*Specializing in Medical and Surgical Care of the Eye*

# PATIENT HEALTH QUESTIONNAIRE

Date_____

Name_____ Date of Birth: _____

PRIMARY CARE PHYSICIAN: _____

Please list all **medications** you are currently take (including eye medications & Vitamins)?

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

Do you have any **allergies** to medications? _____YES _____NO
If YES, list the medications:

_____ _____
_____ _____

Please list any **illnesses** or **injuries** you have had?

_____ _____
_____ _____

Please list all **hospitalizations** and **operations** you have ever had?

_____ _____
_____ _____
_____ _____
_____ _____

**Please check if you or anyone in your Family (BLOOD RELATIVE) have ever had any of the Following?**

| | You | Family | | You | Family |
|---|---|---|---|---|---|
| Diabetes | | | Inherited disease | | |
| High Blood Pressure | | | Mental impairment | | |
| Heart Disease | | | Crossed eyes | | |
| Stroke | | | Cataracts | | |
| Asthma | | | Glaucoma | | |
| Bronchitis | | | Blindness | | |
| Hepatitis | | | Ulcer Disease | | |
| Tuberculosis | | | Alcoholism | | |
| HIV infection/AIDS | | | Other eye disease | | |
| Thyroid disease | | | Cancer | | |
| Migraine headaches | | | Bleeding disorder | | |
| Arthritis | | | History of anesthesia complications | | |
| Latex Allery | | | High Cholesterol/ Triglycerides | | |
| Rheumatoid Arthritis | | | Other_____ | | |

**Do you have any other Disease or condition not listed? _____Yes _____No**
**If yes, please explain:**_____
_____

**Please list your occupation:** _____

**Have you ever done any of the following?**

Taken Oral Flomax YES/ NO
Consumed Alcohol YES/ NO
Smoked YES/NO
Been exposed to excessive sun YES/NO
Been exposed to hazardous materials YES/NO

**Do you presently:**

Smoke YES/NO How many per week? _____
Drink Alcohol YES/NO How many per week? _____

**Please check if you have a problem with any of the following.**

| | | | | | |
|---|---|---|---|---|---|
| Fever | | Weight Loss | | Tiredness | |
| Ears | | Nose | | Mouth | |
| Throat | | Heart | | Blood Vessels | |
| Lungs | | Esophagus | | Stomach | |
| Intestines | | Kidney | | Bladder | |
| Genital System | | Muscles | | Bones | |
| Skin | | Breasts | | Nervous System | |
| Psychiatric System | | Endocrine | | Blood System | |
| Lymph System | | Allergies | | Immune System | |

_____ _____
Signature of person completing this form Print Name

_____ _____
Relationship to patient Date

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(Do not write below line)

I have reviewed and confirmed the information above.

_____ _____
Physician Signature Date

# REGISTRATION FORM

(PRINT CLEARLY, USE BLACK INK ONLY)

| Today's date: | PCP: |
|---|---|
| *Preferred Pharmacy:* *Phone: ( ) -* | |

*PATIENT INFORMATION*

| Patient's last name: First: Middle: | | | Marital status (circle one): Single / Mar / Div / Sep / Wid | | |
|---|---|---|---|---|---|
| Is this your legal name? ❑ Yes ❑ No | If no, what is it? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| Street address: | | Social Security #: | Home phone: ( ) - | Cell phone: ( ) - | |
| City State: Zip Code: | | Email address: | | | |
| Occupation: Employer: Employer phone no.: ( ) ____ - _____ | | | | | |
| Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other:_____ | | | | | |
| Other family members seen here: | | | | | |

*INSURANCE INFORMATION*

(Give your insurance card to the receptionist.)

| **1.Primary Insurance Company:** | **Phone: ( ) -** |
|---|---|
| Address: State: Zip: | |
| Person responsible for bill: Birth date: / / Address (if different): | Home phone no.: ( ) - |
| Subscriber's name: Policy No: Group No: | |
| Patients Relationship to Subscriber: _____ Self _____ Spouse _____Child _____ Other | |
| **2.Secondary Insurance Company:** | **Phone: ( ) -** |
| Address: State: Zip: | |
| Person responsible for bill: Birth date: / / Address (if different): | Home phone no.: ( ) - |
| Subscriber's name: Policy No: Group No: | |
| Patients Relationship to Subscriber: _____ Self _____ Spouse _____Child _____ Other | |

*IN CASE OF EMERGENCY*

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
|---|---|---|---|
| | | ( ) - | ( ) - |

# Kaz Vision & Laser Center

## FINANCIAL AGREEMENT/ PATIENT FINANCIAL BILLING POLICY
## AUTHORIZATION AND CONSENT TO TREATMENT

We are pleased you have chosen us as your healthcare provider and are committed to providing you with the highest level of service and quality care. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your healthcare.

