Welcome To Our Office | Family Eyecare of Roswell | Maurice E. Zadeh, Optometrist & Associates

To help us better serve you, we ask that you please fill in the information requested below. Thank you.

Patient Demographic Information: (Required Fields)

Name: _____ **Gender:** M F
Last First MI Preferred

Primary Language: _____ **DOB:** _____ _____
Month / Day / Year Age

Race: African / Australian / Caucasian / Chinese / Japanese / Korean / Other: _____

Ethnicity: African American / Asian American / Hawaiian/Pacific Islanders / Hispanic/Latino
Middle Eastern / Multiracial / Native American / White American / Other: _____

Additional Family Members:

Name: _____ **Gender:** M F
Last First MI Preferred

Primary Language: _____ **DOB:** _____ _____
Month / Day / Year Age

Race: African / Australian / Caucasian / Chinese / Japanese / Korean / Other: _____

Ethnicity: African American / Asian American / Hawaiian/Pacific Islanders / Hispanic/Latino
Middle Eastern / Multiracial / Native American / White American / Other: _____

Name: _____ **Gender:** M F
Last First MI Preferred

Primary Language: _____ **DOB:** _____ _____
Month / Day / Year Age

Race: African / Australian / Caucasian / Chinese / Japanese / Korean / Other: _____

Ethnicity: African American / Asian American / Hawaiian/Pacific Islanders / Hispanic/Latino
Middle Eastern / Multiracial / Native American / White American / Other: _____

Patient Contact Information: (Required Fields)

Preferred Method of Contact:

Postal / Email / Cell # / Work #

Address: _____
Street APT

_____
City State Zip

Email: _____
Home / Work

Cell: ( ) Texting okay? Yes ☐

Work: ( )

Relationship to Patient: Self / Spouse / Parent / Other: _____

Referred by: _____
Insurance / Patient / Doctor / Website / Google / FB

PCP: _____ ( ) _____
Name Phone Address

Emergency Contact: _____ ( )
Name Phone Number

Pharmacy: _____ ( )
Name / Address Phone Number

Guarantor: _____ ☐ Same as Pt ( )
Last Name First Name Phone Number cell / work

Does the guarantor live with patient? Y / N If no, list address: _____

**** Guarantor is the person finanically responsible for all balances on this account.** **Today's Date:** _____

_____ _____
Patient Name (Print) **Patient / Guarantor Signature (under 18)**

Family Eyecare of Roswell

Maurice E. Zadeh, Optometrist & Associates

Insurance Billing Information

- This form is for finanical obligation purposes. All fields MUST be completed in order to file a claim on your behalf.
- Failure to provide the following information will result in self payment of your office visit today.
- Presentation of your Insurance Cards and a valid Driver's License, or valid photo ID Card, are required at your visit.
- If you are not using insurance today, the "Primary Insurance" section must still be completed and a valid Driver's License or valid photo ID Card must be presented.

Patient & Primary Insurance Information

Patient: _____ (Last / First / MI) Gender: Male | Female (circle one)

DOB: _____ (Month / Day / Year) SSN: _____ (Full SSN) Email: _____

Primary: _____ (Last / First / MI) Gender: Male | Female (circle one)

DOB: _____ (Month / Day / Year) SSN: _____ (Full SSN) Email: _____

Address: _____ (Street Number & Name) Employer: _____

_____ (City / State / Zip Code) Relationship to Patient: Self / Spouse / Parent (Circle One) Other:

Vision Plan Name: _____ ID# _____ Phone # _____

Second Vision Plan: _____ ID# _____ Phone # _____

Medical Plan Name: _____ ID# _____ Phone # _____

Secondary Medical: _____ ID# _____ Phone # _____

**** The insurance information that you provide on the day of service will be used to file your insurance claim(s).**

- If you would like a specific plan to be utilized for your visit, you must indicate which plan before you check out that day.
- All insurance claims are processed on the date of service, it is vital that we have the correct insurance information on file. If you request to have your office visit resubmitted or canceled and/or filed to a different insurance carrier after services have been rendered, **there will be a $50 fee for each claim processed.**

I am authorizing that the information I provided on this form is current and correct. I understand that any services provided to me that are not paid by my insurance carrier are my, or the guarantor's, finanical responsibility.

_____ Print (Patient Name)

_____ Print (Guarantor Name)

* Guarantor is the person responsible for account balances.

_____ Patient or Guarantor's Signature

_____ Today's Date

Family Eyecare of Roswell Financial Policy

Patient Name (print) Date

Please initial each section indicating that you have read and understood our financial policy agreement.

Insurance Coverage

You must provide your insurance card or proof of insurance at the time of each visit. If you do not have insurance, are unable to provide proof of insurance, are on a plan in which we do not participate, or if your plan requires that a deductible be met before services will be covered, full payment is required at the time of your visit.

It is very important that you become familiar with your insurance plan and understand its benefits. Some plans have restrictions on certain services such as contact lens evaluations and special medical testing. It is your responsibility to be aware of any restrictions or limitations on your plan. If you have questions regarding your coverage and payment determination, then you need to contact your insurance company directly.

Verification of benefits is not a guarantee of payment. All claims are subject to review by your insurance company. All co-payments and co-insurance fees are due at the time of service. Some of the services provided may not be covered by your plan and therefore not paid by your insurance company. You are personally responsible for these services. You will also be responsible for all balances your insurance carrier does not pay within 90 days. You will receive a bill which must be paid upon receipt.

