ViewFinder
Low Vision Resource Center

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

Your appointment is with:

Dr. Carlos Grandela, OD

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

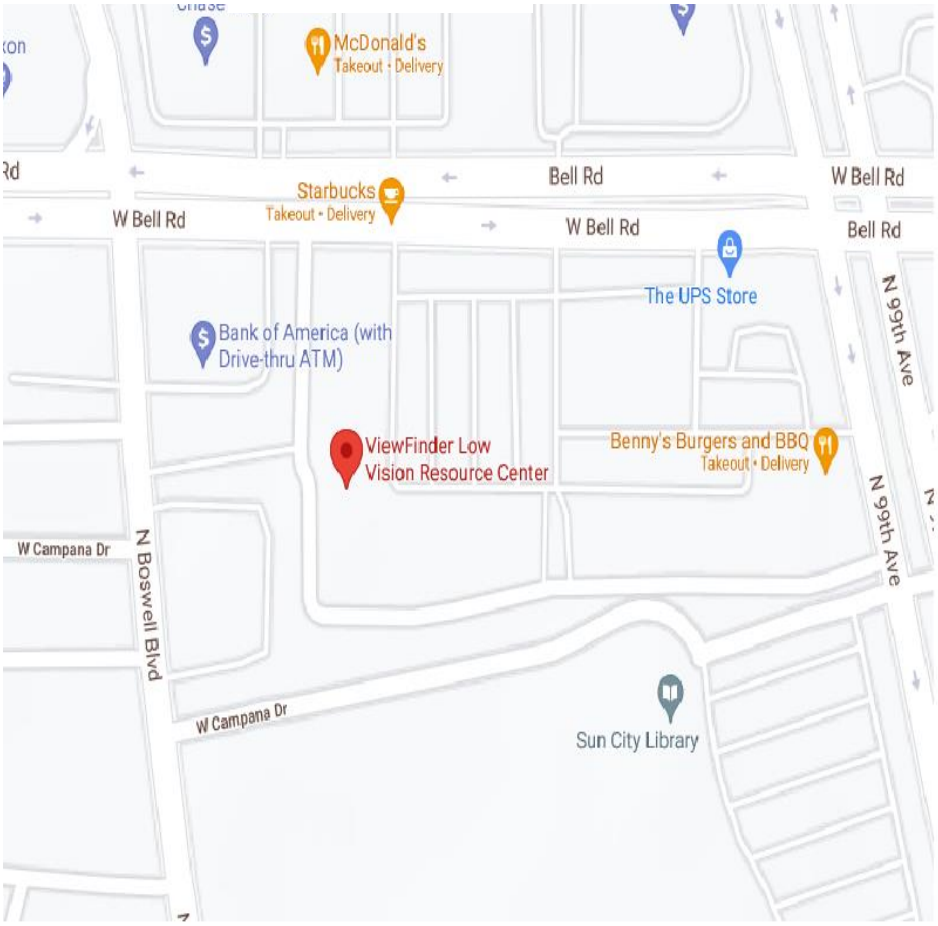
Preparing for your low vision evaluation

This paperwork has been sent or given to you so that you can fill it out at home. Please bring your ***completed paperwork*** and your ***insurance cards*** to your appointment. 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 $60.00 for all patient "no show" appointments.



ViewFinder
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.

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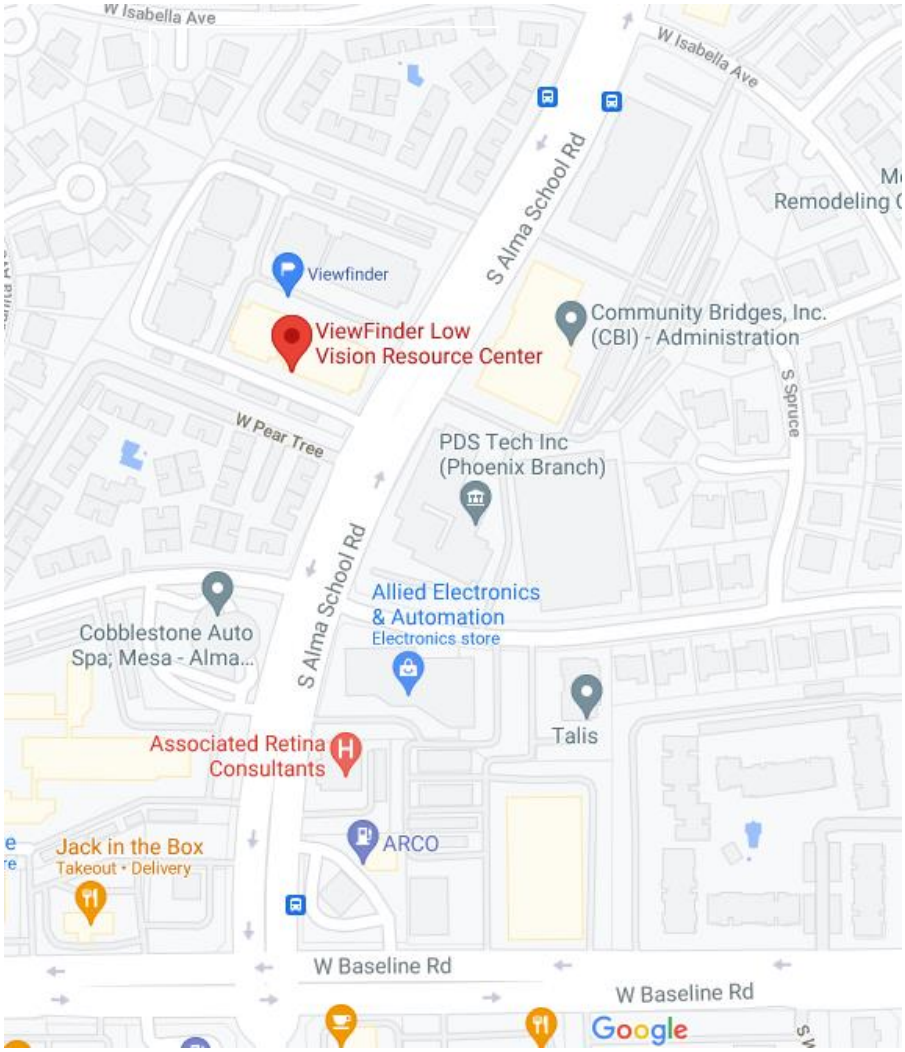
1830 S Alma School Road
Suite #131
Mesa, AZ 85210

