GRAYHAWK
EYE CENTER, PLLC.

Name (Last, First): _____Middle Initial _____Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____ Circle One: Male Female

Social Security: _____ Height:_____ Weight:_____

GUARDIAN/SPOUSE INFORMATION

Name (Last, First): _____ Cell Phone: _____

Address (if different from above): _____

City: _____ State:_____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name (Last, First): _____ Cell Phone: _____

How did you hear about us? _____

What brings you in today? _____

_____

Date Last Eye Exam: _____Age of current glasses and/or contacts? _____

Please list ***eye medications*** currently taking: _____

_____

Referring Dr. _____Phone: _____

Primary Care Physician: _____ Phone: _____

Optometrist: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy #_____Group:_____

Secondary Insurance: _____Policy # _____ Group: _____

Preferred Pharmacy:_____Phone:_____

FAMILY HISTORY: In your family history, do any of the following apply? If so, who?

Macular Degeneration _____ Glaucoma_____

Diabetes_____ Other _____

Do YOU have any of the following eye concerns? (Please circle all that apply)

Blurred vision	Redness	Mucous Discharge	Foreign Body Sensation
Burning	Sandy/Gritty Feeling	Double Vision	Flashes/Floaters

Have you had any eye surgeries, including laser (Please circle all that apply)

Cataract	Glaucoma	Lasik/PRK	RK
Pterygium	Muscle surgery	Retina	Other: _____

Do you have any of the following issues (Please circle all that apply to you)

Diabetes	Heart Problems	High Blood Pressure	High Cholesterol
Chronic Bronchitis	Kidney Problems	Seizures	Shortness of Breath
Asthma	Bleeding disorder	Hepatitis	Tuberculosis
HIV/AIDS	Sinus	Dizziness	Chest Pain

Other:_____

Previous surgeries in your lifetime (include all even in childhood):

Pacemaker Heart Surgery Other:_____

_____

Allergic to any medications Yes No If yes _____

Please list all medications that you are currently taking:

_____

_____

PATIENTS RIGHTS AND RESPONSIBILITIES:

1. Release of information: I hereby give consent to Grayhawk Eye Center, PLLC., and Associates to release any information regarding my care and treatment as may be required by any insurance carrier for any portions of my bill, or needed be referring doctors or referrals
2. Responsibilities for payment/patient agreement: I understand that the doctors at Grayhawk Eye Center, PLLC and Associates are not responsible for deductibles made by any insurance company, government agency HMO/PPO plans, etc. I agree to pay any portion of fees charged by Grayhawk Eye Center, PLLC., and Associates for services rendered to me that are not covered by my insurance company.
3. Assignment of Benefits: I authorize my insurance company to assign benefits to Grayhawk Eye Center, PLLC., and Associates
4. I have read and understand the above

Patient/Guarantor Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Grayhawk Eye Center, PLLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Health Insurance Portability Act (HIPAA) is a federal law which maintains that patients' health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so, is subject to electronic disclosure.

How we may use & disclose your patient health information:

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, a nurse or medical assistant obtaining medical information about you and recording it in your medical record to determine the appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment.

Payment: We will use and disclose health information for payment purposes. For example, for obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. Example: sending a bill for your visit to your insurance company for payment.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging of legal services and to assess the care and outcomes of your case and others like it. **Special uses and disclosures:**

 We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voicemail, or through other methods.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request:

The right to request restrictions on certain uses and disclosures of your health information to family members, relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to such a restriction. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

The right to request restrictions on certain uses and disclosures.

In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies of your health information.

The right to amend your protected information.

The right to receive an accounting of disclosures of your protected health information. The right to obtain a paper copy of this notice form in unabridged text upon request.

The right to file a written complaint regarding the handling of your health information.

Complaints:

If you are concerned about violations to your privacy rights, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request.

If you have any questions, requests, complaints, please contact our Office Manager at 480-419-3937.

I have read this document and understand it. I acknowledge that I have received the *Notice of Privacy Practices* from the above-mentioned practice, and I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

_____ _____ _____

Print Name **Signature** **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form: _____

Relationship to Patient/ Print Name _____

Source of Authority: _____

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1. **What is a refraction?**

   Refraction is a diagnostic test and is the process of determining the eye's refractive error, or need for corrective glasses.

2. **Why is it sometimes necessary?**

   Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is especially important for children of all ages -- from infancy to teenagers -- to help us identify problems such as amblyopia (lazy eye) and strabismus (crossed eyes) as well as to determine why a child may have failed vision screenings at school or at the pediatrician or family practitioner's office. We must prove that your vision cannot be simply improved with a glasses prescription. ***As you can see a refraction is an essential part of an eye exam, however, Medicare and most insurance DO NOT cover it***. Some companies may provide reimbursement for this service, but most do not, therefore you will need to pay for this service on the day of your exam.

3. **Will I be notified in advance if I need it?**

   Yes, ONLY a technician or doctor is qualified to tell you if this procedure is necessary. They will let you know if this procedure is necessary BEFORE it is done. You will be given the option to accept or decline this service. IMPORTANT: If you decline, we may not be able to determine the cause for your decrease in vision.

4. **How much is it?**

   Our office policy is to charge $50 for this procedure in addition to the office visit copay and/or deductible. This is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. However, if your insurance pays the fee, we will gladly refund you this prepaid $50 amount once we receive notice from your insurance.

   NOTE: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and a new prescription will not be given. However, the fee covers the technician's and physician's time and effort in achieving this process.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in, the refraction fee.

_____	_____	_____
Print Name	Signature (Parent if minor)	Date