

# Schwartz Laser Eye Center

## PATIENT INFORMATION

**Please Print Clearly**

*FILL IN ALL BLANK AREAS*

Date \_\_\_\_\_

Name Mr. Mrs. Ms. Miss \_\_\_\_\_  
Last First Middle Initial

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male Female Referred by: \_\_\_\_\_

Current Street Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov \_\_\_\_\_ PC/Zip Code \_\_\_\_\_

Telephone/Home ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_

Telephone/Cell ( ) \_\_\_\_\_ Work Telephone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Person to contact in case of emergency \_\_\_\_\_

Daytime telephone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

**In addition to contacting me by phone or automated dialing system, I authorize Schwartz Laser Eye Center to contact me via:**  
E-Mail \_\_\_\_\_ Text \_\_\_\_\_ All \_\_\_\_\_

**I authorize Schwartz Laser Eye Center to share my medical information with the following person(s).**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_ Date \_\_\_\_\_

### **INSURANCE INFORMATION (Required Information)**

Insurance Provider \_\_\_\_\_ Provider Phone # ( ) \_\_\_\_\_

Address Claims submitted to \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS # \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouses Name \_\_\_\_\_

Primary SS# \_\_\_\_\_ Primary Birthdate \_\_\_\_\_ Primary Cardholder \_\_\_\_\_

### **OCULAR HISTORY**

Eye medications presently taking: \_\_\_\_\_

Do you currently use artificial tears? Yes No If yes, what type and how often? \_\_\_\_\_

How old are your current glasses? \_\_\_\_\_ Years/Mos How often has your prescription changed? \_\_\_\_\_

Do you currently wear contact lenses? Yes No If yes, what type? \_\_\_\_\_Soft Daily \_\_\_\_\_Soft Toric \_\_\_\_\_Soft Extended

How long have you worn contact lenses \_\_\_\_\_ Yrs/Mos \_\_\_\_\_Hard/Gas Permeable \_\_\_\_\_ Monovision?

If Extended wear contacts, how often do you remove them? \_\_\_\_\_ Clean them? \_\_\_\_\_

When was your last eye examination? \_\_\_\_\_ Where? \_\_\_\_\_

Do you have any of the following or a history of the following? (Please answer all)

Iritis Yes No Retinal tear/detachment Yes No Family History of Macular Degeneration Yes No

Eye Injury Yes No Lazy / Crossed Eye Yes No

Cataract Yes No Keratoconus Yes No SPECIFY ANY OTHER EYE ISSUES: \_\_\_\_\_

Glaucoma Yes No Family history of Glaucoma Yes No

Dry Eyes Yes No Macular Degeneration Yes No \_\_\_\_\_

Do you have a history of any eye surgeries? Yes No If yes, please specify \_\_\_\_\_

**ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO THE DOCTOR,  
FOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

Patient Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim/Group: \_\_\_\_\_

SS# or ID#: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Company  
to pay by check, made out to and mailed to:

**Jay L. Schwartz, D.O., P.C.  
8416 E Shea Blvd., Suite C-101  
Scottsdale, AZ 85260**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. I have agreed to pay, in a current manner, any balance of said professional service charge(s) over and above this insurance payment if elective.

**INSURED MEMBER DIRECT PAYMENT NOTIFICATION**

If you are an insured member and your health care <facility/provider> is contracting with your health plan, the following guidelines apply:

- 1.) You may not be required to pay the health care <facility/provider> directly for the services covered by your plan, except for cost-share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.
- 2.) Your provider's agreement with your health plan may prevent the health care <facility/provider> from billing you for the difference between the <facility/provider's> billed charges and the amount allowed by your health plan for covered services.
- 3.) If you pay directly for a health care service, your health care <facility/provider> is not responsible for submitting claim documentation to your health plan. Before paying your claim, your health plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.
- 4.) If you do not pay directly for a health care service, your health care <facility/provider> may be responsible for submitting claim documentation to your health plan for the health care service.

