Arizona Retina & Vitreous Consultants, LLC
Patient Information Form

Last Name: First Name:	MI:	Gender: (circle one) Male Female	Date of Birth: SS#

Mailing Address:	City:	State:	Zip:
Physical Address: (If different):	City:	State:	Zip:

Primary Phone: Please circle one: Home / Work / Cell	Secondary Phone: Please circle one: Home / Work / Cell	Email Address:

Preferred Language:	Ethnicity: (please select one) Hispanic Not Hispanic Decline To Answer	Marital Status:

Race: (please select)
American Indian/Alaskan Native Asian Black/African American White

Native Hawaiian/Other Pacific Islander Other Decline to Answer

EMERGENCY CONTACT

Name:	Relationship:
Phone Number:	May We Release Protected Health Information to This Individual: YES NO

Preferred Pharmacy:

Referring Provider: Name: _____ Phone Number: _____	Primary Care Provider: Name: _____ Phone Number: _____

INSURANCE INFORMATION
(please present insurance cards to the front desk)

Primary Insurance:		Secondary Insurance:	
Subscriber:	Relation:	Subscriber:	Relation:
Policy ID:	Group ID:	Policy ID:	Group ID:
Date of Birth:	Social Security#:	Date of Birth:	Social Security#:

RESPONSIBLE PARTY
(if different from patient)

Last Name:	First Name:	Social Security #:	Date of Birth:

Address:	Phone Number:	Email Address:
Gender:	Relationship to Patient:	May We Discuss Account Details With This Individual: YES NO

Do you have Veteran's Benefits: (circle one) YES NO

Are You Currently Living in a Nursing Center or Assisted Living Facility: (circle one)
YES NO

I give permission to Arizona Retina & Vitreous Consultants to mail appointment reminders, office updates, etc to my address on file: (circle one) YES NO

Assignment of Benefits

I hereby assign all money to which I am entitled for medical or surgical expense relative to the service reported herein, but not to exceed my indebtedness to said office. It is understood that any money received over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am responsible for any and all charges not covered by my insurance company.

SIGNED _____ DATE _____/_____/_____

ARIZONA RETINA & VITREOUS CONSULTANTS LLC
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that Arizona Retina and Vitreous Consultants LLC has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of their Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restricted restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient Signature: _____

Date: _____/_____/_____

Patient Representative Name: _____

Relationship to patient: _____

Patient Representative Signature: _____

Date: _____/_____/_____

You may give us permission to disclose your health information to a friend/ family member

Name: _____Relationship:_____

Phone Number: _____

ARIZONA RETINA AND VITREOUS CONSULTANTS LLC
INSURANCE COVERAGE POLICY

To accommodate our patients we have enrolled in numerous insurance plans. With your cooperation and our assistance you should be able to receive all of the insurance benefits to which you are entitled. Each plan has its own restrictions regarding where and how often service may be rendered.

It is your responsibility to understand your plan's guidelines and inform us of any special requirements or changes in your insurance. If a referral is required by your insurance, it is the patient's responsibility to have the referral prior to the appointment and prior to any procedures. Without a current referral, we may not be able to provide services and you may have to reschedule your appointment for another day.

All claims must be sent to your insurance company within a period of time determined by the insurance company. We send claims on a daily basis, making it imperative that you inform us of any new insurance or changes in coverage prior to receiving any services. Any time that you receive a new insurance card, please present it to the reception desk as there may be information that needs to be updated in our system in order to effectively process your medical claims. If we are not informed by you of changes in your insurance coverage in a timely manner, your insurance may deny the claims for failure to file in a timely manner. In this case payment for those services would then become your responsibility.

I understand that I am responsible for any and all charges not covered by my insurance company.

In the case in which collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred and a finance charge of 1% per month applied to any unpaid balance.

CONSENT FOR RELEASE OF INFORMATION

I consent to treatment necessary for the care of the patient mentioned below. I hereby authorize the release of medical information to physicians and to my insurance companies with the following exceptions, if any:

Patient Name: _____ PatientSignature:_____

Authorized SignerName:_____AuthorizedSignature:_____

Relationship to patient: _____ Today's Date:_____