ViewFinder™
LOW VISION RESOURCE CENTER
www.ViewFinderLowVision.com

Lynne Noon, OD, FAAO
*Diplomate in Low Vision Rehabilitation*

Kevin Huff, OD

Janet Menke, OTR/L, CLVT

# PATIENT REGISTRATION INFORMATION

PLEASE PRINT

## PATIENT

**Name:**
______________________________________________________

**Address:**
______________________________________________________

**City:**_____________________**State:**_______**Zip Code:** ______

**Social Security #:** ____________________________________

**Phone:** _____________________ **E-mail:** _________________

**Date of Birth**_____/_____/_____

**Male**________ **Female**_________

**Referred by:**___________________________________________

**SPOUSE OR LEGAL GUARDIAN Name:**
______________________________________________________

**Social Security #:** _____________________________________

**Date of Birth**_____/_____/_____

**PLEASE HAVE INSURANCE CARDS READY**

1830 South Alma School Road, Suite 131 | Mesa, Arizona 85210 | 480.924.8755
10001 West Bell Road, Suite 115 | Sun City, Arizona 85351 | 623.583.2800
Appointments for satellite offices throughout Arizona can be made at 866.924.8755

**ViewFinder™**
LOW VISION RESOURCE CENTER

# CLIENT HEALTH HISTORY

**Please check all that apply to you:**

**EARS/NOSE/THROAT:**
_____Sinus Problems
_____Allergies
_____Hearing Loss
**CARDIOVASCULAR:**
_____Chest pain
_____Heart attack
_____Irregular
_____heartbeats
_____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 (present / past)
_____Alcohol abuse
_____Drug addiction

**OTHER:** ______________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________

**PREVIOUS SURGICAL HISTORY:**______________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________

**NAMES & DOSAGES OF ALL MEDICATION:**
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________
________________________

**MEDICATION ALLERGIES:**____________
________________________
________________________
________________________
________________________
________________________
________________________

________________________
Reviewed by:

Lynne Noon, OD, FAAO
*Diplomate in Low Vision Rehabilitation*
Kevin Huff, OD
Janet Menke, OTR/L, CLVT

**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 make a 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) from this examination?***

**Name:**_________________________________________________________________

**Address**______________________________________________________________

ViewFinder™
LOW VISION RESOURCE CENTER

# HIPPA Notice of Privacy Practices

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.

Our office follows the guidelines set up by HIPPA. If you would like to read or receive a copy of our *HIPPA Privacy Practice Policy*, please ask our front desk staff for a copy. **Because we work with many visually impaired clients, we will also read our policy to you.**

As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third party payers or insurers for claims review, determination of benefits and payment; (3)our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have either received a copy or declined a copy of our *Notice of Privacy Practices.*

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. *Our Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it, I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received or declined to receive the Notices of Privacy Practices from ViewFinder.

______________________________ ____________

**Signature** **Date**

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

______________________________________________

**Relationship to Patient Print Name**

# ViewFinder™
LOW VISION RESOURCE CENTER

## 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 Address:**_________________________

ViewFinder™
LOW VISION RESOURCE CENTER

# 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 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 **$49.00** 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 written consent.

Signature: ________________________ Date: __________

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

Print Name: _______________________________________

Relationship to Patient: _______________ Date: _________