Patient Name: _____

Chandler EYE Center

Robert C. Davidson, M.D.

PATIENT INFORMATION:

PATIENT'S NAME:

Last Name _____First Name _____ Middle Initial____

SEX: Male ___ Female ___ DATE OF BIRTH: ____/____/____ SSN: _____

ADDRESS _____APT. #_____

CITY _____STATE _____ ZIP CODE _____

PHONE NUMBER: PRIMARY_____SECONDARY _____

E-MAIL _____ LANGUAGE: English ___ Spanish ___ Other ___

MARITAL STATUS: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

ETHNICITY: Hispanic or Latino ___ Not Hispanic or Latino ___ Unknown ___ Decline___

RACE: White ___ African American___ Native American___ Asian___ Other ___ Decline___

PRIMARY CARE DR._____PHONE #_____

PREFERRED PHARMACY _____ PHONE # _____

EMERGENCY CONTACT_____PHONE #_____

HOW DID YOU HEAR ABOUT US?_____

EMPLOYER_____OCCUPATION_____

Patient Name: _____

Chandler EYE Center

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RESPONSIBLE PARTY INFORMATION (If NOT the patient):

Last Name _____ First Name _____Middle Initial _____

Sex: Male ___ Female ___ Date of birth: ____/____/____ SSN: _____

Address _____APT./UNIT #_____

City _____State_____ Zipcode _____E-Mail_____

Phone Number: Primary _____Secondary _____

Language: English ___ Spanish ___ Other ___ Relationship to Patient: _____

PRIMARY INSURANCE:

Name of Insurance Co.:_____Policy # _____

Policy Holder's Name:_____Group #_____

Relationship to Patient:_____ Date of Birth: ____/____/____

SECONDARY INSURANCE (If Applicable):

Name of Insurance Co.:_____Policy # _____

Policy Holder's Name:_____Group #_____

Relationship to Patient:_____ Date of Birth: ____/____/____

MEDICARE PATIENTS ONLY:

(12) Working Aged _____ (13) End Stage Renal Disease _____ (14) Auto No Fault Insurance _____

(15) MSP Workers Compensation _____ (16) Federal _____ (41) Black Lung _____ (42) VA _____

(43) Disability Insurance _____ (47) Other/Liabilities _____

Patient Name: _____

Chandler EYE Center

Robert C. Davidson, M.D.

OFFICE POLICIES AND PROCEDURES

Thank you for choosing Chandler Eye Center as your vision care provider. We are committed to providing you with the best possible care.

REQUIRED AT CHECK IN:

- Verify/Update contact information
- Current medical insurance card
- Current valid picture ID
- Any co-payment and/or outstanding balance

CO-PAYMENTS

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. If you do not have your co-payment, your appointment may be rescheduled.

INSURANCE

While, filing insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date services are rendered. In order for us to file a claim on your behalf, you must present a CURRENT copy of your insurance card(s) at each visit and communicate any changes in your personal information.

Not all services are a covered benefit, so it's very important that you understand the provisions of your individual policy. You are responsible for the unpaid balance of your visit including deductibles, coinsurance, and non-covered services.

MISCELLANEOUS CHARGES

Return check fee: $25.00. Motor vehicle/FAA Paperwork: $25.00. Medical Records (paper copies): $0.25 per page. Accounts 90 days past due may be sent to a collection agency & have a 33% surcharge added to cover additional costs along with possible removal from the practice.

Printed Name: _____

Signature: _____ Date: ____/____/____

Patient Name: _____

Chandler EYE Center

Robert C. Davidson, M.D.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our notice before signing the acknowledgement. By signing this form, you acknowledge that you had the opportunity to review the Chandler Eye Center Notice of Privacy Practices describing the use and disclosure of protected health information about you for treatment, payment, health care operations, and other uses and disclosures as stated in our Notice. We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION UPON REQUEST

I, _____, give my permission to disclose protected health information from my health record, including financial information, to the following people:

Name (s): _____

Patient Signature _____Date _____/_____/_____

AUTHORIZATION TO ASSIGN BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize and request that the payment of Medicare and/or insurance benefits be made directly to Chandler Eye Center. If my health insurance will not allow direct payment to Chandler Eye Center or if Chandler Eye Center chooses not to accept assignment of medical benefits, I agree to immediately forward to Chandler Eye Center any and all health insurance payments I receive. This also applies if coverage is provided by Medicare, a Health Maintenance Organization, a Worker's Compensation policy, or any other third-party payers. **I acknowledge that I am responsible for all charges for services provide by Chandler Eye Center, including any non-covered services or amounts not paid by insurance.**

Printed Name: _____

Signature: _____Date: _____/_____/_____

Relationship to Patient (If other than patient): _____

AUTHORIZATION FOR TREATMENT

I authorize the health care providers at Chandler Eye Center, to perform diagnostic procedures and treatments as may be necessary for proper medical care for myself or dependent.

