EYE CONSULTANTS

OF ARIZONA

PATIENT FINANCIAL RESPONSIBILITY

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I accept ultimate financial responsibility for the account incurred by the signature signed named patient at Dr. Luis W. Lu's office. I understand that nonpayment by third party carrier does not relieve me of the responsibility. Once you receive a statement from our office you have 30 days from the date of the statement to send in a payment, or call with a debit or credit card, after 30 days 1.5% (percent) interest each month will be accrued to your account.

****

ATTENTION: PLEASE READ AND SIGN BELOW

_____ _____

Date Patient/Guardian or POA Signature

EYE CONSULTANTS OF ARIZONA

Dr. Luis W. Lu, M.D.

PATIENT INFORMATION

Last Name:	**First Name:**	**M.I.:**
Date of Birth:	**Sex:**	**Occupation:**
Address:		**Apt. #:**
City/State/Zip:		
Cell Phone:	**Work Phone & EXT:**	
Email:		
Hobbies:		
Family Physician or Pediatrican:		
Phone:	**Location:**	
Pharmacy Name & Cross Roads:		
Emergency Contact Name:	**Relation:**	
Emergency Contact Number:		
SIGNATURE		**DATE**

EYE CONSULTANTS OF ARIZONA - PATIENT HISTORY FORM

What is the main reason for your visit?
•
Duration of problem?

Any ocular medications or eye drops? ☐ Y ☐ N
• _____

Do you wear glasses? ☐ Y ☐ N
If yes, do you wear them for: DIST, NEAR, BOTH
Do you wear contact lenses? ☐ Y ☐ N
Last eye exam? _____
Last medical exam? _____

Do you have any allergies to medication? ☐ Y ☐ N
If yes, name drug and reaction:
• _____
• _____
• _____

Are you taking any medications? ☐ Y ☐ N
(Name/Dose/How many times a day?)
• _____
• _____
• _____

Are you pregnant? ☐ Y ☐ N
Do you flashes of lights in your eyes? ☐ Y ☐ N
Do you see floating objects in your eyes? ☐ Y ☐ N
Do you suffer from blackouts of vision? ☐ Y ☐ N
Do you have any eye pain? ☐ Y ☐ N

Any history of surgeries? When?
• _____ • _____
• _____ • _____

Have you had previous eye surgery for: If so, when?
☐ NONE
☐ Cataract
☐ Retinal Detachment
☐ Muscle Surgery
☐ Lasik/PRK
☐ Foreign Body Removal
☐ Other _____

Do you suffer from:
☐ NONE
☐ High Blood Pressure
☐ Diabetes
☐ Lung Disease
☐ Cancer
☐ Rheumatoid Arthritis
☐ High Cholesterol
☐ Seizures
☐ HIV
☐ Multiple Sclerosis
☐ Asthma
☐ Stroke
☐ Thyroid Disease
☐ Kidney Disease
☐ Other _____

Have your eyes ever suffered from:
☐ NONE
☐ Cataract
☐ Strabismus (eye turn)
☐ Amblyopia (lazy eye)
☐ Glaucoma
☐ Macular Degeneration
☐ Keratoconus
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Iritis
☐ Retinal Detachment
☐ Retinal Disease
☐ Optic Nerve Disease
☐ Other _____

Has anyone in your family suffered from:
Who (father, mother, sibling, grandparent, etc.)
☐ NONE
☐ Blindness
☐ Glaucoma
☐ Diabetes
☐ High Blood Pressure
☐ Macular Degeneration
☐ Other _____

Smoking/Tobacco ☐ Never ☐ Current, How many? _____ ☐ Quit, How long ago? _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Alcohol ☐ Never ☐ Occasional/Social ☐ 1-2 Drinks/Day ☐ 3-4 Drinks/Day
Substance Abuse ☐ Never ☐ Yes, _____
Occupation ☐ Retired ☐ Working ☐ Student ☐ Unemployed ☐ Disabled
Driving ☐ Yes ☐ No
Living Conditions ☐ Alone ☐ With Family ☐ Retirement Home ☐ Other _____

SIGNATURE _____ **DATE** _____

EYE CONSULTANTS

OF ARIZONA

CANCELLATIONS

If you cannot make any of your appointments, please call our office at (480) 857-3333 at least 24 hours prior to your appointment. There will be a **$50.00** fee for **NO SHOWS** and **NO CALLINGS** at least 24 hours prior to your appointment.

REFRACTION (covered by separate VISION insurance - NOT MEDICAL insurance)

This is the part of the exam in which the doctor determines a new prescription for glasses or contact lenses. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we asses your eyes and look for problems. It is NOT a covered service by Medicare and many other Medical insurances. Our office fee for refraction is **$40.00** and is collected only in addition to any copayment of your plan **if this service is completed**. Should your plan pay us for the refraction, we will reimburse you accordingly.

WIDE FIELD RETINAL EXAM

The Wide Field Retinal Camera is the latest 200-degree digital imaging of the retina and its vessels. The exam is important in determining the health of the patient. The camera non-invasively captures an instantaneous, ultra-widefield digital image of the retina, revealing important information for the comprehensive evaluation of systemic and ocular health. The unit will allow early detection of changes in the vessels, brain, lungs, and heart, as well as help with the screening of macular degeneration, diabetic retinopathy, glaucoma, retinal detachments, and other ocular conditions.

Would you be interested to know how healthy your vessels are?

The most important reason for having this test is that when you return in a year, two, or more, we will have a baseline to compare all future visits. Unfortunately, if not covered by insurance, it will be an additional cost of **$30.00** for the exam.

PLEASE CHECK ONE: YES_____ NO_____

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By signing below, I have read the above information and understand all sections of this page. I understand the financial policies of Eye Consultants of Arizona and accept full responsibility for any costs that are due at the time of service. I also understand that Eye Consultants of Arizona reserves the right to change any and all fees at any time.

Patient/Guardian Signature: _____ Date: _____

EYE CONSULTANTS OF ARIZONA

HIPAA Acknowledgment and Consent Form

I understand that under the Health Insurance Portability and 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 care among the multiple healthcare providers who may be involved in the treatment directly
- Obtain payment from designated third-party payers
- Conduct normal healthcare operations such as quality assessment or evaluation and physician certifications

I have been informed by Eye Consultants of Arizona of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the privacy practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing how this organization restricts my private information. This can include how my information is used/disclosed to carry out treatment, payment, or healthcare operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree, that it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that the organization has taken action relying on this consent.

_____ _____

PATIENT'S NAME DATE OF BIRTH

_____ _____

SIGNATURE (Patient/Guardian) DATE