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: ______________________ **Ethnicity:** ______________________

Patient's Medical History: (Required Fields)

Yes — Any immediate family members with conditions:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Eye Injuries
- ☐ Eye Surgery
- ☐ Dry Eyes / Watery Eyes
- ☐ Amblyopia (Lazy Eye)
- ☐ Strabismus (Crossed Eyes)
- ☐ Color Vision Problems
- ☐ Sinus Problems
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Seasonal Allergies
- ☐ Drug Allergies
- ☐ Thyroid Problems

Please list ALL current medications:

- ☐ Do you have headaches?
- ☐ Are you light sensitive?
- ☐ Do you wear sunglasses?
- ☐ Do you use a computer or other electronics? If yes, how many hours do you spend in front of a screen daily? ______
- ☐ Do you use tobacco?
- ☐ Do you consume alcohol on a frequent basis?
- ☐ Do you use other substances?

Patient Contact Information: (Required Fields)

Address: ______________________________
Street APT

____
City State Zip

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

PCP: ______________________ ( )
Physician or Practice Name Phone

Pharmacy: ______________________________
Name / Address

Emergency Contact: ______________________________
Name

Preferred Method of Contact:

Email / Work / Cell - Is Texting okay? ☐

Email: ______________________
Recall & Office Communications

Cell: ( )

Work: ( )

Employer: ______________________

( )
Phone Number

( )
Phone Number

______________________ **Patient Name (Print)**

______________________ **Patient Signature / Guardian Signature (under 18)**

Family Eyecare of Roswell

Maurice E. Zadeh, Optometrist & Associates

Insurance & Billing Information

- This form is for financial 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: (required fields)

Patient: ______________________________ Gender: Male | Female

Last First MI (circle one)

DOB: ____________ SSN: ____________ Relationship to Insured: Self / Spouse / Child

Month / Day / Year Full SSN (Circle One) Other: ____________

**** Please note: The "Primary Insurance Policy Holder" is considered the Guarantor on this patient's account.**

(The Guarantor is the person who will be held financially responsible for all balaces on this account.)

Primary: ______________________________ Gender: Male | Female

Last First MI (circle one)

Address: ______________________________ DOB: ____________

Street Number & Name Month / Day / Year

______________________________ SSN: ____________

City State Zip Full SSN

Vision Plan: ID# Phone #

Vision Plan (additional): ID# Phone #

Medical Plan (Primary): ID# Phone #

Medical Plan (Secondary): 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 claim resubmitted, canceled and/or filed to a different insurance carrier after the claim has been submitted, **there will be a $50 fee for each reprocessed claim.**

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, financial responsibility.

______________________________ ______________________________

Print (Patient Name) Print (Guarantor Name)

______________________________ ______________________________

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.

Professional Services / Eyeglass / Contact Lens Purchases

- No refunds will be issued for professional services, eyeglasses or opened or damaged boxes of contact lenses.

- All balances on material orders (eyeglasses and contact lenses) must be paid for in full within 60 days of the purchase. After 60 days, all deposits made will be forfeited. No refunds or in-store credits will be issued.

1. **Eyeglass Lenses are customized and cannot be returned**. 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 eyeglass lenses at no additional cost to you. ** Fees may apply if upgrades are made to your order.

- If you have not adjusted to your eyewear within the first 1 – 2 weeks of receiving them, please call our office and speak with an Optician. It is your responsibility to communicate your concerns to our Opticians.

- If you are having problems with your eyeglasses and it has been more than 2 months (60 days) since your exam and refraction, we will have to recheck your refraction; this procedure is $49.

- 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. ** Fees apply to this request.

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

3. **Defective Frames.** Frame manufacturers provide a 1-year warranty for <u>defects only</u>. If your frame breaks, do not attempt to repair it or alter it in any way, doing so will void a defective warranty and will make it very difficult to repair.

- 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.

_______________ (initial)

4. **Contact Lenses.** <u>Do not write on boxes of contact lenses.</u> Once the box has been altered (including opening, writing, or making any marks on the box) they cannot be returned to the manufacturer and you cannot receive a credit.

5. **Contact Lens Fittings.** Our office allows a 60-day window to fit patients in contact lenses. It is the patient's responsibility to return for progress checks and have any necessary adjustments made to their prescription within this time-frame. If changes need to be made after the prescription has been finalized or after the allotted 60 days, a modification fee may apply.

_______________ (initial)

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.

Verification of benefits is not a guarantee of payment. All claims are subject to review by your insurance company.

_______________ (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 not pay with a check for future payments. Any unpaid balances will be subject to referral of a collection agency.

_______________ (initial)

Medical Referrals

If you are being seen for a medical service and your insurance plan requires a referral to see a specialist, you are responsible for requesting a referral from your Primary Care Physician (PCP) before we render services. Your PCP may require 24 or more hours for this request.

_______________ (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 referral to a collection agency. Habitual delinquent accounts may be dismissed from our practice.

**Please note: Patient balances over 90 days will require payment prior to scheduling any appointments at our office. 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

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 01/01/2018, and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices, provided law permits the changes. You may request a copy of our Privacy Notice by asking our staff in person or contacting our office.

We will keep your protected health information (PHI) confidential, using it only for the following purposes:

Treatment: We may share your PHI, including electronic protected health information (ePHI), with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment.

Payment: We may use and disclose your PHI to seek payment for services we provide to you. This disclosure involves our office staff and may include insurance organizations, collections, or other third parties that may be responsible for such costs.

Health Care Operations: We will use and disclose your PHI to keep our practice operable. Examples of personnel who may have access to this information may include, our staff, insurance operations, clearinghouses and individuals performing similar activities.

Appointment Reminders, Treatment Alternatives and Services: We may use your health records to remind you of recommended services, treatment alternatives or scheduled appointments.

Emergencies: We may share your PHI to notify, or assist in the notification, of a family member or anyone responsible for your care, in case of an emergency involving your care, your location or your general condition. When possible, we will provide you with an opportunity to object to this disclosure, however, in an emergency, or if you are incapacitated, we will use our professional judgement to disclose only information that is directly relevant to your care. We will also use our professional judgment to allow someone to pick up prescriptions, other health information or supplies on your behalf, unless you have advised us otherwise.

Marketing: We will not use your PHI for marketing purposes unless we have your written authorization to do so.

Required by Law: We will disclose your PHI when required to do so by law. Some examples include: court or administrative orders, subpoena, requests by national security, intelligence or other State or Federal officials, or other lawful purposes.

Your rights regarding your PHI:

You have the right to inspect and copy your PHI or ePHI, to amend your PHI if you feel something is incorrect or incomplete, to request an accounting disclosure, to request restrictions regarding your PHI, to request confidential communications, to receive a paper copy of this Notice, and to receive notice if there is a breach of privacy or if your PHI is used improperly.

Complaints:

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. All complaints must be submitted in writing. You may also file a complaint to the Department of Health and Human Services. You will not be penalized for filing a complaint.

____

Name of Patient (Please Print)

____

Signature of Patient or Guardian **Date**

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