**The Determination of Refractive State may not be covered by insurance. The fee for the Determination of Refractive State in order to provide a written prescription is \$50.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Your signature below acknowledges that you received this notice before paying Jay L. Schwartz, D.O., P.C. directly for a health care service.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Responsible Party

**Jay L. Schwartz, D.O., P.C.**  
**dba Schwartz Laser Eye Center**  
**Notice of Patients Privacy Practices**

**This notice describes how Jay L. Schwartz, D.O., P.C. and/or Schwartz Laser Eye Center (here in and after referred to as SLEC) may use or disclose your protected health information (“PHI”). It also describes our legal obligations to you and your rights to access your PHI. PHI is individually identifiable health information, including actual medical information, your name, address, phone number, identification number, insurance information or other identifiers. Please review this notice carefully.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice’s policies regarding the use and/or disclosure of protected health information, whether communicated electronically, on paper or in oral conversations. This notice takes effect on **April 14, 2003**.

SLEC reserves the right to decline a patient who elects not to sign this notice and reserves the right to change and to make any new provisions effective under HIPAA Privacy Regulations. This notice explains the rights of the patient and policies followed and implemented by the SLEC in accordance with HIPAA and other governing organizations for all non-exempt uses of medical records with no expiration. A patient’s health care information may be used and/or disclosed for treatment, payment, administrative or healthcare operation activities.

**Treatment** – We may use PHI to provide you with medical treatment or services. This includes communications between other healthcare professionals, hospitals and other healthcare facilities, and other providers for administering treatment.

**Payment** – We may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. This includes typical payment activities, such as verification of coverage, pre-certifications, referrals and claims processing. Please see your plan documents for a full explanation of your insurance benefits.

**Administrative or Healthcare Operation Activities** – We may use and/or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement and business planning. These uses and/or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services. We contract with individuals and entities (business associates) to perform various functions on our behalf which involve the use and/or disclosure of your PHI. These business associates must agree in writing to appropriately protect your PHI.

The patient reserves the right to request restrictions on the policies listed in this notice, receive a copy of all information used and/or disclosed, access, inspect and amend his or her own records, with limited exceptions, by submitting a written request to the SLEC. We may deny your request to inspect and copy your PHI as set forth in the HIPAA Privacy Regulations. Written requests for the patients own PHI will only be honored with a photo proof of identification from the patient.

SLEC reserves the right to contact patients, including the use of an automated telephone dialing system, for appointment reminders or to transmit relevant information about other health or administrative services that may be necessary. This may require us to leave a message, which other individuals may have access to. By signing this release you also authorize the SLEC to mail to you appointment reminders, information about newly released technology, products or services, promotional and other marketing offers.

Per Arizona State Law, all medical records will be kept for six years from the patient’s last date of service. After which; patient records will be destroyed.

All written requests or complaints may be submitted to the Privacy Officer of the SLEC and/or with the Secretary of Health and Human Services if you believe your privacy rights with respect to our protection of your PHI has been violated. Call 480-483-3937 or mail to 8416 E. Shea Blvd. Suite C101, Scottsdale, AZ. 85260. Please include all names, dates, relative and detailed information in the complaint. You will not be penalized for filing a complaint.

If you receive this form electronically you have the right to obtain a paper copy, only upon your written request.

There will be a \$50 fee for the determination of refractive state in order to provide a written prescription.

I hereby agree and understand the information in this notice and understand that I have the right to revoke this consent in writing at any time and all future use or disclosures will cease, with limited exceptions and only in accordance with HIPAA Privacy Regulations.

