

ViewFinderTM

LOW VISION RESOURCE CENTER

_____ has an appointment on _____ at: _____
Name Date Check-In Time

Your appointment is with: Dr. Lynne Noon
 Dr. Kay Powell

Location:

- 10001 West Bell Road · Suite 115 · Sun City, Arizona 85351
Phone: 623.583.2800
- 1830 South Alma School Rd. #7-131 · Mesa, Arizona 85210
Phone: 480.924.8755

Preparing for your low vision evaluation

This paperwork has been sent or given to you so that you can fill it out at home. Please arrive for your evaluation 10 minutes ahead of schedule and bring your **completed paperwork** and your **insurance cards**. If you are unable to complete the paperwork at home, please arrive 20 minutes ahead of schedule and we will be happy to help you complete the necessary forms.

Please bring all current eyeglasses and easily transportable low vision aids to your appointment.

Because our doctors often schedule up to an hour for each client, we ask that you let us know 24 hours before your appointment if you need to cancel or change your appointment time. We have a waiting list of patients who would love to move their appointment to an earlier date.

Please bring your insurance cards to all appointments.
We charge \$50.00 for all patient "no show" appointments.



ViewFinderTM
LOW VISION RESOURCE CENTER

**10001 W Bell Road
Suite #115
Sun City, AZ 85351**

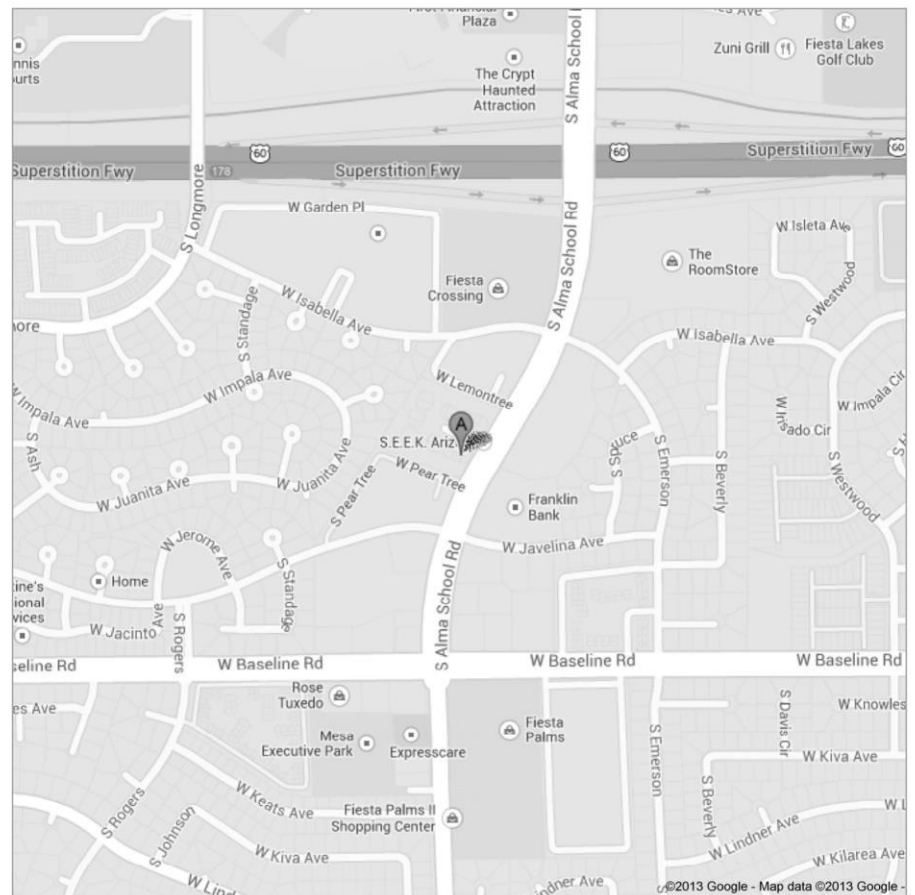
**Located in the
Promenade Shopping
Center on the southwest
corner of 99th Avenue
and Bell Road.**

ViewFinderTM
LOW VISION RESOURCE CENTER

**1830 S Alma School Road
Suite #131
Mesa, AZ 85210**

**Located in Mesa Office
Suites on the west side of
Alma School Road.**

**Our front door faces the
south side of complex.
Turn at the second
entrance.**





Patient Registration Information
Please Print Clearly

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **E-mail:** _____

Date of Birth: ____/____/____ **Male** _____ **Female** _____

Social Security #: _____ **Race:** _____

Referred by: _____

Where have you seen our advertising?

Alternate address for billing purposes:

Yes **No** I give permission to ViewFinder to leave personal medical information on the answering machine of the telephone numbers I have listed or via my email address.

