



Eye Physicians & Surgeons of Arizona

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Eye Physicians & Surgeons of Arizona for services furnished me by Dr. Reiss, Dr. Patel, Dr. Anspaugh & Dr. K. Patel. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents and information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Dr. Reiss, Dr. Patel, Dr. Anspaugh & Dr. K. Patel accepts the charge de-termination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in the item of the HCFA 1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eye Physicians & Surgeons of Arizona, is possible or otherwise me.

OTHER INSURANCE: As a courtesy, Eye Physicians & Surgeons of Arizona will bill all primary insurance coverage if he is a contracted provider. If they are not a contracted provider, I will pay for all services at the same time they are rendered. I authorize payment of my medical and surgical insurance benefits to Eye Physicians & Surgeons of Arizona. **I understand I am financially responsible for any charges whether or not paid by my insurance.** If co-payment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Physicians & Surgeons of Arizona. I authorize Eye Physicians & Surgeons of Arizona to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be in place of the original.

NON-COVERED SERVICES: I understand that Eye Physicians & Surgeons of Arizona contract with health care services plans (i.e., HMO's, PPO's) relates only to items and services which are "covered" by the health care service plans. These procedures may include, but are not limited to refractions. A refraction may be performed to verify whether or not my vision can be improved with a new prescription or whether surgery is indicated. A refraction is considered routine by Medicare and most other health care service plans. Accordingly, **I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered.**

FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Eye Physicians & Surgeons of Arizona, I will pay my account, including co-pay, deductible, and non-covered fees at the time service is rendered. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not pay a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to Eye Physicians & Surgeons of Arizona. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Physicians & Surgeons of Arizona.

- However, I understand that I am primarily responsible for the payment of my bill.
- **CO-PAYS AND NON-COVERED FEES ARE DUE AT TIME OF SERVICE!**

X _____ Date _____

Signature of Beneficiary or Authorized Party



Eye Physicians & Surgeons of Arizona

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

(PLEASE READ CAREFULLY & COMPLETE ALL SECTIONS)

The information below can only be released to the following persons (Family Members, Personal Representative, etc., NOT INCLUDING DOCTORS):

PRINT NAME/S

RELATIONSHIP

****Please check here if you DO NOT authorize anyone to have access or to discuss your account or medical information.****

All medical information, including but not limited to records pertaining to examination, treatments, consultations, billing records, x-rays and reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

Only the following types of information:

.....
I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

Until revoked in writing.

I know that I am entitled to receive a copy of this agreement.

Name: _____

Signature: _____

Signed Date: _____

Eye Physicians & Surgeons of Arizona



TO OUR PATIENTS
IMPORTANT PAYMENT INFORMATION
ABOUT NON-Covered/ OUT OF POCKET SERVICES

Disability/FMLA Forms:

There will be a **\$25.00** fee for the completion and processing of all **disability and FMLA** related paperwork. **Please also allow 5-7 business days for these to be completed.**

AZDOT MVD forms:

Fee \$60 for completion and service

By signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

_____ (Signature is required)

Print Name

_____ Date: _____

Patient Signature or Parent for Minor



CLARUS Scanning Images of your Eye

A baseline retinal and optic nerve exam can be uncomfortable for patients due to the continuous bright light that is needed to obtain a clear image. The CLARUS Imaging device utilizes a more powerful yet rapid source of illumination which captures a wide field high resolution image that your physician can review with you.

The Clarus high-resolution imaging technology allows us to:

- Capture excellent retinal images in seconds.
- Focus with greater accuracy on areas of concern such as Glaucoma, diabetic changes, Macular Degeneration, tumors and other conditions.
- Make comparisons with previous scans to determine disease progression and the overall health of the eye.

As a screening test, the Clarus photo is **not** considered a covered service by most insurances and is therefore an expense paid directly by the patient. There is \$30.00 fee for this photo and the patient may request a copy at no additional charge for their records.

Our physicians recommend an annual Clarus scan to provide the most comprehensive exam possible. Please let us know if you have any additional questions regarding this exciting new technology.

Patient Consent

I understand this screening examination is intended to reduce discomfort and improve my doctor's ability to evaluate and monitor the health of my eye for disease and choose to have the exam.

Check accept or decline as appropriate: Accept Decline

Print Name: _____

Signature: _____ Date: _____

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of *Eye Physicians & Surgeons of Arizona* Notice of Privacy Practices effective Jan. 1, 2021.

(You may obtain a copy in office or on-line at www.eyesarizona.com)

Name (please print): _____

Signature: _____

Date: _____

Co-managing Ophthalmologist/Optomtrist confirmation:

In response to the pandemic, we have developed a team-based approach with Dr. Kim Patel and Dr. Melanie Anspaugh; Residency-Trained Doctors of Optometry that have mentored further with Dr. George Reiss & Dr. Shamil Patel. By creating this model, we are able to care for more of our patients in need while maintaining the highest level of care that our patients deserve.

We most value our relationships and have adjusted our clinic to provide our patients with the best clinical and surgical care we can offer you. In the event that we cannot serve your medical eye needs we will help coordinate care for you elsewhere as needed. Your vision is our highest priority.

If you have any questions regarding your care, please discuss it with your doctor at your next appointment.

By signing below I agree to co-managed care with **Eye Physicians & Surgeons of AZ.**

Signature _____ Date _____