



COHEN OPHTHALMOLOGY
STEVE COHEN, M.D.
“Excellence in Eye care”

It is with great pleasure and true appreciation that I welcome you to my office. Our office is located at 310 North Wilmot Road, Suite 104, Tucson, Arizona 85711.

You will find that we are conveniently located in the Academy Medical Center (Suite 104) at the intersection of Wilmot and Carondelet Roads, near St. Joseph’s Hospital.

Our office is open from 7:45am to 4:30pm Monday through Thursday and 7:45am to 3:30pm on Fridays.

Cohen Ophthalmology was established to provide patients with excellence in eye care. A warm and friendly office with state-of-the-art technology has been created for your comprehensive eye care needs. As an innovator and leader in the ophthalmic community, I will provide only the best care with compassion and trust. Our office is here to assist you in any way possible and to help you with any questions or needs.

Please complete the enclosed patient packet forms and bring the forms with you at the time of your appointment.

In addition, please bring the following items with you:

- A photo ID
- Your insurance card(s)
- A referral (if required by your insurance plan)
- A list of any medications you are currently taking
- Eyeglasses and/or any contact lens packaging of whatever you are currently wearing at this time

I am looking forward to meeting with you and to addressing all of eyecare needs.

Sincerely,

Steve Cohen, M.D.
Medical Director

**COHEN OPHTHALMOLOGY
PATIENT REGISTRATION**

Patient Name (Last): _____ First: _____ Int: _____

Address: _____ Apt #: _____ City, State & Zip: _____

Home Phone: _____ Work Phone: _____ DOB: _____

Patient Social Security #: _____ Male ___ Female ___ Marital Status: M ___ S ___ D ___ W ___

Patient Employer: _____ Address: _____

Occupation: _____ Work Status: _____ Student Status: _____

Your Primary Care Doctor (First/last name): _____ Phone# _____

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Social Security # _____ DOB: _____

How will the bill be paid today? _____

EMERGENCY CONTACT: _____ **PHONE #** _____

Primary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: Employer: _____

Policy Number: _____ Group Number: _____

Co-pay: _____ Deductible: _____

Effective Date of Coverage: _____

Secondary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Co-pay: _____ Deductible: _____

Effective Date of Coverage: _____

Where did you hear about Dr. Cohen? _____

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 Cohen Ophthalmology & Consulting 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

Signature: _____ Date: _____

Cohen Ophthalmology Financial Policy

Welcome to our office! We are pleased that you have chosen Dr. Steve Cohen to provide your care and service. We want to take a moment of your time to inform you of our policies regarding payment with our office.

We accept credit cards, cash and personal checks for payment on your account. If you have insurance which we do not contract with, you will be expected to make a full or partial payment 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.

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, photo ID and all necessary billing information. If you owe on your deductible or owe 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 INSURANCE: 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 Dr. Cohen is not contracted with your health plan, you will be responsible
Initial here for any out of network, coinsurance, or deductible applied.**

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.

RETURNED CHECKS: In the event your bank returns your check to our office unpaid, there will be a \$25.00 return check fee charged to your account.

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 Cohen Ophthalmology & Consulting Inc and have provided to the best of my ability the information requested accurately and completely.

Patients/Responsible Party Signature

Date

Cohen Ophthalmology

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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.

I hereby acknowledge that I have been presented with a copy of Cohen Ophthalmology 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.

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

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:

Date: _____ Initials: _____ Reason: _____

COHEN OPHTHALMOLOGY

Medical History

Date: _____

Patient Name: _____ DOB: ____/____/____

Primary Care Physician: _____ Height: _____ Weight: _____

Medical Condition:

Medication being taken:

_____	_____
_____	_____
_____	_____

If you do not have enough space to write all your medical conditions and medications being taken you may write additional information on the back of this page.

Allergies: (please list all foods and medications)

Patient Eye History; (please check all that apply)

- Cataract Glaucoma Retinal Detachment
 Floaters Injury to the eye Other (please explain below)

Family History: (please check the boxes that apply if any of your immediate family members have/had any of the following conditions)

	<u>Father</u>	<u>Mother</u>	<u>Brother</u>	<u>Sister</u>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other not listed: _____

Surgical History: (please list all ocular and non-ocular surgeries and dates)

