal ☐ Hysterectomy

** Please note that our facility does not have the capability to perform pregnancy testing. If you are unsure if you are pregnant but wish to proceed with your surgery, you will need to sign a separate consent form.

I attest that the above health history is correct to the best of my recollection.

Patient's Signature #1_____ Date:_____ #2: _____Date:_____

Physician Signature #1_____ Date:_____ #2:_____ Date:_____

NAEA Surgery Center LLC

HEALTH QUESTIONNAIRE

OCULAR HISTORY:

Do you currently wear contact lenses? Yes / No If so, are they Soft / Hard / Gas Perm / Other
Power (if known): _____

Do you suffer from: Dry Eye / Allergy Eye / Blepharitis / Watery Eyes

Which eye drops do you use or have you tried for these problems_____

Do you have any of the following conditions:

☐ Cataracts ☐ Glaucoma (For how long?_____) ☐ Macular Degeneration Dry / Wet

☐ Retinal Disease:_____ ☐ Corneal Disease:_____

☐ Eye Muscle Imbalance ☐ Amblyopia or 'Lazy Eye' ☐ Prisms in your glasses

☐ Other_____

Have you had any of the following procedures:

☐ Cataract Surgery: Right eye / Left eye / Both eyes When_____

☐ Glaucoma Procedures Describe_____

☐ Retinal Procedures Describe_____

☐ Vision Correction Surgery If yes, what type? RK / LASIK / PRK / RLE / ICL

Right eye / Left eye / Both eyes When_____

Have you had any eye Injury or other eye surgery?: _____

SOCIAL HISTORY:

Have you ever smoked tobacco? Yes / No Do you currently smoke? Yes / No

Do you chew tobacco? Yes / No Do you regularly use recreational drugs? Yes / No

Do you drink alcohol? Yes / No If yes, what kind & how frequently? _____

EMPLOYMENT:

Occupation or Employer: _____

How many hours per day are you using a computer / electronic device? _____

How many hours per day do you perform "near" activities (reading, find handywork, etc) _____

Do you have a Commercial Drivers' License? Yes / No Do you drive frequently at night? Yes / No

FAMILY HISTORY: Please note the relation to the patient of the person with the condition:

(f) father (m) mother (s) sister (b) brother (gp) grandparent (o) other family member

___	Glaucoma	___	Cataracts	___	Diabetes
___	Macular Degeneration	___	"Lazy Eye"	Type: _____	
___	Retinitis Pigmentosa	___	Retinal Detachment	___	Heart Disease
___	Other eye problems: _____				

_____ _____ _____

Patient/guardian signature Technician signature Date

Northern Arizona Eye Associates

Protecting your Confidential Information is Important to Us

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes. i.e., if you are a victim of a crime, suspected abuse or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners
We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for funeral.

Medical Research
Advancing medical knowledge often involves learning from the careful study of medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use of Disclose Health Information
Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office. We are required by law to maintain the privacy of your health information and to provide to you this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Rights
This new law is careful to describe that you have the following right related to your health information.

Restrictions
Protecting your confidential health information is important to us. You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family member present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

To Contact You
We may use your information to contact you. For example, we may send newsletters or other information pertaining to patient wellbeing, practice news and product updates. We may also want to call or text you about your appointments.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at time. We may need to charge you a reasonable fee for you request.

Patient Acknowledgment
Thank you for taking the time to review how we are carefully using your health information. If you have any questions, we want to hear from you. Please acknowledge your receipt of your policy by signing below.

Patient's Name: _____ Patient's Signature: _____

Today's Date: _____

Northern Arizona Eye Associates

Advance Beneficiary Notice of Refraction Fee's

This notice is required by Medicare to inform you that this service will not be paid by Medicare or most insurance company's.

A Manifest Refraction is the measurement of the eye that is required to determine an eyeglass prescription. Many people know this as the "Which is better…" game. The refraction can also give the eye doctor information about the health of the eye. A Refraction may be performed for a variety of purposes other than to issue an eyeglass prescription.

The medical portion of your exam will be performed, as usual, regardless as to whether or not you opt to have the refraction. In other words, the doctor will still be assessing the health of your eyes in the usual manner, which may include having your eyes dilated.

Regardless of the reason the Refraction is done, Medicare and most insurance company's do not pay for it. It is not a covered benefit.

Our fee for a Refraction is $40.00. This will be due and payable on the day of your visit.

You have the right decline to have the Refraction performed. However, this may limit the doctors' ability to fully assess the condition of your eyes in some cases. Please be aware that if you DO want a prescription for eyeglasses, the Refraction is the ONLY way to measure for this.

Yes, I understand that my insurance company may not pay for this service. I understand that I will be required to pay for this on the date of service. I agree to be personally and fully responsible for payment.

I understand that the refraction is the only service this refers to, and that all medically necessary testing will still be performed and billed to my insurance carrier as usual. I understand that if I do NOT have a Refraction, it may limit the doctors' ability to fully assess the health of my eyes, and I will not get a prescription for glasses.

_____ _____

Patient Signature (or person acting on patient's behalf) Todays' Date

_____ _____

Print Patient Name Patient Account #