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.



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Patient Registration Information

Please Print Clearly

Name: _____

Address: _____ **Apt. #** _____

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

Phone: _____

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

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

Email address: _____

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: _____

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Low Vision Resource Center

Client Health History

Please check all that apply to you:

CONSTITUTION
____ Appetite Changes
____ Weight Gain/Loss
____ Fatigue

CARDIOVASCULAR:
____ Chest pain
____ Heart attack
____ Irregular heartbeat
____ Pacemaker
____ Heart murmur
____ Open heart surgery
____ Artificial heart valve
____ Cardiac arrest
____ High blood pressure
____ High cholesterol

EARS/NOSE/THROAT:
____ Sinus problems
____ Allergies
____ Hearing loss

LUNGS:
____ Asthma
____ Emphysema
____ Shortness of breath
____ COPD
____ Chronic cough
____ Lung surgery
____ Lung cancer
____ Oxygen use

DIGESTIVE:
____ Ulcer
____ Intestinal problems
____ Diarrhea
____ Constipation

URINARY:
____ Kidney infection
____ Kidney stones
____ Prostate problems
____ Frequent urination
____ Bladder infection
__ Urinary tract infection

MUSCULAR/SKELETAL:
____ Arthritis
____ Joint Pain
____ Back problems
____ Arm weakness
____ Difficulty walking
____ Skin Cancer

NERVOUS SYSTEM:
____ Stroke
____Headaches/migraines
____ Head injury
____ Alzheimer's
____ Confusion
____ Dementia
____ Dizziness
____ Multiple Sclerosis
____ Anxiety
____ Depression

ENDOCRINE:
____ Diabetes Type 1/2
Diagnosed year: _____
____ Hypothyroid
____ Hyperthyroid
____ Hypoglycemia

IMMUNE SYSTEMS
____ Rheumatoid Arthritis
____ Crohn's disease
____ AIDS/HIV
____ Lupus
____ Allergic Disorder
Other: _____

SOCIAL:
Tobacco use (Circle One)

Never / Past / Present

____ Alcohol Abuse
____ Drug Abuse

OCULAR HISTORY:
__ Glaucoma R / L
__ Macular Degeneration
____ Dry R / L
____ Wet R / L
____ Injections R / L
__ Cataracts R / L
__ Eye injury R / L
__ Retinal disease R / L
__ Strabismus R / L
__ Amblyopia R / L
__ Diabetic Retinopathy R / L
__ Dry eyes R / L
__ Optic Nerve Disease R / L
Other: _____ R / L

MEDICATION/DOSAGES:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES: _____

_____
_____
_____
_____

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www.ViewFinderLowVision.com

Carlos Grandela, OD
Low Vision Rehabilitation Optometrist

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: _____

Phone# _____Fax#_____

Current Retinal Specialist (or other eye specialist):

_____

Address: _____

Phone# _____Fax#_____

Primary Care Physician: _____

Address: _____

Phone# _____Fax#_____

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

Name: _____

Address: _____

Phone# _____Fax#_____

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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 **$60.00** 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: _____

ViewFinder
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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

While 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: _____

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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: _____

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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 $60.00 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 our patients.

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

Signature: _____ Date: _____

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In order to securely communicate confidential Patient Health Information, a Patient Portal has been registered to you through our office. You will receive an automated email to the address you provided today with a link to your Patient Portal. You will be asked to create a Username, Password, and Security Question for future access. Summaries of your vision examinations will be uploaded to this Patient Portal, where you may view, download, and share the documents at your convenience.