Printed Name: _____

Signature: _____Date: _____/_____/_____

Relationship to Patient (If other than patient): _____

Patient Name: _____

Chandler EYE Center

Robert C. Davidson, M.D.

TO OUR PATIENTS

IMPORTANT INFORMATION

ABOUT NON-COVERED/OUT OF POCKET EXPENSES

Refraction/Eyeglass Prescription Policy

A refraction is the process to measure the refractive error of the eyes. This measurement is used to determine your eyeglass and/or a contact lens prescription. Medicare considers this a **non-covered service**, as do most insurance companies. It is the policy of Chandler Eye Center to only charge the fee if an eyeglass or contact lens prescription is being provided to the patient. The following are the fees associated with the Refraction Policy:

- **Eyeglass Prescription: $50.00**
- **Contact Lens Fitting: $50.00**

Fees are collected on the day of service. Should your insurance cover this refraction process, we will reimburse you after payment has been received from the insurance company.

A refraction is **not** required. If you prefer not to have a refraction performed, please inform the technician.

By signing this form, I am stating that I have read and understand the above policy.

Signature: _____Date: ____/____/____

Patient Name: _____

Chandler EYE Center

Robert C. Davidson, M.D.

Health History Questionnaire

Date of last eye exam: _____

Do you have any allergies to medications or substances (including latex)? YES NO

If yes, please specify: _____

Social History

Do you drink alcohol? YES NO If yes, how much? _____ How often? _____

Do you use tobacco? YES NO FORMERLY If yes, how much? _____

If formerly, how long? _____ When did you stop? _____

Please list ALL current medications (Prescription/Non-Prescription)**:**

Name Dosage Route of Administration

_____
_____
_____
_____
_____
_____
_____

Please provide your surgical history (Procedures and Dates)**:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Chandler EYE Center

Patient Name: _____

Eye Health History

Please indicate if the current or past health issue pertains to yourself, family, or N/A:

	SELF	FAMILY	N/A
Cataract			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Strabismus (Eye Muscle)			
Amblyopia			

General Health History (For yourself only)

	YES	NO	Additional Info
Diabetes			
Thyroid Problems			
High Blood Pressure			
Pacemaker			
Irregular Heartbeat/A-fib			
Shortness of Breath			
Asthma			
Hearing Impairment			
Joint Pain			
Arthritis			
Back Problems			
Headaches			
Stroke			
Allergies			
Blood Disorders			
Cancer			
Intestinal Problems			
Fatigue			

Patient/Guardian Signature: _____ Date: ____/____/____

Patient Name: _____

Chandler EYE Center

Robert C. Davidson, M.D.

CANCELLATION/NO SHOW POLICY

Thank you for trusting Chandler Eye Center as your vision care provider. When an appointment is scheduled with Dr. Davidson, time is set aside to provide the highest quality eye care. However, we do understand that unexpected circumstances may arise. Should you need to cancel or reschedule an appointment, please promptly contact our office. A timely cancellation allows us an opportunity to provide care for another patient.

WE REQUIRE A 24 HOUR NOTICE FOR CANCELLATIONS OR RESCHEDULING

- 1ST No Show or Cancellation without sufficient notice: $50.00
  - This fee is not covered by your insurance.
  - This fee will be due upon scheduling your next visit. (If there are extenuating circumstances, the fee may be waived.)

- 2nd No Show or Cancellation without sufficient notice: $75.00
  - This fee is not covered by your insurance.
  - This fee will be due upon scheduling your next visit. (If there are extenuating circumstances, the fee may be waived.)

- 3rd No Show or Cancellation without sufficient notice:
  - Chandler Eye Center reserves the right to terminate its doctor/patient relationship with you. We value our patients and it would grieve us to take these steps.

By signing this form, I am stating that I have read and understand the above policy.

Signature: _____ Date: ____/____/____