I give permission to ViewFinder to use the name(s) listed below as my emergency contact(s) and/or to share my health information with via telephone or in person:

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Client Health History

Please check all that apply to you:

EARS/NOSE/THROAT:

- Sinus problems
- Allergies
- Hearing loss

CARDIOVASCULAR:

- Chest pain
- Heart attack
- Irregular heartbeat
- Pacemaker
- Heart murmur
- Open heart surgery
- Artificial heart valve
- Cardiac arrest
- High blood pressure

LUNGS:

- Asthma
- Emphysema
- Shortness of breath
- Tuberculosis
- Chronic cough
- Lung surgery
- Lung cancer
- Oxygen use

DIGESTIVE:

- Ulcer
- Intestinal problems
- Diarrhea
- Constipation

URINARY:

- Chronic kidney infection
- Kidney stones
- Prostate problems
- Frequent urination
- Chronic bladder infection

LIVER:

- Hepatitis
- Jaundice

MUSCULAR/SKELETAL:

- Arthritis
- Joint Pain
- Back problems
- Arm weakness
- Difficulty walking
- Stroke

NERVOUS SYSTEM:

- Stroke
- Stroke affected vision
- Head injury
- Alzheimer's
- Confusion
- Dizziness
- Multiple Sclerosis
- Field defect
- Depression

IMMUNE/ENDOCRINE:

- Diabetes _____ # of years
- Thyroid (hypo/hyper)
- Hypoglycemia
- AIDS/AIDS related complex
- Lupus

SOCIAL:

- Tobacco use (Circle One)
Never / Past / Present
- Alcohol abuse
- Drug addiction

OTHER: _____

PREVIOUS SURGICAL HISTORY: _____

OCULAR HISTORY:

- Glaucoma R / L
- Age Related Macular Degeneration
 - Dry R / L
 - Wet R / L
 - Injections R / L
- Cataracts R / L
- Surgery R / L
- Eye injury R / L
- Retinal disease R / L
- Strabismus R / L
- Amblyopia R / L
- Diabetes R / L
- Dry eyes R / L
- Other _____ R / L
- Other _____ R / L

NAMES & DOSAGES OF ALL MEDICATION:

MEDICATION ALLERGIES:

We would like the names of your current eye doctors and primary care physician so that we may dictate a summary of this evaluation. Please list any other doctors that require a dictated letter.

Patient Name: _____ Date: _____

Current Eye Doctor: _____

Address: _____

Current Retinal Specialist (or other eye specialist):

Address: _____

Primary Care Physician: _____

Address: _____

Who else needs a summary (dictated letter) of your examination?

Name: _____

Address: _____

**BE THE FIRST TO LEARN ABOUT NEW PRODUCTS,
TREATMENTS & VISION REHABILITATION NEWS**



If you would like to receive our quarterly newsletter, **ViewFinder E-News**, and would like to receive an emailed copy of our presentation "**Tips to Maintain Independence Despite Visual Impairment**" please enter your email below:

Email address:

(Please print clearly)

Additional Email Addresses:

FINANCIAL RESPONSIBILITY POLICY

Unless we are contracted with your insurance carrier, payment is due at the time of service. As a courtesy, we will bill your insurance on your behalf and will reimburse you, should your services be covered.

If you carry an HMO insurance policy along with Medicare, the HMO plan takes over as your primary insurance. HMO insurance policies MAY OR MAY NOT COVER low vision examinations. Please contact your HMO provider to discuss your covered benefits.

Your insurance coverage is a contract between you and your insurance company. Your doctor has no control over what is covered. You are responsible for knowing the benefits and restrictions of your insurance policy. Some insurance companies may not cover **“out of network”** services or **“non-participating provider”** services. **Your supplemental insurance may not pay the remaining balance of your charges, in which case the balance is your responsibility.**

A low vision examination normally includes a refraction. This is a test to determine the power of eyeglasses or other low vision devices you may need. The charge for this test is **\$59.00** and is **not covered by most insurances. Please note that this is only a portion of the low vision exam and will be collected at the time of service.** The complete examination fee is determined by the amount of time the doctor spends with the patient and/or the tests performed.

By signing below, I acknowledge that I have read and understand the above Financial Responsibility Policy.

Signature: _____ Date: _____

DELINQUENT ACCOUNTS

By signing below, I acknowledge that in the event my insurance company does not pay for the services I receive, it is my responsibility to provide prompt payment to ViewFinder Low Vision Resource Center.

I understand that if my account becomes 60 days past due, ViewFinder will send my account to a collection company for resolution. All delinquent accounts that are sent to our collection agency will be increased in amount owed by 40% to cover our collection fees.

Signature: _____ Date: _____

INSURANCE AUTHORIZATION

I hereby authorize ViewFinder Low Vision Resource Center to release any medical information necessary to process my claim to my insurance company.

Signature: _____ Date: _____

PRIVACY POLICY AND CONSENT

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

When you sign this consent document, you signify that you agree that we can and will disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. Under the privacy policy, we cannot disclose your information without your consent.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

A copy of the HIPAA Notice of Privacy Practices is available upon your request. It is also located on our website.

Please check your preference:

Yes I would like a copy

No I do not want a copy

Signature: _____ Date: _____

Yes **No** Do you have a Power of Attorney to assist in your medical care decisions?
(For VF staff – scan P.O.A. documents)

Name: _____ Relationship: _____

Phone: _____

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

Name: _____ Relationship: _____

Phone: _____



24 HOUR CANCELLATION AND "NO SHOW" **FEE POLICY**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, ViewFinder Low Vision Resource Center reserves the right to charge a fee of \$50.00 for all missed appointments ("no shows") and appointments which, without a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature: _____ Date: _____