ABC CHILDREN'S EYE SPECIALISTS

Account Number:_____

Today's Date: _____

Patient Name:_____ Age:_____ Birth Date:_____

How did you first hear about ABC Children's Eye Specialists? Please circle all that apply.

Primary Care Physician Family friend Family member seen here Insurance company School Referral

Found us online - Please circle one: Google / Yelp / Facebook / HealthGrades / Phoenix Magazine

Other: _____

Birth History

Gender: Male ____Female____

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? _____ If yes, 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? _____ If yes, include type and frequency:

_____

Does the patient have special accommodations at school? _____ What kind? _____

_____

Does the patient have a teacher for the visually impaired? If yes, 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:
Please include family members with any of the listed diagnosis

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

Reviewed by: _____Date: _____

Account Number:_____

Today's Date: _____

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 in full at the time of service.

- **$225 for a new patient visit**
- **$150 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 authorization/referral, it is still **your** responsibility. If the appropriate referral or authorization is **NOT** obtained, my appointment will be canceled 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 $75.00 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.
- I understand that ABC Children's Eye Specialists **ONLY** bills medical insurance for in office appointments. ABC Children's Eye Specialists does **NOT** bill vision insurance.

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 our 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 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 of 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.

Account Number:_____

Today's Date: _____

- 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. 1010 E. McDowell Road, Suite 301, Phoenix, AZ 85006. 602-222-2234
- 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 you 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.

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: _____

Account Number:_____

Today's Date: _____

Patient Photos

At ABC Children's Eye Specialists, we try to provide the best services 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

_____ _____

Parent/Guardian Signature Date

ABC Children's Eye Specialists

Brendan Cassidy, MD | Rasha Barham, MD | Emily Shortridge, MD | James Plotnik, MD
Nicholas Silvestros, OD | Julia Sewell, OD | Lois Filipelli, OD | Monica LaDouceur, OD
Sara Sillik, OD | Alexa Saul, OD | Jeanette Stromme, OD | Andrew Abela, OD
Christopher Johnson, OD | Julie McCutcheon, OD | Lotus Schifsky, OD | Heba Al-Baiaty, CO

Pediatric Ophthalmology and Strabismus

Account # _____

Records Release

I, _____ authorize and request release of complete medical records of patient _____ that was born on _____.

Records From: _____

Address: _____

Phone: _____

Fax: _____

Records To: _____

Address: _____

Phone: _____

Fax: _____

Signature of Parent / Guardian: _____

Date: _____