Print Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History:

Do you have a history of any general medical surgeries? Yes No If yes, please specify: \_\_\_\_\_

Indicate any of the following problems in which you have experienced: (Please answer all)

High Blood Pressure	Yes	No	Shortness of Breath	Yes	No	Chest Pain	Yes	No	Date of last Seizure _____
Heart Attack	Yes	No	Irregular Heartbeat	Yes	No	Seizures	Yes	No	
Asthma	Yes	No	Emphysema	Yes	No	Bronchitis	Yes	No	
Pacemaker	Yes	No	Diabetes	Yes	No	Thyroid	Yes	No	
Arthritis	Yes	No	Bladder/Kidney	Yes	No	Lupus	Yes	No	
Chronic Cough	Yes	No	Tuberculosis	Yes	No	Hearing Loss	Yes	No	
Abdominal Pain	Yes	No	Sinus Problems	Yes	No	Fatigue	Yes	No	
Chrons Disease	Yes	No	Hepatitis A	Yes	No	Hepatitis B	Yes	No	
Hepatitis C	Yes	No	STD	Yes	No	Smoke	Yes	No	Packs per day _____
AIDS	Yes	No	HIV Positive	Yes	No				

Other \_\_\_\_\_

If female, are you pregnant or breast feeding? \_\_\_\_\_

**\*Please notify staff members if you are pregnant, plan to be, or are presently nursing\***

Any other health problems we should be aware of? \_\_\_\_\_

**The following may pertain to patients having refractive procedures and will be discussed with you during evaluation.**

Reading glasses may be required after refractive surgery.

Contact lenses **MUST** be removed prior to Complete Eye Exam (Soft lenses 7 days \*\* Hard/RGP 4 weeks)

Refractive surgery is not 100% predictable. Vision may vary from present prescription.

Vision may be blurred for a week or more after your procedure. Driving and reading may be difficult during this time.

Normal healing period after refractive surgery is 6-8 weeks.

**I understand that I can NOT drive myself home the day of the procedure and that my driver must be in the office prior to starting my procedure.**

In compliance with HIPAA and Insurance guidelines; Schwartz Laser Eye Center requires an updated History and Physical form annually.

\_\_\_\_\_ **Patient Initials**

**I understand the fee for the *Determination of Refractive State* in order to provide a written prescription is \$50.**

\_\_\_\_\_ **Patient Initials**

I attest that all of the information above is correct to the best of my knowledge. I hereby authorize and consent to Schwartz Laser Eye Center and staff to perform any evaluations necessary during my eye exam or surgical procedures. I understand that all insurance information will be held by Schwartz Laser Eye Center in strict confidentiality and will only be released as part of the standard protocol deemed necessary for insurance billing. I authorize the release of any medical or other information necessary to process any insurance claims. I also request payments of government or insurance benefits either to myself or to the assigned physician or supplier for services described within. \_\_\_\_\_ **Patient Initials**

I understand that payment is expected in full on the day of my procedure, except in the case where prior arrangements have been approved by Schwartz Laser Eye Center for insurance billing or financing. I understand that I am financially responsible for all services rendered at Schwartz Laser Eye Center. Please note, we do NOT accept personal checks on the day of your procedure, nor do we accept them within 10 days prior to the procedure date. A \$25 charge will apply to all returned checks.

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

# Schwartz Laser Eye Center

**Patient Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

<b>Medical Allergies</b> (medications, anesthesia, Latex, etc.)	<b>Reaction(s)</b> (skin rash, hives, itching, fever, swelling, runny nose, shortness of breath, etc.)

Medication (Rx, over the counter herbals, vitamins, mineral, dietary (nutritional) supplements, etc.)	Strength	Frequency	Form of Medication (liquid, capsule, tablet, inhalant, injection, drop, etc.)

<b>PHARMACY:</b>	<b>Phone:</b>	<b>Location:</b>
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Doctor Name	Physician type (PCP, Cardiologist, Retina, Endocrinologist, etc.)	Practice Name / Location	Phone Number

***Patient Signature:*** \_\_\_\_\_ **Date:** \_\_\_\_\_

Confirming Doctor's Signature: \_\_\_\_\_ D.O. / O.D. Date: \_\_\_\_\_  
 G8427

Jay L. Schwartz, D.O.                      Kevin Donausky, O.D.                      Marc Bloomenstein, O.D.                      Kristi Rhodes, O.D.