THE CHILDREN'S EYE CENTER of El Paso

Violeta Radenovich, MD

PATIENT REGISTRATION

(Registro paciente)

PLEASE FILL OUT COMPLETELY

(LLENE POR FAVOR COMPLETAMENTE)

Complete ON-LINE and Email, or PRINT OUT and bring the completed form to the appointment.

Patient Name: Last (apellido) _____ First (nombre)_____Middle Int. (inicial): _____

Address: _____ Apt #:_____City, State & Zip: _____
(Direccion) (Apto) (Ciudad/estado y codigo postal)

Home Phone: _____ Cell Phone: _____ DOB:_____
(telefeno) (telefeno de trabajo y cellular) (feche de nacimiento)

Email Address: _____ ☐Male ☐Female SSN#: _____
(Hombre) (femina) (seguridad social)

Family Pediatrician/Doctor : _____
(doctor de cuidado primario)

Referred By: ☐Physician/Doctor ☐Optometrist ☐Other (Name): _____

Responsible Party/Parent Name: _____ Relationship to Patient: _____
(persona responsible a pagar) (relacion con el paciente)

Responsible Party SSN#: _____ DOB: _____
(number de seguro de persona responsible) (fecha de nacimiento)

Parent Cell Phone:_____ How will bill be paid today? ☐Insurance ☐Cash ☐Both
(Cellular de parente) (¿Cómo será pagada la cuenta hoy?)

EMERGENCY CONTACT: _____ **PHONE #:** _____
(contacto de caso de emergencia) (numero de telefono)

Primary Insurance Company Name: _____
(nombre de segura primario)

Policy/Insurance ID Number: _____ Group Number: _____
(numero de politica) (numero de grupo)

Primary Policy Holders Name: _____ Policy Holder DOB: _____
(el nombre de la persona que lleva el seguro) (fecha de nacimiento)

Relationship to Patient: _____ Employer: _____
(relacion con el paciente) (patron)

Co-pay: _____ Deductible: _____
(copago) (deducible)

Secondary Insurance Company Name: _____
(nombre de aseguranaza secundaria)

Policy/Insurance ID Number: _____ Group Number: _____
(numero de politica) (numero de grupo)

Primary Policy Holders Name: _____ Policy Holder DOB: _____
(el nombre de la persona que lleva el seguro) (fecha de nacimiento)

Relationship to Patient: _____ Employer: _____
(relacion con el paciente) (patron)

Co-pay: _____ Deductible:_____
(copago) (deducible)

Where did you hear about Children's Eye Center? ☐Family doctor's office ☐Internet ☐Friend/Family ☐Patient ☐Other
Como Se Entro de Children's Eye Center? (oficina de los medicos) (internet) (amigo/familia) (paciente) (otro)

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Children's Eye Center. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Yo certifico que la información proporcionada en relación a mi cobertura de seguro de salud es verdadera y correcta. Yo autorizo que el pago por los servicios prestados deben hacerse pagaderos a los niños? S Eye Center, PLLC autorizar la liberación de la información médica necesaria para este proceso (estos) crédito (s). He leído todos los términos y condiciones contenidos en este acuerdo y se obligan a cumplir con estos términos y condiciones.

Signature: _____ Date: _____
(firma) (fecha)

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OFFICE AND FINANCIAL POLICY

WELCOME TO OUR OFFICE! We are pleased that you have chosen Children's Eye Center to provide your care and service. We want to take a moment of your time to inform you of our policies regarding our office and payment.

PAYMENT: We accept cash and debit/credit card for payment on your account. If you have insurance which we do not contract with, you will be expected to make a full on the day of your visit. If your insurance is one we do contract with, you are expected to pay your co-pay at the time of your visit.

PHOTOGRAPHIC RELEASE: By signing this form you are giving consent/authorization for Children's Eye Center along with those affiliated, the right and permission to copyright, reproduce, telecast, and/or publish the photograph and/or video in which your child may be involved for treatment, research purposed, or for any lawful reproduction whatsoever, without limit or reservation.

COMMERCIAL/PRIVATE INSURANCE: As a courtesy we will be happy to file your insurance for you. You will be required to provide a copy of your insurance card and all necessary billing information. If you owe on your deductible or owe a co-pay we will need to collect that at the time of service. All insurance payments that are paid directly to you must be endorsed and paid to this office/physician. It is your responsibility to contact your insurance in the event of non-payment or discounted payments. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have hired consulting firms to ensure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us, based upon their willingness to pay.

