ViewFinder
Low Vision Resource Center
1830 S Alma School Rd #131
Mesa, AZ, 85210
(480)924-8755

Prepare For Your Low Vision Consultation

Please fill out the online HIPAA-secure paperwork at this address to import directly to your medical record:

https://www.viewfinderlowvision.com/new-patient-forms

Otherwise, fill out and bring a ***completed*** paper copy of the following forms to your appointment. If you are unable to complete the paperwork at home, please arrive 15 minutes early for assistance from the front desk staff.

Bring the current eyeglasses, magnifiers, and other low vision aids that you are using.

Please bring your insurance cards to all appointments.

Bring a copy of your most recent eye exam report to allow a focus on low vision devices and tools during your consultation. If you have not been seen by an eye doctor within the last 12 months, please arrange a driver and any other plans needed for a dilated eye exam during your first appointment.

To allow for appropriate rescheduling, please call at least 24 hours in advance for all cancellations. Cancelled appointments on the same day or missed appointments may receive a "no show" charge of $60.00.

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Patient Registration Information

Name: _____

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

Social Security #: __ __ __ - __ __ - __ __ __ __

Address: _____ **Apt. #** _____

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

Phone: _____

Email address: _____

Primary Care Physician: _____

Address: _____

Phone: _____ **Fax:**_____

Date of Last Exam: _____/_____/_____

Primary Eye Doctor: _____

Address: _____

Phone: _____ **Fax:**_____

Date of Last Exam: _____/_____/_____

Retinal, Glaucoma, Cornea, Neuro-Ophthalmology Specialist:

_____

Address: _____

Phone: _____ **Fax:**_____

Date of Last Exam: _____/_____/_____

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Medical History: Please check all that apply to you.

OCULAR HEALTH:
__ Macular Degeneration
____ Dry R / L
____ Wet R / L
____ Injections R / L
__ Glaucoma R / L
__ Cataracts R / L
Surgery R / L
__ Diabetic Retinopathy R / L
__ Optic Nerve Disease R / L
__ Retinal Dystrophy R / L
__ Eye injury R / L
__ Strabismus R / L
__ Amblyopia R / L
__ Dry eyes R / L
__ Hemianopsia R / L

GENERAL CONSITUTION:
____ Appetite Changes
____ Weight Changes
____ Fatigue
____ Cancer
Type: _____

CARDIOVASCULAR:
____ High blood pressure
____ High cholesterol
____ Chest Pain
____ Heart Attack
____ Cardiac arrest
____ Irregular Heartbeat
____ Pacemaker
____ Artificial Heart Valve

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

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

DIGESTION:
____ Ulcer
____ Irritable Bowels
____ Diarrhea
____ Constipation

URINARY:
____ Kidney Infection
____ Kidney Failure
____ Frequent urination
____ Bladder infection
__ Urinary tract infection

NERVOUS SYSTEM:
____Headaches/migraines
____ Head Injury
____ Alzheimer's
____ Confusion
____ Dementia
____ Dizziness
____ Multiple Sclerosis
____ Stroke / TIA
When?_____

MUSCULAR/SKELETAL:
____ Arthritis
____ Joint Pain
____ Back Pain
____ Arm Weakness
____ Difficulty Walking

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

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

SOCIAL:
____ Anxiety
____ Depression

Tobacco Use (Circle One)
Never / Past / Present

Alcohol Use
Never / Past / Present

Recreational Drugs Use
Never / Past / Present
Type: _____

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Please provide an updated medication list to the front desk staff. Otherwise, fill in below.

Medication	Dosage	Medication	Dosage

Allergies to Medications:

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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: _____

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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 90 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: _____

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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.

☐ **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:

1. Name: _____ Relationship: _____
   Phone: _____
2. Name: _____ Relationship: _____
   Phone: _____
3. Name: _____ Relationship: _____
   Phone: _____

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**

☐ **Yes** ☐ **No** Do you have a Power of Attorney to assist in your medical care decisions?

Name: _____ Relationship: _____

Phone: _____

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.

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.