ABC CHILDREN'S EYE SPECIALISTS **Account Number: __________**

Patient's Name: _________________________________ Age: _____ Birth Date: _____________

How did you first hear about ABC Children's Eye Specialists?
□Primary Care Physician □Family friend □Family members seen here □Insurance company
□School referral □Found us online - Please circle one: Google / Yelp / Facebook / HealthGrades
□Phoenix Magazine □Other: ____

Birth History

Gender: M___ F___
Birth weight: _________ Gestation:_________ APGAR Score: _________
Normal vaginal delivery: _____ Cesarean Section: _____ Twin: ______
Foster care: _____ Adopted: _____
How long was that first stay at the hospital? Was there any oxygen treatment?
____
Any problems during pregnancy?
____
Any problems during delivery?
____

Medical History

Primary Care Doctor:______________________ Phone #:_______________ Fax #:_______________
Has the patient been diagnosed with any medical problems? _________________________________
____
Any convulsions/seizures? ___________________
List of medications taken daily and for WHAT condition? __________________________________
____
Allergies to medications? ____
Other known allergies? ____

Vision History

Date of last eye exam? _________ Examining doctor:____________________
Glasses?_______ Age of first glasses?________ Full-time use:_______ Reading only: ______
Any ocular surgeries in the past? ____
Use of patching in the past?______ Include which eye, for how long each day and total
duration:____
Any previous ocular disease diagnosis or problems? _____________________________________
____
Family member with ocular disease diagnosis? ____
Family member who uses glasses? ____
Other family members treated here at ABC? ____

School Information

Grade: ________ Name of School: ____
Is the patient receiving speech/occupational/physical therapy?_______ Include frequency:
____
Does the patient have special accommodations at school?_______ What kind?
____
Does the patient have a teacher for the visually impaired? Include the name:
____

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Medical History Questionnaire - Review of Systems

Does the patient have, or has ever had any of the following? If Yes, please indicate when diagnosed:

AIDS/HIV Positive	______ Yes	______ No
Anemia	______ Yes	______ No
Asthma	______ Yes	______ No
Blood Disease	______ Yes	______ No
Blood Transfusion	______ Yes	______ No
Breathing Problem	______ Yes	______ No
Bruises Easily	______ Yes	______ No
Cancer	______ Yes	______ No
Cold Sores/Fever Blisters	______ Yes	______ No
Convulsions	______ Yes	______ No
Diabetes	______ Yes	______ No
Epilepsy or Seizures	______ Yes	______ No
Excessive Bleeding	______ Yes	______ No
Excessive Thirst	______ Yes	______ No
Fainting Spells/Dizziness	______ Yes	______ No
Headaches	______ Yes	______ No
Double Vision	______ Yes	______ No
Hepatitis A	______ Yes	______ No
Hepatitis B or C	______ Yes	______ No
High Blood Pressure	______ Yes	______ No
Hypoglycemia	______ Yes	______ No
Irregular Heartbeat	______ Yes	______ No
Leukemia	______ Yes	______ No
Liver Disease	______ Yes	______ No
Lung Disease	______ Yes	______ No
Thyroid Disease	______ Yes	______ No
Weight Loss	______ Yes	______ No
Sickle Cell Disease	______ Yes	______ No
Tonsillitis	______ Yes	______ No
Tuberculosis	______ Yes	______ No
Tumors	______ Yes	______ No
Jaundice	______ Yes	______ No
Other	______ Yes	______ No

Please list family members with any of the above diagnosis:_______________________________

Reviewed by: ____ Date:_________________

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Patient Insurance and Financial Responsibilities

I understand I am expected to provide ABC Children's Eye Specialists with ALL of my MEDICAL insurance information. This includes any secondary plans such as AHCCCS. I also understand I will provide ABC Children's Eye Specialists with the correct information.

I understand I am expected to pay for services at the time services are rendered. Depending on my insurance plan this may be payment in full, co-payment, deductible amount and/or co-insurance.

If I am a self-pay patient, I understand payment is expected to be made <u>in full at the time of service.</u>

- **$150 for a new patient visit**
- **$100 for an established patient visit**
- **$50 for any special testing (Visual Fields, OCT's, etc.)**

If my insurance is a managed care plan and/or any AHCCCS plan, it is my responsibility to be sure that all necessary referrals or authorizations are obtained prior to my appointment. Although we will do our best to obtain your auth/referral, it is still **your** responsibility. If the appropriate referral or authorization is NOT obtained, my appointment will be cancelled until the information is obtained.

I understand that even if services may be pre-authorized, not all services may be covered or paid by my insurance plan. These services may include visual fields, refractions and sometimes even office visits.

I understand that I am financially responsible for any charges incurred by me. I also understand that any appropriate fees will be added to my account balance if you are forced to send my account to an outside collection agency to collect payment.

- I understand that I will incur a $50.00 rescheduling fee after 2 no shows of regular office visits. A 24 hour notice must be given in order to avoid this fee.
- I understand I will incur a $100.00 rescheduling fee for any pre-operative appointment that is rescheduled without medical necessity and a note from a physician.
- I understand I will incur up to a $250 rescheduling fee for any surgery that is rescheduled without medical necessity and a note from a physician.

Printed Patient Name: ____

Guardian Signature: ____

Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

How we may use and disclose information about you

- Medical treatment information to doctors, nurses, technicians, medical students or hospitals personnel who are involved in your care. We also may discuss your medical information with you, your family members, or other personal representatives authorized by you or by a legal mandate.
- Medical information about you for services and procedures so they may be billed and collected from your insurance company or any other third party and to obtain prior authorization.
- Information about you to auditors, billing companies to comply with legal requirements or for internal or external utilization review.
- We may ask you to sign in the front desk on the day of your appointment. We may contact you by phone, in writing, e-mail or on an answering machine to remind you of an appointment or to discuss test results or other health information.

Use and disclosure of your health information in certain special circumstances The following circumstances may require us to use or disclose your health information without your consent:

- To public health authorities and oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
- If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions of law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For workers compensation or similar programs.

Your rights regarding your health information

- Communications: you can request that our practice communicate with you about your health and other related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
- You can request a restriction in our use or disclosure or your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your

request; however, if we do agree, we are bound by our agreement when otherwise required by law, in emergencies, or when information is necessary to treat you.

- You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records.
- You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice.
- Right to a copy of this notice: you are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice, any time. To obtain a copy of this notice, please contact our office at the address listed above.
- Right to file a complaint: if you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact our office.
- Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or health information privacy policies, please contact our office at the address above.

I hereby acknowledge that I have been presented with a copy of ABC Children's Eye Specialists Notice of Privacy Practices and consent to the use and disclosure of medical information as listed in this form.

Patient Name____

Parent/Guardian Signature ____

Relationship_____________________ Date__________________

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Patient Photos

At ABC Children's Eye Specialists, we try to provide the best service possible to all of our patients. Having patient photos included in the patient charts is just one of the ways.

By signing below I agree that pictures of my child will not be used for any other purposes other than for their medical record at ABC Children's Eye Specialists.

______________________________	______________________________
Patient Name	Account Number
______________________________	______________________________
Parent/Guardian Signature	Date

ABC CHILDREN'S EYE SPECIALISTS **Account Number: __________**

Records Release

I, ____________________________________, authorize and request release of complete medical records of patient ___________________, that was born on ___________________ in your possession to:

ABC CHILDREN'S EYE SPECIALISTS

Date: ____________________

____
Signature of Parent/Guardian