



Patient ID# \_\_\_\_\_

Date: \_\_\_\_\_

Lynn Polonski, M.D. • Ovette Villavicencio M.D., Ph.D. • Leslie Weintraub, O.D. •  
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3925 E Ft. Lowell Rd Ste. 100 Tucson Az. 85712 Office: (520)576-5110 Fax: (520)529-7165

WELCOME TO OUR OFFICE!

In order to complete a thorough evaluation of your eye health, please allow 1 ½ - 2 hours for your visit.

Patient's Name \_\_\_\_\_ Sex: M / F \_\_\_\_\_ Single / Married / Widowed / Divorced

Age \_\_\_\_\_ Birthdate (MM/DD/YYYY) \_\_\_\_\_ Patient SS # \_\_\_\_\_

Patient's Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email Address \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_

Responsible Party Name \_\_\_\_\_ Responsible Party SS # \_\_\_\_\_

Relationship to Patient: Self / Spouse/ Parent \_\_\_\_\_ Is Patient: Employed / Student / Disabled / Retired

Employer Name / Address / Phone \_\_\_\_\_ Occupation: \_\_\_\_\_

Who can we speak with pertaining to your Health Care?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Referring Doctor Name & Address \_\_\_\_\_

Primary Care Doctor Name & Address \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Policyholder Name \_\_\_\_\_

Policyholder Name \_\_\_\_\_

Policyholder Sex: M or F Birthdate \_\_\_\_\_

Policyholder Sex: M or F Birthdate \_\_\_\_\_

Pharmacy \_\_\_\_\_ Cross Streets \_\_\_\_\_ Phone# \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I authorize Catalina Eye Care PC to release medical information requested by insurance companies and or correspondence with your other physicians.

This release of medical information and assignment of benefits is considered in force from the date of signing until  
revoked in writing. Patient's Initials \_\_\_\_\_

**Indicate any of the following medical problems in which you may have experienced:**

(Please answer all)

High Blood Pressure	Y/N	Cholesterol	Y/N	Pregnant	Y/N	Asthma	Y/N
Heart Attack	Y/N	Irregular Heartbeat	Y/N	Seizures	Y/N	Pacemaker	Y/N
Arthritis	Y/N	Contact Lens	Y/N	Diabetes	Y/N	Thyroid	Y/N
Abdominal Pain	Y/N	Crohn's Disease	Y/N	Emphysema	Y/N	Tuberculosis	Y/N
Bladder/Kidney	Y/N	Sinus Problems	Y/N	Bronchitis	Y/N	Lupus	Y/N
Hepatitis A	Y/N	Hepatitis B	Y/N	Hepatitis C	Y/N	Fatigue	Y/N
AIDS/HIV	Y/N	Alcohol Use	Y/N	Smoke	Y/N	Seasonal Allergies	Y/N

What is the main reason for your visit today? \_\_\_\_\_

Have you received the Flu- Shot? Yes / No When \_\_\_\_\_

Have you received the Pneumococcal (Pneumonia) Shot? Yes / No When \_\_\_\_\_

Have you fallen in last 6 months? Y/N When \_\_\_\_\_

Any other health problems we should be aware of (example; Family History, Other Medical Surgeries)?:

\_\_\_\_\_

\_\_\_\_\_

Eye medications presently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How old is your current eyeglass/contact lens prescription? \_\_\_\_\_ Years/Months

Who performed your last eye exam? \_\_\_\_\_

Practice Name: \_\_\_\_\_ Phone# \_\_\_\_\_

**Do you have any of the following or a history of the following?**

(Please answer all)

Iritis	Y/N	Retinal Tear/Detachment	Y/N	Eye Injury	Y/N	Lazy Eye/Turned Eye	Y/N
Glaucoma	Y/N	Family history of Glaucoma	Y/N	Cataract	Y/N	Keratoconus	Y/N

Specify any other eye issues: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had eye surgery? Y/N If yes, please explain: \_\_\_\_\_



**REFERRALS:** I understand that obtaining a referral is my responsibility. If I am seen without the necessary authorization and/or referral, I understand that I am liable for all charges. **Patient's Initials**  
\_\_\_\_\_

**VISION INSURANCE vs MEDICAL COVERAGE:**

We often have patients that have both vision and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses, help pay for eyeglasses or contact lenses, and to evaluate the health of their eyes. It is not designed or equipped to deal with medical conditions, diagnosis, and/ or treatment plans.

When a medical diagnosis or condition is present (such as high blood pressure, diabetes, or an eye disease such as infections, dry eyes, allergy, and cataracts, to name just a few) it is necessary to file the claim for your visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered service. Vision insurance does not cover medical eye problems, just as medical insurance does not cover routine vision problems. Our office does not make these rules; they are defined by the insurance carriers themselves.

There is no way to know prior to the examination which type of insurance will apply or with whom our office will be able to file a claim for you. We make every effort to be a provider on every major carrier for your convenience and we will file those claims for you when there is a medical problem. In the event that we do not take your major medical/ vision insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

**Patient's Initials** \_\_\_\_\_

**No Show/Late Cancellation Policy**

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

**A charge of \$50.00 will be assessed for each no-show or late-cancellation office visit appointment if less than 24 hour notice is given\_\_\_\_.(Initial)**

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



## Refraction Billing Policy

A refraction is conducted to measure the strength of the prescription for your glasses. A refraction is also an important tool that aids in the diagnosis and treatment of many eye conditions.

Most insurers, including Medicare, classify this as a “Non-Covered” Service and require that patients be responsible for payment. Federal guidelines require that refractions be billed separately for all patients.

Our staff is expected to collect payment for refractions, currently \$55.00, on the day of service. This is in addition to any co-pay; deductible or other non-covered service charge you may have.

### Patient Waiver and Authorization:

I understand that a refraction is a Non-Covered Service and agree to comply with the above policy. If I choose to have a refraction performed, I accept full responsibility for the cost of this service.

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_





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### INSURANCE ADVANCE BENEFICIARY NOTICE (ABN)

**\*Insurance will only pay for services that it deems medically necessary.**

If my insurance determines that a particular service, although it would otherwise be covered, is not reasonable and medically necessary, they may deny payment for that service. For instance, your insurance may likely deny payment for:

- A-SCAN \$90.00
- Topography \$40.00
- Tomography (OCT) \$45.00
- Pachymetry \$25.00
- Pentacam \$65.00
- Digital Retinal Image \$40.00

**Please read and sign the following statement:**

Most Insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. **I understand that I am responsible for any balance my insurance does not pay.**

Signed: \_\_\_\_\_ . Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ . Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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### Billing Service Agreement.

Please read and initial:

Catalina Eye care will apply its best efforts to obtain reimbursement for all medical consultations, procedures and vision service charges from your insurance(s). the term for this agreement will be effective for three (3) years from the effective start date.

**Patient's initials:** \_\_\_\_\_

I understand and agree signing as a patient, that in consideration of the services to be rendered I hereby individually obligate myself to pay the account of the medical facility (ies) in accordance with the regular fees on the unpaid balance set out by Catalina Eye Care. I understand that payment is due at the time of billing. I understand and agree that if payment is not received within 30 days of initial billing, I may be charged late fees and/or may be subject to be placed with a collection agency. In the event that it becomes necessary to place the account with a collection agency to recover the balance due, an additional interest rate of the principal balance due will be added to help defray the cost of collection.

**Patient's initials:** \_\_\_\_\_

Signed: \_\_\_\_\_ . If not patient, relation: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ . Date: \_\_\_\_/\_\_\_\_/\_\_\_\_