We require all patients to sign our Authorization and Consent To Treatment form before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services as set forth in this policy.

We provide Medical and Surgical eye care as well as Routine eye exams. Our office participates with most major insurance plans. We ask that all patients provide their insurance card and proof of identification (photo ID or driver's license) AT EVERY VISIT. If you do not provide current proof of insurance, your appointment may be rescheduled and a same day cancellation fee may be applied to your account. If you provide incorrect insurance and your claim is denied, you will be billed as an uninsured patient (self-pay) and payment for the full amount of the services will be required. We will not rebill your insurance if provided incorrect or expired insurance information. You will be responsible as an uninsured (self-pay) patient for the full amount of the services.

Patients or their legal representatives and/or guardians are ultimately responsible for all charges and payments for services provided. Patients are responsible to be fully aware of their insurance responsibilities including copays, deductibles, referrals, covered and non-covered services. Payment at the time of service is required in addition to payment of any deductibles, past balances, non-covered services, administrative fees, interest, and/or collection fees. We may request payment for your share or responsibility of your medical services when you schedule and/or when you present for your appointment.

Copay payments are due at the time of service. If copayments are not paid at the time of service your appointment may be rescheduled and subject to a same day cancellation/reschedule fee or a minimum administrative fee of $50.00 may be added to your account. If you are unable to make payment (co-pay, co-insurance, deductible, administrative fee, interest, collection fees, etc.) at the time of service OR provide a photo ID or insurance card your appointment may be rescheduled and subject to a same day cancellation/reschedule fee. You are required to pay the entire amount determined by your insurance company to be the patient's responsibility. If your insurance company does not remit payment within sixty days, the balance may be your responsibility and due in full. If payment from your insurance company is made directly to you for services billed from Kaz Vision and Laser Center, you are required to remit timely payment to Kaz Vision and Laser Center upon your receipt of this payment. If timely payment is not made to Kaz Vision and Laser Center, an additional administrative fee may be applied. Our fees are for physician services only. You may receive additional billings for any radiology, laboratory, or surgical center/hospital providers.

**Insurance Referrals:**
You understand that if your insurance company requires a referral form for treatment, it is your responsibility to obtain this referral prior to your appointment. If you do not have a current valid referral on file for your provided date of service, your appointment may be rescheduled and a same day

cancellation fee may be applied to your account or you may be billed as an uninsured (self-pay) patient and payment in full is due at the time of service.

**Medical Insurance Plans:**
You are responsible to know if we are a participating provider with your health insurance. If we are not a participating provider you understand that you may be responsible for filing claims and/or for paying a higher amount or in full for services and at the time of service.

**Vision Insurance Plans:**
We participate with a number of Vision Plans. It is your responsibility to know which Vision plans are accepted. Some medical plans have routine vision benefits. Sometimes these vision benefits are with a different insurance carrier than your medical plan. We may be participating providers with your medical plan but not your vision plan. You are responsible for contacting your carrier to verify your benefits and whether the practice is a provider for both your medical and vision insurance plans. Our practice cannot usually bill your vision and medical insurance plans on the same day of service.

**Refractions:**
Refraction is the process of testing an individual's ability to see an object at a specific distance. The test involves looking through a device called a phoropter to read letters or symbols on a wall chart through lenses of differing strength which are contained within the device to determine your best corrected visual acuity. It is an essential part of an eye examination and is necessary for us to completely evaluate your ocular health. This may also be necessary to determine a contact lens or glasses prescription. Since this is a non-covered service with Medicare and many medical insurance companies, it is a billable fee of $65.00. If your insurance company does not cover this service, you understand that you are responsible for the full amount of this fee.

**Non-Covered Services:**
You are responsible to know what are non-covered services of your insurance, of which payment is due at the time of service.

**No Surprise Act/Good Faith Estimate:**
If you do not have insurance or are not using insurance to pay for your care, you have the right to a "Good Faith Estimate" explaining the potential cost of your healthcare services. Please ask your healthcare provider for a "Good Faith Estimate" before you schedule your medical services.

**Forms and Fees:**
There is a charge for completing and/or processing any required forms, documents or letters (e.g. employment, disability, life insurance, DMV, etc). This charge is determined by the complexity of and time required to complete the form, document, letter, or communication with a minimum fee of $40.00. Prepayment is required prior to completing any forms, documents or letters. These fees cannot be billed to your health insurance.

**Release of Medical Records:**
There is a charge for release of medical records according to the Virginia Code 8.01-413.