CONTRACTED INSURANCES: We will submit a claim directly to the insurance carrier if you provide us with the necessary information. This includes a copy of your insurance card, an address to submit claims to and a telephone number allowing us to verify your coverage. You still are responsible for payment of your co-pay at the time of service and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

In the event Children's Eye Center is not contracted with your health plan, you will be responsible for any out of network, coinsurance, or deductible applied. INITIAL HERE: _____

NO INSURANCE: If you do not have insurance, we expect you to pay for your visit at the time of service. In the event of surgery, our Financial Advisor can help answer questions about financial arrangements.

MEDICARE: We are participating providers with Medicare. We will submit your claim to your insurance. Medicare will process the payments to us. You are responsible for your deductible and any co-pays/co-insurance at the time of service.

NO SHOW FEE: In the event your appointment is not canceled 24 hours in advance and/ or you do not show for your appointment, there will be a $25.00 fee assessed to your account. Appointment confirmation is provided electronically. Please respond appropriately to avoid this fee.

ADDITIONAL FEES: Dictated reports, letters, and other similar services are provided at a minimum charge of $25.00. Telephone consultations are collected from the patients' responsible party, as they are usually not a covered service.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collection on your account. These include but are not limited to interest charges, rebilling fees, court costs, attorney fees, and collections costs. A collection agency may be used to collect on delinquent accounts. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for the payment on your account.

If you have any questions regarding our payment policies, please ask us before your visit. **Thank You!**

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Children's Eye Center, PLLC and have provided to the best of my ability the information requested accurately and completely.

_____ _____

SIGNATURE (Patient/Responsible Party) DATE

(firma) *(fecha)*

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OFFICE AND FINANCIAL POLICY

"Bienvenidos a nuestra oficina! Nos complace que usted haya elegido la **Children's Eye Center** of El Paso para brindarle atención y servicio. Queremos tener un momento de su tiempo para informarle de nuestras políticas en cuanto al pago con nuestra oficina."

"Aceptamos dinero en efectivo y cheques personales para el pago en su cuenta. Si usted tiene seguro que no con el contrato, se le espera para hacer un pago total o parcial en el día de su visita. Si su seguro es un contrato con nosotros, se espera que usted pague su co-pago en el momento de su visita."

seguros privadas en un esfuerzo para establecer las tasas médico que indica que limitar el pago de sus honorarios son \"normales y de costumbre\" honorarios para esta área. Hemos contratado a empresas de consultoría para asegurar que nuestros honorarios son comparables a los de otras oficinas que proporcionan la misma calidad y nivel de atención. No permitiremos que las compañías de seguros a tasas establecidas por nosotros, sobre la base de su disposición a pagar."

"COMERCIAL / SEGUROS PRIVADOS: Como cortesía estaremos encantados de presentar su seguro para usted. Se le pedirá que proporcione una copia de su tarjeta de seguro y todos los datos de facturación. Si usted debe en su deducible o debemos un co-pago que tendrá que recoger que en el momento del servicio. Todos los pagos de seguros que se pagan directamente a usted debe ser aprobado y pagado a esta oficina / médico. Es su responsabilidad ponerse en contacto con"

"XXX_____ En el caso de Children's Eye Center of El Paso no es un contrato con su plan de salud, se le Inicial aquí responsables de ninguna de red, el coseguro, o deducible aplicado."

"NO SEGURO: Si no tiene seguro, esperamos que usted pague por su visita en el momento del servicio. En el caso de la cirugía, nuestro asesor financiero puede ayudar a responder preguntas acerca de los arreglos financieros.

MEDICARE: Estamos participando con los proveedores de Medicare. Vamos a presentar su reclamo a su seguro. Medicare proceso de los pagos a nosotros. Usted es responsable de su deducible y cualquier co-pays/co-insurance en el momento del servicio."

"No se presente PRECIO: En el caso de su designación no se cancela con 24 horas de anticipación y / o que usted no se presente para la cita, habrá una tasa de 25,00 dólares evaluarse a su cuenta.

Cheque devuelto: En caso de que su banco devuelve un cheque a nuestra oficina de pago, habrá un retorno $ 25.00 cheque de pago con cargo a su cuenta."

"NO PAGO: En caso de que su cuenta se convierte en delincuentes, usted será responsable no sólo de los gastos, sino también de todos los costes asociados en la extracción en su cuenta. Estos incluyen, pero no se limitan a los intereses, rebilling honorarios, gastos judiciales, honorarios de abogado, y las colecciones de los costos. Una agencia de cobranza puede ser utilizado para recoger en las cuentas morosas. Las prestaciones de los seguros son un asunto entre usted y su compañía de seguros. Usted es responsable en última instancia para el pago en su cuenta." "Si tiene alguna pregunta acerca de nuestra políticas de pago, por favor pregunte antes de su visita. Gracias!

