KOKOPELLI
EYE INSTITUTE

OUR VISION IS TO CARE ABOUT YOURS

Patient Name: _____

Date: _____

SPEED (Standard Patient Evaluation of Eye Dryness) QUESTIONNAIRE

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. **Report the type of <u>SYMPTOMS</u> you experience and when they occur:**

SYMPTOMS	HOW FREQUENT/SEVERE?			
	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never 1 = Sometimes 2 = Often 3 = Constant

2. **Do you use eye drops for lubrication?** ☐ **YES** ☐ **NO**

   a. **If yes, how often?** _____

TOTAL: _____/ 12

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Authorization to Share Patient Information

Please list anyone with whom you might need Kokopelli Eye Institute to share information. **This would include any information that might be conveyed to any other person in your family or a caretaker**. Information you are authorizing us to share includes medical records, including patient histories, test results, referrals, consults, appointment dates and times, billing records, insurance records, and records received from other health care providers.

Should this information change, please let us know in writing.

Please list the person or persons we have permission to share your information with:

1. _____ Relationship: _____ Phone #: _____
2. _____ Relationship: _____ Phone #: _____
3. _____ Relationship: _____ Phone #: _____
4. _____ Relationship: _____ Phone #: _____
5. _____ Relationship: _____ Phone #: _____
6. _____ Relationship: _____ Phone #: _____

Patient's Name (Please Print): _____**DOB:** _____

Patient Signature: _____ Date: _____

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1. **FINANCIAL RESPONSBILITY POLICY:**
   The following statements set forth the detailed policy of Kokopelli Eye Institute with regard to financial responsibilities.

   All patients are held personally responsible for prompt and full payment of fees. A billing statement will be provided so that the patient can file a claim with their insurance carrier for reimbursement, if necessary.

   Kokopelli Eye Institute is under contract with Medicare and will accept assignment on all claims. Patients will be responsible for the deductible and the small balance which Medicare allows but does not pay. Kokopelli Eye Institute will bill your secondary insurance company if you want us to do so.

   Patient accounts which become delinquent shall be assigned to our collection department for resolution. Such assignment gives the patient responsibility for the balance and additional costs incurred in the collection process including, but not limited to, interest, filing fees, attorney fees, and court costs.

   IT IS UNDERSTOOD THAT THE UNDERSIGNED/PATIENT ARE RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL

2. **MEDICARE LIFETIME AUTHORIZATION: (If and when covered by Medicare)**
   I request that payment of authorized Medicare benefits be made on my behalf to Kokopelli Eye Institute for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services.

3. **DIRECT PAYMENT TO KOKOPELLI EYE INSTIUTE FROM HEALTH INSURANCE COMPANY:**
   I request that payment of authorized insurance benefits be made on my behalf to Kokopelli Eye Institute for any 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. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

4. **RELEASE OF INFORMATION:**
   Kokopelli Eye Institute may disclose all or any part of the patient's medical records to the following:

   A. Third Party: Including but not limited to any person or corporation, or their designee, which may be liable under a contract for payment of all or part of Kokopelli Eye Institute's charges, such as insurance companies, workers' compensation payers, hospital or medical employer; quality assurance and peer review committees, utilization review organizations, Medicare review organization, accrediting surveyors, clinic and treating physician's and professional liability insurance carriers.

   B. Medical Research: Information may be released for use in medical studies and medical research.

   C. Other Health Care Providers: Information may be released to other health care providers to whom I may be referred in order to provide continued patient care.

********** **Lifetime Authorization** **********

I understand that the authorization granted above may be revoked by me at any time, with written notice. This authorization will stay in effect as long as the need for the above information exists. A photocopy of this assignment shall be considered as effective and valid as the original.