_____ (initial)

Professional Services / Eyeglass / Contact Lens Purchases

**** No refunds will be issued for professional services, eyeglasses or opened contact lenses. ****

1. Eyeglass Lenses are customized and cannot be returned. However, if you believe an error was made with your eyeglass prescription, the doctor must re-check your prescription within 60 days of your original exam and we will remake your eyeglasses at no additional cost to you. ** Some fees may apply if upgrades are made to your order.

- If you are having trouble with your new eyeglasses, it is your responsibility to inform our optician so that we can address your concerns. All errors or changes to your eyeglass order must be corrected within the time frame we are given from our labs; 60 days. If you have not adjusted to your eyewear within the first 1 – 2 weeks of receiving them, you need to communicate this with our Optician.

- If you are having problems with your eyeglasses and it has been more than 3 months (90 days) since your exam and refraction, we will have to recheck your refraction; this procedure is $45.

- Orders cannot be remade free of charge after 90 days, regardless of what the problem is. Orders that require remakes after 90 days will be charged half of the original retail cost of the lenses.

2. Frame changes (Re-Styles). We want each of our patients to be happy and comfortable with their frame selection. Sometimes the initial frame that was chosen does not work. Whatever the reason may be, we can change your frame once. However, there is an additional expense to do this depending on the type of lenses you wear. The Optician can go over these fees with you when applicable.

Single Vision Lenses – $40 | Bifocal or Trifocal Lenses – $60 | Progressive Lenses – $80

3. Defective Frames. Frame manufacturers provide a 1-year warranty for defects only. If your frame breaks, do not alter it in any way; doing so will void a defective warranty and will make it very difficult to repair. Do not ever use glue to try and fix your frame. Defects to a frame are subject to review by the individual frame company, not our office.

** **If your frame is defective, Family Eyecare of Roswell will be happy to exchange your frame with the manufacturer for a $30 fee. This fee covers the expenses associated with reordering, replacing and returning your original frame to the manufacturer.** If your frame breaks and is not under warranty, you will be responsible for the costs associated with the replacement, and/or parts. All frames are subject to availability from the manufacturer.

4. Contact Lenses. Do not write on boxes of contact lenses. Once the box has been altered (including opening, writing, or marking on the box) they cannot be returned to the manufacturer and you cannot receive a credit. After 60 days contacts cannot be exchanged. If you feel that your prescription for contact lenses needs to be adjusted, we will be happy to re-check your contact lens fitting within 90 days free of charge. After this time period the doctor will have to perform a new contact lens fitting and you will have to pay the fees associated with the level of fitting your contact lenses require.

** Any orders for eyeglasses or contact lenses that have not been paid in full at the time of service must be paid for and picked up within 60 days of the purchase. After 60 days, all deposits made will be forfeited. No refunds or in-store credits will be issued.

** Please note: If you cannot pay your balance within this time period, please contact our billing department to make payment arrangements to avoid forfeiting your deposit.

_____ (initial)

Payment Procedures & Methods

All co-payments, deductibles and balances owed are due at the time of service. **These fees by law cannot be waived.** We accept Cash, Personal Checks, Visa, Discover, MasterCard, American Express and Care Credit.

** Please note: If you have a returned check, you will be charged a fee of $25 and may be asked to leave the Practice. Any unpaid balances will be subject to referral to a collection agency.

_____ (initial)

Referrals

If you are being seen for a medical service and your plan requires a referral to see a specialist, you are responsible for requesting a referral from your Primary Care Physician (PCP) before services are rendered. Your PCP may require 24 or more hours for this request. Once services have been rendered you will be responsible for any unpaid fees.

_____ (initial)

Missed Appointments / Canceling Appointments

Late or missed appointments seriously disrupt the practice's patient schedule. Therefore, we ask that you please give us a 24-hour notice when canceling or rescheduling an appointment. If you fail to show for an appointment 2 or more times, your account will be put on a 'walk-in basis only' for future visits. Walk-in appointments are seen upon availability.

_____ (initial)

Delinquent Accounts

Past due payment arrangements can be made with our billing department. Failure to pay or arrange payments will result in a referral to a collection agency. Habitual delinquent accounts may be dismissed from our practice.

**Please note: Patient balances over 90 days will require payment in full or payment arrangements with our billing department prior to scheduling any appointments at our office. Your records will not be released until unpaid balances have been satisfied.

_____ (initial)

Patients under 18 Years of Age

All patients under 18 must be accompanied by a parent or legal guardian. Services cannot be performed without a parent or legal guardian's presence and consent.

_____ (initial)

The original copy of this financial policy will be kept in your file for future reference. If you would like a copy for your records, please ask the front desk coordinator to provide you with a copy. We welcome any questions you may have regarding our financial policy.

Notice of Privacy Practices

Effective: 2018

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions please contact our office.

We are required by law to:

-Maintain the privacy of your protected health information;

-Give you this notice of our duties and privacy practices regarding health information about you;

-Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non-health related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for

contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. ***Law Enforcement.*** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials, so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. ***We are not required to agree to all such requests.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.familyeyecareofroswell.com. To obtain a paper copy of this notice please request it in writing.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

I acknowledge having been provided this Notice.

Signature: _____ Date: _____