# Schwartz Laser Eye Center

PATIENT INFORMATION

**Please Print Clearly** ***FILL IN ALL BLANK AREAS***

Date_____

**Name** Choose One: _____ _____ _____
Last First Middle Initial

Date of Birth _____ Age _____ Choose One: 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 wih 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? 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? 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 | No | Retinal tear/detachment | No | SPECIFY ANY OTHER EYE ISSUES:_____ |
| Eye Injury | No | Lazy / Crossed Eye | No | |
| Cataract | No | Keratoconus | No | _____ |
| Glaucoma | No | Family history of Glaucoma | No | |
| Dry Eyes | No | Macular Degeneration | No | Family History of Macular Degeneration Y / N |

Do you have a history of any eye surgeries? Y / N 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 heath 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? No If yes, please specify: _____

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

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

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? _____

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**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**

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

**_____Patient Initials**

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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**

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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** _____/_____/_____

| **Allergy** | **Reaction** (skin rash, hives, itching, fever, swelling, runny nose, shortness of breath, ect. |
|---|---|
| | |
| | |
| | |

| **Medication** (Rx, over the counter, herbals, vitamins, mineral, dietary (nutritional) supplements, ect.) | **Strength** | **Frequency** | **Form of Medication** (liquid, capsule, tablet, inhalant, injection, drop, ect.) |
|---|---|---|---|
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| **PHARMACY:** | **Phone:** | **Location:** |
|---|---|---|

| **Doctor Name** | **Physician type** (PCP, Cardiologist, Retina, Endocinologist, ect.) | **Practice Name / Location** | **Phone Number** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***Patient Signature:*** _____ **Date:** _____

Confirming Doctor's Signature: _____ D.O. / O.D. Date: _____
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Jay L. Schwartz, D.O. Kevin Donausky, O.D. Marc Bloomenstein, O.D. Kristi Rhodes, O.D.