Signature _____ Date _____

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HIPPA CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy at any time by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Kokopelli Eye Institute provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Kokopelli Eye Institute has a Notice of Privacy Practices at each office location and the patient has the opportunity to review and request a copy of the Notice at any time.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

This Consent was signed by:

_____ _____

Patient or Representative Signature Date

_____ _____

Printed Patient Name Date of Birth

Relationship to Patient (if other than patient): _____

Employee Witness Initials: _____

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Patient Medical History

Name: _____

First Middle Last Nickname

What brings you in for examination, or what concerns do you have with your eyes? _____

_____

Eye history, including surgeries: _____

Past Medical History: _____

Past Surgical History: _____

Family History of eye problems: Cataracts / Macular Degeneration / Blindness / Glaucoma / Diabetes /

Other: _____

Social History: Tobacco use (Present / Past) / Alcohol abuse / Drug Addiction /

Other: _____

Have you any new or ongoing problems with the following review of systems: (circle None if no problems)

In General: _____ / None

Neurological: _____ / None

Skin: _____ / None

Ears: _____ / None

Nose: _____ / None

Respiratory: _____ / None

Cardiovascular: _____ / None

Gastro-intestinal: _____ / None

Genito-Urinary: _____ / None

Musculoskeletal: _____ / None

Endocrine: _____ / None

Immunological: _____ / None

Psychiatric: _____ / None

Eye Medications / Eye Drops: _____

_____

_____

Other medications you take: _____

_____

_____

_____

Are you allergic to any medications, soaps, or topical iodine? Yes / No

Please Specify: _____

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Patient Registration Form

How did you hear about our practice? (Information provided is strictly for marketing purposes and appreciation letters.)

Friend/Relative-Please List: _____ Yellow Pages _____

Doctor's Office – Name: _____ Established patient with practice _____

Newspaper – Name of Newspaper: _____ Other: _____

PATIENT INFORMATION:

Legal Name: _____

First Middle Last

Sex: Male Female Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Home Address: _____

Street City, State, ZIP

Mailing Address (if different): _____

Street City, State, ZIP

Phone: Home (_____)_____ Work: (_____)_____ Cell: (_____)_____

Email Address: _____

***We encourage you to share your email with us so we can communicate appointment reminders, provider special offer notices, and eye-related health care tips. Use it for internal purposes only. Your email will not be shared with other entities or third party groups. _____ Initial here to authorize use of your email address.**

MARITAL INFORMATION Marital Status: Single Married Divorced Widowed

Spouse's Name: _____ DOB: _____/_____/_____ Social Security #: _____-____-_____

MINOR INFORMATION (17 YEARS AND YOUNGER)

Legal Guardian/Parent Name: _____ Date of Birth: _____/_____/_____

Legal Guardian/Parent Social Security #: _____-____-_____ Phone: (_____) _____

INSURANCE INFORMATION

Do you have insurance? Yes / No If yes, please completely fill out below to ensure payment.

Primary Insurance: _____ Secondary Insurance: _____

Relationship to policy holder: Self Spouse Parent Other

Social Security #: _____ Phone: (____)_____ Employer of Policy Holder: _____

Vision Insurance: _____ Policy Number: _____

In case of emergency, whom should we notify? Name: _____ Phone: (____)_____

Who is your primary care physician (PCP): _____

Referring Doctor Name: _____

BY SIGNING BELOW YOU ACKNOWLEDGE THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE. YOU ALSO ACKNOWLEDGE YOU HAVE OBTAINED, UNDERSTAND, AND AGREE TO ABIDE BY THE GUIDELINES CONTAINED IN THE RELEASE INFORMATION AND PATIENT FINANCIAL POLICY.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**

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Refraction Notification

What does "refraction" mean?

"Refraction" is the process of determining your refractive error, or need for corrective spectacle lenses (glasses).

The test to determine the prescription for eye glasses is NOT considered a treatment for a disease. Therefore, Medicare and most other *medical* insurance plans do not include this as a covered medical service.

Our highly trained technicians and doctors will do refraction for you. You can be confident that your refraction will be accurate or we will do one again at no charge.

Refractions are recommended at least once per year. Also, if you feel that you might need glasses, or you feel your current glasses prescription might need to be changed, then you should have refraction. Although the *medical* examination is covered by your *medical* insurance, the refraction is not. We cannot bill vision insurance and medical insurance on the same day.

THE REFRACTION CHARGE IS $_____. THIS FEE IS DUE ON THE DAY YOU RECEIVE THE REFRACTION TESTING UPON CHECK OUT.

_____ _____

Patient Signature Date