He leído y entiendo las políticas de pago establecidas y se les ha ofrecido la oportunidad de hacer preguntas sobre esta política. Entiendo mi responsabilidad de pago de mi cuenta con el Centro de **Children's Eye Center of El Paso** y han proporcionado a lo mejor de mi capacidad la información solicitada con exactitud y completamente."

Firma:_____ **Fecha:**_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

AVISO DE RECONOCIMIENTO DE PRÁCTICAS DE INTIMIDAD

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

Entiendo que conforme al Acto de Responsabilidad y Portabilidad de Seguro Médico de 1996 ("HIPAA") tengo el derecho a la intimidad en cuanto a mi información de salud protegida. Entiendo que esta información será usada para realizar tratamiento, pago y operaciones de asistencia médica.

IF YOU WOULD LIKE A COPY OF THE FULL PRIVACY POLICY, PLEASE ASK THE FRONT DESK

I hereby acknowledge that I have been presented/offered a copy of Children's Eye Center's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

Por este medio reconozco que me han presentado una copia del Aviso del Centro de Ojo de Niños de Prácticas de Intimidad que contienen una descripción más completa del uso.

PATIENT NAME: _____
(nombre de paciente)

SIGNATURE:_____ **DATE:**_____
(firma) Parent/Guardian (fecha)

OFFICE USE ONLY (USO DE OFICINA SÓLO)

I have attempted to obtain the patient's signature in acknowledgement of this **Notice of Privacy Practice Acknowledgement,** but was unable to do so as documented below:

He intentado obtener la firma del paciente en el reconocimiento de este Aviso del Reconocimiento de Práctica de Intimidad, pero era incapaz de hacer para documentó abajo:

Date: _____ Initials: _____ Reason:_____

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PATIENT NAME: _____ DATE OF BIRTH: _____
(nombre de paciente) (feche de nacimiento)

Who is accompanying the patient today?: ☐mom ☐dad ☐grandparent ☐guardian ☐other _____
La persona que acompaña al paciente?: ☐mama ☐papa ☐fomente mama/papa ☐guardián ☐otro _____

Please check either yes or no for each of the following questions: Verifique por favor o sí o no para cada una de las preguntas siguientes

Social History: ☐Student excellent/average/below average ☐Smokers in the home ☐Lives with parents/grandparents/foster care/adopted

Family Ocular/Medical History: Which of the patient's **relatives** have had any of the following? (IN BLANK SPACE RIGHT IN RELATIONSHIP) Historia Familiar: ¿Cuál de los pacientes familiares han tenido cualquiera de los siguientes?

Yes	No		Yes	No	
☐	☐	Blindness (Ceguero)_____	☐	☐	Cataracts in childhood (cataratas en la infancia)_____
☐	☐	Amblyopia (lazy eye) (ojo perezoso) _____	☐	☐	Glaucoma in childhood (Glauoma en la infancia)_____
☐	☐	Patching Treatment(tratamiento de parches)_____	☐	☐	Other serious eye disease (otras graves enfermedades del ojo) _____
☐	☐	Strabismus (crossed eye) (ojo Cruzados)_____	☐	☐	Complications from anesthesia (complicaciones de anesthesia)_____
☐	☐	Eye Muscle Surgery(cirugia del ojo musculo)_____	☐	☐	Genetic disease (in family) (enfermades genetic) _____
☐	☐	Glasses before age 6(Lentes antes de los 6 anos)_____	☐	☐	Other serious illnesses (otras graves enfermedades)_____
☐	☐	Are both parents alive and in good health? (son ambos padres vivos y en buen estado de salud)? _____			

Patient Medical History (medical history and review of symptoms)

Yes	No		Yes	No	
☐	☐	Fever or weight loss (Fiebre de la perdida de peso)_____	☐	☐	Skin rash (la erupcion cutanea)_____
☐	☐	Frequent ear infections (infecciones del oido) _____	☐	☐	Neurologic problems (problemas ,eurologicos)_____
☐	☐	Other ear, nose, or throat problems (problemas de oido, nariz, o garganta)_____	☐	☐	Mental illness (enfermedad mental)_____
☐	☐	Heart problems (problemas del corazon)_____	☐	☐	Sickle cell disease (enfermedad de celulas falciformes)_____
☐	☐	Lung disease (enfermedad pulmonary)_____	☐	☐	Allergies: (alergias)_____
☐	☐	Kidney or urinary disease (enal o urinaria)_____	☐	☐	Missing Immunizations (falta inmunizaciones _____
☐	☐	Arthritis (atritis)_____			
☐	☐	Allergies to medications? (If "yes" list):_____ (Alerigia a los medicamentos? "Si" la lista)			

List previous surgery, hospitalization, major illnesses, or injuries (other than eye problems):_____
(Lista anteriores cirugia, la hospital, las principales enfermedades, o lesions (except de los ojos)

List any medications the patient is taking, including eye drops: _____
(Lista de medicamentos que esto tomando, incluyendo gotas para los ojos)

History of Eye Problems: Has the patient had any of the following and at what age (other than today)? (WRITE IN AGE IN BLANK SPACE)
Historia de problemas de los ojos: el paciente ha tenido alguno de los siguientes y ¿a qué edad?