**Missed Appointments:**
You understand that you may be given a return appointment in order to follow-up on your eye status or condition. In the event that, for any or no reason, you do not keep that return appointment and do not promptly reschedule, you agree to not hold Kaz Vision and Laser Center, its physicians, and/or staff

responsible for any resulting consequences. Any missed new patient appointment or cancelled without a 48-business hour notice may be charged a $100 fee. Any missed return patient appointment or cancelled without a 48-business hour notice may be charged a $75.00 fee. Any missed Laser surgery procedure or cancelled without a 48-business hour notice may be charged a $100.00 fee. Any missed surgical preoperative education appointment or cancelled without a 48-business hour notice may be charged a $150.00 fee. Any missed office procedure or cancelled without a 48-business hour notice may be charged a $150 fee. Any missed major surgery or cancelled without a 7-business day notice may be charged a $250 fee. These fees will need to be paid before you are allowed to schedule another appointment. These fees cannot be billed to insurance.

**Return Check Policy:**
Any check payments that do not clear will be subject to a returned check fee at a minimum of $50.00 and an additional administrative fee.

**Past Due Balance:**
All outstanding balances are due in full upon receipt. All accounts are considered past due if not paid within 30 days of service. Payments can be made on our website: Kazvision.net Additional fees including late fees and finance fees will be applied for all balances not paid within 30 days. If your full balance is not paid within 90 days, your account will be turned over to our collection agency and you agree to pay any and all fees imposed by the collection agency in order to collect the overdue amount. Past due balances may result in the refusal of future appointments. Non-payment of delinquent balances may result in discharge from the practice. We do not accept postdated checks.

**Consent to Call, Email, Text and Electronic Billing:**
You consent that we may contact you using automated calls, emails, text messaging sent to your mobile device and/or landline. We request that you provide your email address and thus consent to receive medical information, appointment information and billing statements by electronic communication and/or email correspondence.

**Card-On-File Process:**
You may be requested to provide a credit card when you check-in for your visit. Your credit/debit card information will be stored using a PCI-DSS compliant payment processor. We do not retain card data in paper form or on local systems. All card data is encrypted and tokenized for security. You authorize Kaz Vision and Laser Center to charge your card for any charges related to your healthcare including copayments, deductibles, and co-insurance amounts; non-covered services; missed appointment fees; administrative or finance fees as disclosed in this policy; collection fees; and any other outstanding amount due. For outstanding amounts related to insurance, your outstanding balance will be charged to your credit card within five (5) days from the date we receive notification from your insurance. You can confirm your payment responsibility by accessing your EOB (explanation of benefits) available from your insurance company. You may call our billing department if you have any questions about your balance. We will send you a receipt for the charge if requested.

If you credit card on file transaction is declined, an administrative fee for nonpayment of $50 may be charged.

The “Card-On-File” program simplifies payment for you and eases the administrative burden of your providers office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have any questions, please let us know.

By signing below, I acknowledge that I have read, understand, and agree to all of the above stated terms and policies and grant all requested consents.

_____ _____

Patient or Authorized Representative Signature Date

_____

Patient Name and Authorized Representative (Printed)

_____

Patients Date of Birth

_____

Email

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make significant change, this notice will be amended to reflect the changes and we will make the new Notice available. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Kian M. Kaz M.D. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know "standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only that information directly relevant to your care. We will also our professional judgement to make reasonable inferences of your best of your best interest by allowing someone to pick up filled prescriptions, x rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medication, product recalls, disease / infection exposure and to prevent and control disease, injury and/or disability.
**Marketing Health-related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

# NOTICE OF PRIVACY PRACTICES

**YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ _____ for each page and the staff time charged will be $_____ per hour including the time required to locate and copy your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee schedule.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-Routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

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**QUESTIONS AND COMPLAINTS.**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**HOW TO CONTACT US.**

Practice Name: Kian M. Kaz M.D., Eye Physician & Surgeon, P.C. - Privacy Officer.
Telephone: 757-875-7700 Fax: 757-875-7721
Address: 12690 McManus Blvd. Newport News VA 23602

# PRIVACY STATEMENT

Dear Patient:

The Privacy Act of 1977 was designed to protect you. To give you a feeling of security, be assured that when you come into this office your medical and financial affairs will not be discussed without your permission. This means that your spouse, your personnel director and even your parents have to have an authorization signed by you before they may receive information regarding your medical care.

For those of you who wish for your spouse, social worker, personnel director, parent, etc. to call this office and receive information about you and your bill, please complete the form below. In order for us to give out information, anyone who in calls will have to provide our staff with your date of birth. If there is not anyone whom you would like to receive information about you, please draw a line through the bottom portion and sign and date it.

Thank you for your cooperation in this matter.

I, _____, give permission for Dr. Kaz or staff to release medical information to my

_____, _____.
Relationship Name

I, _____, give permission for Dr. Kaz or staff to release medical information to my

_____, _____.
Relationship Name

I, _____, give permission for Dr. Kaz or staff to release medical information to my

_____, _____.
Relationship Name

I, _____, give permission for Dr. Kaz or staff to release medical information to my

_____, _____.
Relationship Name

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Patient Name Date of Birth