Yes	No		Age	Yes	No		Age
☐	☐	Last Eye Exam (examen de ojos)	_____ (Do NOT include today)	☐	☐	Eye Injury (lesion en el ojo)	_____
☐	☐	Glasses (lentes)	_____	☐	☐	Eye Surgery (cirugia ocular)	_____
☐	☐	Patching (parches)	_____	☐	☐	Other Eye problems (otros problemas de ojo)	_____

Recent Symptoms los últimos síntomas cuánto tiempo?

Yes	No		How Long?	Yes	No		How Long?
☐	☐	Crossed/wandering eye (ojos cruzados)	_____	☐	☐	Frequent Headaches (Dolores de cabeza frecuentes)	_____
☐	☐	Excessive squinting (excesivo squinting)	_____	☐	☐	Tired eyes when reading (ojos cansados al leer)	_____
☐	☐	Double vision (doble vision)	_____	☐	☐	Weakness or numbness (dedilidad o entumencimiento)	_____
☐	☐	Excessive eye rubbing (excesivo de ojos frontando)	_____	☐	☐	Clumsiness or bumping into things (torpeza o golpes)	_____
☐	☐	Frequent tearing or discharge (lagrimeo o descarga)	_____	☐	☐	Can't make normal eye contact (no puede hacer contacto con los ojos)	_____
☐	☐	Blurred vision (vision borrosa)	_____	☐	☐	Change in performance in school (cambio en la escuela)	_____
☐	☐	Light sensitivity (sensibilidad a luz)	_____	☐	☐	Other symptoms not mentioned above (otras no mencionados)	_____

Birth History (historia de nacimito de pacientes)

Yes	No	(If "YES" what was the problem?)
☐	☐	Pregnancy problems (problemas durante el embarazo)_____
☐	☐	Forceps delivery problems (problemas de forceps)_____
☐	☐	Cesarean section (cesarea) _____

Birth Weight: (peso al naciemento) _____

Yes	No	(If "YES" what was the problem?)
☐	☐	Delivery more than 2-weeks ☐early or ☐late (entrega mas de dos semanas temprano o tarde)
☐	☐	Baby keep in hospital due to illness. What illness? _____ (mantenerse bebes en el hospital)
☐	☐	Delayed development (retraso en el desarrollo) _____

Forms completed by: _____ Relationship : _____

Reviewed by DR. _____ __Date: _____

ALL NEW, INTERMEDIATE (6-MONTH) and 1-YEAR FOLLOW-UP

PATIENT'S EYES ARE DILATED

Your child's eyes may need to be dilated to allow the doctor to look inside and to the back of your child's eye. The dilation drops administered may keep your child's eyes dilated for:

Twenty-four
To
Seventy-Two Hours

_____ _____

Guardian/Responsible Party Signature Date

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Patient's Name: _____DOB: _____

ADVANCE BENEFICIARY NOTICE (ABN)

We expect that your insurance will not pay for ALL item(s) or service(s) that are being administered to you. Your health insurance does not pay for all of your health care costs. Your insurance only pays for covered items and services when insurance rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The purpose of this form is inform you about what services you are receiving, knowing that you might have to pay for them yourself.

Please read this entire notice carefully.

- Ask us to explain, if you don't understand why your insurance probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $_____**), in case you have to pay for them yourself.

_____ _____

Date **Signature of patient or person acting on patient's behalf**

☐**Insurance benefit/deductible has been met. Ok to perform procedure _____** **(initials)**

☐**Patient has paid $_____ today for services not covered by insurance _____** **(initials)**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. Your health information which your insurance sees will be kept confidential by your insurance.

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APPOINTMENT POLICY

You will receive an automated call or text reminding you of your upcoming appointment 48 hours before the appointment. If you do not respond you will receive a live call 24 hours before your upcoming appointment. If you do not answer or confirm, your appointment will be cancelled.

To ensure that we are able to notify you of your upcoming appointment, and to avoid cancellation, please ensure that ***Children's Eye Center of El Paso*** has the most up-to-date contact information on the patient.

Patient's Name: _____DOB: _____

Phone Number: _____

Alternate Phone Number: _____

Please remember to bring your referral to your appointment. Whether or not your Doctor faxed it to us, it is required that we have the **original copy** of the referral.

_____ _____

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance. Your health information which your insurance sees will be kept confidential by your insurance.